

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
APPELLATE PANEL

Commissioner Susan S. Barden
Commissioner Gene McCaskill
Commissioner Melody L. James

Appellate Case No. 2017-001521

Karen M. Duncan, Employee,

Appellant,

v.

Eaton Corporation, Employer, and
Old Republic Insurance Company,
Carrier,

Respondents.

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SC Court of Appeals

RECORD ON APPEAL

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SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1421162

KAREN M. DUNCAN,

Employee,

Claimant,

vs.

EATON CORPORATION,

Employer,

AND

OLD REPUBLIC INSURANCE CO.,

Carrier,

Defendants.

DECISION AND ORDER

DATE OF HEARING:

Hearing held in Laurens, S.C. on August 30, 2016.

APPEARANCES:

Claimant appeared and represented by Willie J. Peters, Esquire and Darren S. Haley, Esquire of Haley Law Firm. LLC of Greenville, South Carolina.

Defendants represented by J. Russell Goudelock, II, Esquire of McAngus Goudelock & Courie, LLC of Columbia, South Carolina.

PURPOSE OF THE HEARING:

To determine all issues as set forth in Defendants' Form 21.

COMMISSIONER:

Commissioner Avery B. Wilkerson, Jr.

ORDER INSTRUCTIONS ISSUED:

September 6, 2016

FILED:

December 1, 2016

STATEMENT OF THE CASE

Claimant sustained an admitted injury to her left shoulder by accident arising out of and in the course of her employment with Defendant, Eaton Corporation ["Employer"], on September 26, 2014. Defendants furnished medical benefits and temporary disability benefits. Defendants assert that Claimant has reached maximum medical improvement and seek a determination regarding permanent partial specific scheduled loss of use to Claimant's left shoulder.

Claimant asserts that she is entitled to compensation benefits for permanent partial specific scheduled loss of use to her left shoulder. She contends that she needs and is entitled to additional medical evaluation and treatment.

Defendants filed a WCC Form 21 (Employer's Request for Hearing) on February 22, 2016 to pay permanent disability compensation benefits to Claimant.

STIPULATIONS

The parties stipulated at the hearing to the following:

1. At the time of the work injury, Claimant earned average weekly wages of \$548.97 and the applicable compensation rate is \$366.00.
2. The impairment rating of 3% upper extremity assigned by Dr. Anthony Timms is equivalent to an impairment rating of 5% shoulder.
3. The South Carolina Workers' Compensation Commission has appropriate jurisdiction to adjudicate these issues and
4. Venue is appropriate in Laurens County.
5. The file of the South Carolina Workers' Compensation Commission is made a part of the record, with the exception of any self-serving declaration or unstipulated medical

records.

APA SUBMISSIONS AND OTHER EXHIBITS

Pursuant to the South Carolina Administrative Procedures Act, Regulations of the South Carolina Workers' Compensation Commission and other applicable law, the following records were submitted into evidence:

Defendants' APA submissions:

1. Records of Anthony Timms, M.D. dated 10/29/14 through 11/2/15, consisting of 29 pages.
2. Records of Self Regional Healthcare dated 3/17/15, consisting of 3 pages.
3. Records of South Carolina Diagnostic Imaging dated 12/11/14, consisting of 2 pages.
4. Records of Tower Point Family Medicine dated 9/30/14 through 10/7/14, consisting of 8 pages.
5. Records of Genesis Sports & Rehabilitation Services dated 4/1/15 through 9/16/15, consisting of 44 pages.
6. AMA Guides to the Evaluation of Permanent Impairment, 5th Edition (cover pages, pages 433-435, 438, 474-479, 498-499, 505-512, 604, consisting of 23 pages.

Claimant's APA submissions:

1. Records of William DeVault, M.D. dated 5/14/16, consisting of 4 pages.
2. Records of Advanced Physical Therapy, LLC dated 3/9/16, consisting of 7 pages.
3. Records of Anthony Timms, M.D., Lakelands Orthopaedic & Sports Medicine Clinic, dated 10/29/14 through 7/13/15, consisting of 14 pages.
4. Records of Anthony Timms, M.D., Self Regional Healthcare, dated 3/17/15, consisting of 3 pages.
5. Records of Dennis Murphy, M.D., Tower Pointe Family Medicine, dated 10/7/14, consisting of 3 pages.

Defendants' Exhibit:

1. Excerpted portions of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (5th Edition 2001) ["AMA Guides"].

EVIDENCE OF THE CASE

The Claimant is 50 years old. She is a high school graduate and has attended some college courses. She has been employed in the manufacturing business since the 1990's, including prior experience managing or supervising other workers. She has been working for Employer since 2008. Claimant is currently employed with Employer as a final inspector and has been in this position for the past three years.

Claimant was injured on Friday, September 26, 2014 while inspecting jobs. She felt something pull in her left shoulder while trying to open a jammed door while inspecting a cabinet. Claimant timely reported the injury on the following Monday. She was initially referred by Employer to Dr. Dennis Murphy at Tower Pointe Family Medicine and, thereafter, to Dr. Anthony Timms at Lakelands Orthopaedic and Sports Medicine Clinic.

Claimant ultimately underwent arthroscopic shoulder surgery on March 17, 2015. Claimant testified that she experienced pain and numbness in her left ring and pinky fingers after the surgery. Claimant also testified that attending physical therapy caused further left shoulder and neck pain.

Claimant was out of work for approximately six weeks from March 17, 2015 through April 29, 2015. She initially resumed light duty work on or about April 30, 2015. She was allowed to resume full duty work on September 3, 2015.

Claimant last saw Dr. Timms on October 14, 2015. Claimant testified that she reported ongoing pain at that visit. However, Claimant thereafter sought no additional medical evaluation or treatment until Claimant, on referral by Claimant's attorney, underwent a functional capacities

evaluation on March 9, 2016 by Jason, Embler, PT, and a medical evaluation on May 14, 2016 by Dr. William DeVault. She has continued to work with no restrictions since October 15, 2015, but she testified that co-workers will assist her with any lifting or pulling and her supervisor is aware that she requires assistance.

Claimant testified described her physical symptoms and limitations in detail. She takes Aleve on a daily basis, but otherwise does not require any prescription pain medications. Claimant is right-hand dominant and has not missed any additional time from work for her left shoulder condition other than the period of time she missed work following her surgery. Claimant stated that she has used several vacation days because of her shoulder condition since returning to work after surgery.

The medical records submitted into evidence by the parties reflect that Claimant underwent arthroscopic left shoulder surgery by Dr. Timms on March 17, 2015. Dr. Timms released Claimant at maximum medical improvement on October 14, 2015 with no physical restrictions and able to work at full duty. Dr. Timms assigned a 3% impairment rating of the left upper extremity due to slight restriction of abduction and external rotation. The parties stipulate that this upper extremity impairment rating is equivalent to a 5% shoulder impairment rating. Dr. Timms completed a WCC Form 14B (Physician's Statement), dated November 2, 2015, stating that Claimant will not need future medical care for her left shoulder.

Claimant attended a medical evaluation on May 14, 2016 by Dr. William DeVault at the direction of Claimant's attorney. Prior to Dr. DeVault's evaluation, her attorney also had Claimant undergo a functional capacities evaluation on March 9, 2016 performed by Jason Embler, PT, on March 9, 2016. Dr. DeVault stated that Claimant's permanent impairment is 53% to her left shoulder. He assigned light duty work restrictions and concluded that Claimant

would need four physician visits and sixteen physical therapy visits per year for treatment of acute exacerbations of her left shoulder conditions. Claimant testified that she was still limited by pain when she saw Mr. Embler and Dr. DeVault.

It is noteworthy in the medical records that Claimant has experienced some symptoms in her neck and the fingers of her left hand. MRI of her neck was normal and nerve testing of Claimant's upper extremity reflected left cubital tunnel syndrome. Claimant separately treated for these conditions under her group health insurance and was experiencing limiting and related symptoms during the times of her functional capacities evaluation by Mr. Embler and medical evaluation by Dr. DeVault. Claimant underwent left ulnar nerve surgery on June 6, 2016. Dr. Timms opined that these conditions were not related to Claimant's work injury.

The relevant portions of the *AMA Guides* reflect that Dr. DeVault inappropriately calculated Claimant's impairment rating.

FINDINGS OF FACT

1. Claimant sustained a compensable work injury on September 26, 2014 to her left shoulder only. I base this finding upon stipulation of the parties, Claimant testimony and the parties' medical evidentiary submissions, including Defendants' APA pp. 27-29.

2. Claimant did not sustain any other or additional injury, including but not limited to no injury to her neck, left arm, left hand or left fingers, by accident or repetitive trauma arising out of or in the course of her employment with Employer. I base this finding upon the Claimant's testimony and the parties' medical evidentiary submissions, including Defendants' APA pp. 27-29.

3. At the time of the work injury, Claimant earned average weekly wages of \$548.97 and the applicable compensation rate is \$366.00 weekly. I base this finding upon stipulation of the parties.

4. Claimant was out of work because of injury from March 17, 2015 through April 29, 2015. Defendants furnished appropriate weekly temporary disability compensation benefits to Claimant. I base this finding upon Claimant's testimony and filed documents contained within the Workers' Compensation Commission's file.

5. Claimant returned to work at light duty on April 30, 2015 and has continued to work at full duty without restrictions since September 2, 2015. I base this finding upon Claimant's testimony and filed documents contained within the Workers' Compensation Commission's file.

6. Dr. Anthony Timms, Claimant's treating physician, assigned Claimant a permanent impairment rating of 3% to the left upper extremity, which is equivalent under the *AMA Guides* to an impairment rating of 5% to the left shoulder. I base this finding upon the parties' medical evidentiary submissions, Defendants' Exhibit No. 1 and the stipulation of the parties.

7. Dr. William DeVault evaluated Claimant on one occasion only and assigned Claimant a permanent impairment rating of 53% to her left shoulder. Dr. DeVault's impairment rating does not appropriately follow the *AMA Guides*. It is based upon an erroneous combination of multiple medical conditions and erroneous calculations. An appropriate calculation, based upon findings reflected in Dr. DeVault's medical report, would reflect an impairment rating of 13% to the left shoulder. I base this finding upon the Claimant's APA pp. 1-4 and Defendants' Exhibit No. 1.

8. Dr. Anthony Timms is the authorized treating physician. He evaluated Claimant's condition and followed Claimant's progress on multiple occasions for almost one year. Greater weight is attributed to Dr. Timms' medical opinion. I base this finding upon Claimant's testimony and the parties' medical evidentiary submissions.

9. Claimant has sustained 10% permanent partial specific scheduled loss of use to her left shoulder. I base this finding upon the Claimant's testimony, Defendants' Exhibit No. 1 and the parties' medical evidentiary submissions.

10. Defendants have provided Claimant with appropriate medical care because of her work injury. I base this finding upon the Claimant's testimony and the parties' medical evidentiary submissions.

11. Claimant has not required any additional medical treatment for her left shoulder since October 14, 2015. I base this finding upon Claimant's testimony and the parties' medical evidentiary submissions.

12. Claimant reached maximum medical improvement on October 14, 2015. I base this finding upon Claimant's testimony and the parties' medical evidentiary submissions, including Defendants' APA pp. 27-29.

13. No further medical treatment or evaluation after October 14, 2015 will effect a cure, give relief or tend to lessen any period of Claimant's disability. I base this finding upon Claimant's testimony and the parties' medical evidentiary submissions.

CONCLUSIONS OF LAW

1. The parties to this proceeding are subject to and bound by the provisions of the South Carolina Workers' Compensation Act.

2. Pursuant to S.C. Code Ann. Sections 42-1-40, 42-1-150, 42-9-30(14) and other applicable law, Claimant is entitled to compensation benefits for 10% permanent partial specific scheduled loss of use to her right shoulder at a compensation rate of \$366.00 weekly for thirty weeks commencing effective October 15, 2015. Such benefits shall be paid to Claimant in an appropriate lump sum.

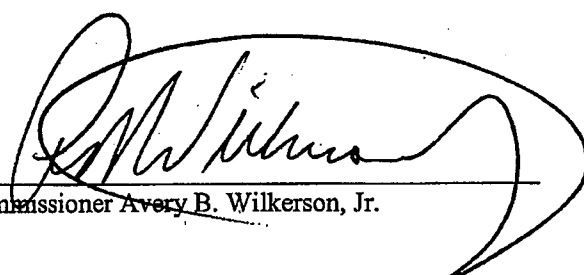
3. Pursuant to S.C. Code Ann. Sections 42-1-120, 42-15-60 and other applicable law, Claimant is entitled to no further medical evaluation or treatment to Claimant after October 14, 2015.

ORDER

IT IS HEREBY ORDERED that Defendants shall pay to Claimant, in a lump sum, disability compensation benefits commencing effective October 15, 2015 at a compensation rate of \$366.00 weekly for thirty weeks.

AND IT IS SO ORDERED.

S.C. WORKERS' COMPENSATION COMMISSION



Commissioner Avery B. Wilkerson, Jr.

CERTIFICATE OF SERVICE

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

to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).
December 1, 2016

By: Elaine Boyd, Administrative Assistant to Commissioner Wilkerson

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

W.C.C. FILE NO: 1421162

Karen M. Duncan,

**EMPLOYEE,
CLAIMANT/RESPONDENT**

vs.

Eaton Corporation,

EMPLOYER,

and

Old Republic Insurance Company,

**CARRIER,
DEFENDANTS/APPELLANTS.**

Appellate Panel Review held in Columbia, South Carolina on March 21, 2017
pursuant to Notices timely and properly served upon all parties of interest.

Appellate Panel Decision and Order Filed: June 13, 2017

APPEARANCES: Claimant/Appellant represented by Willie J. Peters, Esquire and Darren S. Haley, Esquire

Defendants/Respondents represented by J. Russell Goudelock, II

STATEMENT OF THE CASE

Claimant sustained an admitted injury to her left shoulder by accident arising out of and in the course of her employment with Defendant, Eaton Corporation ["Employer"], on September 26, 2014. Defendants furnished medical benefits and temporary disability benefits. Defendants asserted that Claimant has reached maximum medical improvement and sought a determination regarding permanent partial specific scheduled loss of use to Claimant's left shoulder.

Claimant asserted that she is entitled to compensation benefits for permanent partial specific scheduled loss of use to her left shoulder. She also contended that she needs and is entitled to additional medical evaluation and treatment.

Defendants filed a WCC Form 21 (Employer's Request for Hearing) on February 22, 2016 to pay permanent disability compensation benefits to Claimant. A hearing was held on August 30, 2016 in Laurens, South Carolina before Commissioner Avery B. Wilkerson, Jr. Commissioner Wilkerson issued a Decision and Order on December 1, 2016, finding that the Claimant sustained 10% permanent partial specific scheduled loss of use to her left shoulder. The Claimant filed a Form 30 (Request for Commission Review) seeking review by the Full Commission and taking exception to Commissioner Wilkerson's permanent disability award.

In the appellate review, the Appellate Panel shall, pursuant to S.C. Code Ann. §42-17-50, review the award, weigh the evidence that was presented at the initial hearing and, if good grounds be shown therefore, make its own Findings of Fact and reach its own Conclusions of Law consistent with or inconsistent with those of the Hearing Commissioner.

On March 21, 2017, oral arguments were presented before the Appellate Panel. Based upon oral arguments, review and consideration of the parties' Appellate Briefs, review of the

hearing transcript, review of submitted documentary evidence of record, and review of the portions of the Workers' Compensation Commission's file admitted into the record, the Appellate Panel affirms the Decision and Order of the Single Commissioner. Accordingly, the following Findings of Fact and Conclusions of Law shall become the law of the case and, therefore, the Decision and Order of the Hearing Commissioner is hereby **AFFIRMED** in its entirety.

FINDINGS OF FACTS AND RULINGS OF LAW

1. Claimant sustained a compensable work injury on September 26, 2014, to her left shoulder only.

2. Claimant did not sustain any other or additional injury, including but not limited to an injury to her neck, left arm, left hand or left fingers, by accident or repetitive trauma arising out of or in the course of her employment with Employer.

3. At the time of the work injury, Claimant earned average weekly wages of \$548.97 with an applicable compensation rate of \$366.00.

4. Claimant was out of work because of injury from March 17, 2015 through April 29, 2015. Defendants furnished appropriate weekly temporary disability compensation benefits to Claimant.

5. Claimant returned to work at light duty on April 30, 2015 and has continued to work at full duty without restrictions since September 2, 2015.

6. Dr. Anthony Timms, Claimant's treating physician, assigned Claimant a permanent impairment rating of 3% to the left upper extremity, which is equivalent under the *AMA Guides* to an impairment rating of 5% to the left shoulder.

7. Dr. William DeVault evaluated Claimant on one occasion only and assigned Claimant a permanent impairment rating of 53% to her left shoulder. Dr. DeVault's impairment rating does not appropriately follow the AMA Guides. It is based upon an erroneous combination of multiple medical conditions and erroneous calculations. An appropriate calculation, based upon findings reflected in Dr. DeVault's medical report, would reflect an impairment rating of 13% to the left shoulder.

8. Dr. Anthony Timms is the authorized treating physician. He evaluated Claimant's condition and followed Claimant's progress on multiple occasions for almost one year. Greater weight is attributed to Dr. Timms' medical opinion.

9. Claimant has sustained 10% permanent partial specific scheduled loss of use to her left shoulder.

10. Defendants have provided Claimant with appropriate medical care because of her work injury.

11. Claimant has not required any additional medical treatment for her left shoulder since October 14, 2015.

12. Claimant reached maximum medical improvement on October 14, 2015.

13. No further medical treatment or evaluation after October 14, 2015 will effect a cure, give relief, or tend to lessen any period of Claimant's disability.

CONCLUSIONS OF LAW

1. The parties to this proceeding are subject to and bound by the provisions of the South Carolina Workers' Compensation Act.

2. Pursuant to S.C. Code Ann. Sections 42-1-40, 42-1-150, 42-9-30(14) and other applicable law, Claimant is entitled to compensation benefits for 10% permanent partial specific

scheduled loss of use to her right shoulder at a compensation rate of \$366.00 weekly for thirty weeks commencing effective October 15, 2015. Such benefits shall be paid to Claimant in an appropriate lump sum.

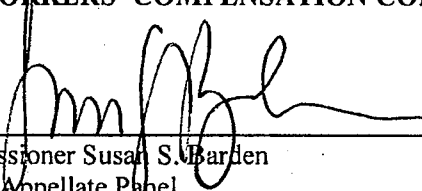
3. Pursuant to S.C. Code Ann. Sections 42-1-120, 42-15-60 and other applicable law, Claimant is entitled to no further medical evaluation or treatment to Claimant after October 14, 2015.

ORDER

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the Order of the Single Commissioner is hereby **AFFIRMED IN FULL**, and the Findings of Fact and Conclusions of Law set forth above are the final decision of the Workers' Compensation Commission. Accordingly, Claimant is entitled to receipt, in a lump sum, of disability compensation benefits commencing effective October 15, 2015 at a compensation rate of \$366.00 weekly for thirty weeks.

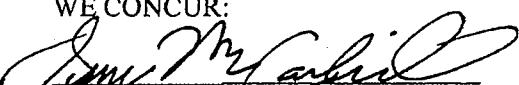
IT IS SO ORDERED.

S.C. WORKERS' COMPENSATION COMMISSION

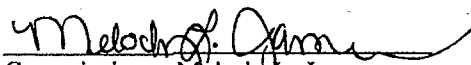


Commissioner Susan S. Barden
For the Appellate Panel

WE CONCUR:



Commissioner Gene McCaskill



Commissioner Melody L. James

CERTIFICATE OF SERVICE

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

By Valerie Deller on June 13, 2017

Karen Martin Duncan

SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. 1421162

KAREN DUNCAN,
 Claimant,
 vs.
EATON CORPORATION and
OLD REPUBLIC INSURANCE
COMPANY, c/o SEDGWICK
CLAIMS MANAGEMENT SERVICES,
INC.,
 Employer/Insurer.

DEPOSITION OF KAREN MARTIN DUNCAN

DATE TAKEN: May 11, 2016
TIME BEGAN: 3:00 p.m.
TIME ENDED: 3:48 p.m.
LOCATION: Haley Law Firm
1007 Pendleton Street
Greenville, South Carolina

REPORTED BY: Eileen Thompson, CCR
EveryWord, Inc.
P.O. Box 1459
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15 803-227-2261
16 rhughey@mgclaw.com
17 Representing the Employer/Insurer

18 Also Present: Mr. Randolph Duncan
19
20
21
22
23
24
25

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9	E X H I B I T S	
10	(None marked.)	

1 (It is hereby stipulated and agreed
2 by and between counsel for the respective
3 parties that this deposition is being
4 taken in accordance with the South
5 Carolina Workers' Compensation Commission
6 and the Administrative Procedures Act; and
7 that the deponent reserves reading and
8 signing of this deposition transcript.)

9 - - -

10 KAREN MARTIN DUNCAN, after having been
11 first duly sworn, was examined and
12 testified as follows:

13 - - -

14 EXAMINATION

15 - - -

16 BY MR. HUGHEY:

17 Q. Ms. Duncan, my name is Rocky Hughey. My
18 law firm represents Eaton and their insurance
19 carrier in your Workers' Compensation claim.

20 A. Okay.

21 Q. I'm here to take your deposition today.
22 Have you ever done this before?

23 A. Yes.

24 Q. Okay. How long ago was your last
25 deposition?

1 A. I don't know. I'm not exactly sure of the
2 year. Maybe 10 plus.

3 Q. Fair enough. Well, I'll give you a little
4 refresher as to how this works. I'm going to ask
5 you a bunch of questions. I'm going to get some
6 background information from you. I'm going to ask
7 you about your education, your work history, and
8 I'm, of course, going to ask you about your accident
9 at Eaton.

10 A. Okay.

11 Q. If I ask you a question that you don't
12 understand, or if I ask a question that doesn't make
13 any sense to you, just ask me to rephrase the
14 question. I'll be happy to do that, okay?

15 A. Okay.

16 Q. Also, as you're doing so far right now,
17 speak loudly and clearly, and give verbal responses
18 to my questions rather than just shaking your head
19 or nodding your head.

20 A. Okay.

21 Q. Also, during the course of the deposition,
22 there are going to be times that I'm going to be
23 very obvious about what my question is going to be.
24 Try to let me finish my question so the court
25 reporter can take down what you're saying, because

1 it's difficult if you and I talk at the same time,
2 okay?

3 A. Okay.

4 Q. Ms. Duncan, I'm normally quick and easy.
5 in your case, it's pretty straight forward. Your
6 injury is admitted, so hopefully we will get you out
7 of here in 30 or 40 minutes or so. But if you feel
8 like you need to take a break during the deposition,
9 just let me know, and I will be happy to do that,
10 all right?

11 A. All right.

12 Q. Ms. Duncan, can you state your full name
13 for the record, please.

14 A. Karen Martin Duncan.

15 Q. And how old are you now, Ms. Duncan?

16 A. 50.

17 Q. What's your date of birth?

18 A. [REDACTED] DOB [REDACTED], 1965.

19 Q. Where are you living right now? Where do
20 you live?

21 A. Greenwood, South Carolina.

22 Q. In Greenwood?

23 A. Yes.

24 Q. All right. And I know Eaton has several
25 plants. Which plant do you work at?

1 A. The main plant.

2 Q. Is that in Greenwood?

3 A. Yes.

4 Q. When did you start at Eaton?

5 A. July 2008.

6 Q. Oak. Fair enough. You mentioned that you
7 live in Greenwood. What's your address there?

8 A. **Address**

9 Q. How long have you been living at that
10 address?

11 A. 23 years.

12 Q. Is this a house that you own?

13 A. Yes.

14 Q. And I take it your husband lives with you?

15 A. Yes.

16 Q. What's your husband's name?

17 A. Randolph Duncan.

18 Q. I don't want to put you on the spot since
19 he's here, but how long have you and Mr. Duncan been
20 married?

21 A. 18 years.

22 Q. Good for you. Do you and Mr. Duncan have
23 any children?

24 A. Yes.

25 Q. How many children do you have by Mr.

1 Duncan?

2 A. By Mr. Duncan, two.

3 Q. Do they still live with you?

4 A. One does.

5 Q. How old is that child?

6 A. 24.

7 Q. And that child is still dependent upon you
8 for support or housing?

9 A. Yes.

10 Q. And do you have any children from a prior
11 relationship?

12 A. Yes.

13 Q. How many children do you have other than
14 the two you have with Mr. Duncan?

15 A. Five.

16 Q. Five other children?

17 A. Yes.

18 Q. Fair enough. Are any of those children
19 still dependent upon you for support?

20 A. No.

21 Q. How far did you go in school, Ms. Duncan?

22 A. Graduated high school and have some
23 college courses.

24 Q. Okay. What high school did you attend?

25 A. McCormick High.

1 Q. That's close to Greenwood, right?

2 A. Yes.

3 Q. Are you from that area originally, born
4 and raised?

5 A. Yes.

6 Q. What year did you graduate from McCormick?

7 A. 1983.

8 Q. And you mentioned that you also had some
9 college courses. Where did you take classes?

10 A. Piedmont Technical.

11 Q. Was that right after high school or
12 sometime later?

13 A. Later.

14 Q. What kind of classes did you take at
15 Piedmont Tech?

16 A. I was starting to my business major, so
17 math, different, you know.

18 Q. How long did you take classes there at
19 Piedmont Tech?

20 A. I did the first and part of the second
21 semester.

22 Q. Have you ever served in the military?

23 A. No.

24 Q. Do you have a South Carolina driver's
25 license?

1 A. Yes.

2 Q. Did you drive to your deposition today?

3 A. No.

4 Q. Your husband drove?

5 A. Yes.

6 Q. Do you have any restrictions on your
7 license?

8 A. No.

9 Q. Any particular reason that your husband
10 drove other -- was it a medical reason or anything
11 like that?

12 A. No.

13 Q. You mentioned that you graduated from
14 McCormick in 1983. Did you begin working at that
15 time, Ms. Duncan?

16 A. No.

17 Q. What were you doing? I know you had some
18 children at some point.

19 A. Yes.

20 Q. I assume that took up a good bit of your
21 time?

22 A. Yes.

23 Q. All right. Were you a stay-at-home mom
24 for a number of years?

25 A. I was still living with my mother, so I

1 was still home with my parents.

2 Q. Fair enough. What's the first job you
3 remember having out of high school?

4 A. Well, actually I drove school buses during
5 high school.

6 Q. When you were still in high school?

7 A. Yes.

8 Q. I remember that when I was a kid. So you
9 drove school buses while you were a high school
10 student, then you graduated. What do you remember
11 doing for work after that?

12 A. Summer jobs, you know. I had little
13 summer jobs after high school, you know, like doing
14 baby-sitting and stuff like that, and then to
15 Greenwood, my first real job was **WORK HISTORY**.

16 Q. And what did you do at **WORK HISTORY**?

17 A. Register, fix treats.

18 Q. How long did you work there?

19 A. I can't remember.

20 Q. Fair enough. Did you have any long terms
21 of employment anywhere before you came to Eaton,
22 say, you know, five, ten years at one place of
23 employment?

24 A. Yes.

25 Q. Where did you work before coming to Eaton

1 for a long period of time?

2 A. I worked for WORK HISTORY.

3 Q. And I believe their plant is also in
4 Greenwood, isn't it?

5 A. Yes.

6 Q. What did you do there?

7 A. Well, when I left, I was a team leader.

8 Q. Team leader?

9 A. Yes.

10 Q. And what were some of your job duties at
11 WORK HISTORY?

12 A. I started as a chemical mix, then I got a
13 promotion to team lead, so just basically managing
14 the shift. I had like nine -- depending on how the
15 shift fell, sometimes it would be nine, sometimes it
16 would be up to twenty, so it depends on how the
17 shift ran scheduling.

18 Q. This is nine to twenty other employees?

19 A. Yes.

20 Q. How long did you work at WORK HISTORY?

21 A. Seven years.

22 Q. How did your employment come to an end
23 there?

24 A. The plant closed.

25 Q. And when did that plant close?

1 A. It was 2007, I want to say.

2 Q. What did you do for work after **WORK HISTORY**?

3 A. I took about three months off, and then I
4 went to **WORK HISTORY**.

5 Q. What did you do for them?

6 A. Lab work, same thing. Lab work.

7 Q. And I believe you told me that you started
8 at Eaton, in 2008, is that correct?

9 A. Yes.

10 Q. And have you been employed at Eaton since
11 2008?

12 A. Yes.

13 Q. Have you worked anywhere else other than
14 Eaton since 2008?

15 A. No.

16 Q. Do you have any source of income right now
17 other than the wages you earn at Eaton?

18 A. No.

19 Q. Just going back over your history, Ms.

20 Duncan, it looks like you began working at **WORK HISTORY**

21 **WORK HISTORY**; you mentioned **WORK HISTORY**; you mentioned

22 **WORK HISTORY**; of course, you worked at Eaton.

23 Any other real jobs you remember having through the
24 years?

25 A. Yes, I worked for **WORK HISTORY**.

- 1 Q. **WORK HISTORY**?
- 2 A. Yes.
- 3 Q. Where are they located?
- 4 A. They're in Greenwood as well.
- 5 Q. How long did you work for them?
- 6 A. I'm not sure of the exact amount of time I
- 7 worked with them. I really don't know.
- 8 Q. How did your employment come to an end
- 9 there?
- 10 A. Ended up being terminated.
- 11 Q. Ms. Duncan, have you been arrested for any
- 12 reason in the last 10 years?
- 13 A. No.
- 14 Q. You shared with me your educational
- 15 background. I take it you have no problems reading
- 16 and writing?
- 17 A. No problems.
- 18 Q. And I assume you can do basic math? Add,
- 19 subtract?
- 20 A. Yes.
- 21 Q. How about working with a computer? Do you
- 22 have any experience working with a computer at Eaton
- 23 or through any other of your jobs?
- 24 A. Yes, my job requires me to work with a
- 25 computer.

1 Q. Do you use an e-mail address at Eaton?

2 A. Yes.

3 Q. Let's see. I've got a date of injury
4 listed for you, Ms. Duncan, as September 26, 2014.
5 Does that sound about right to you?

6 A. September --

7 Q. 26th, 2014.

8 A. Yes.

9 Q. Had you ever been injured on the job prior
10 to this injury on September 26th, 2014?

11 A. At Eaton?

12 Q. Anywhere.

13 A. Yes, I have.

14 Q. Okay. When is the first time you remember
15 being injured on the job?

16 A. I was injured at **WORK HISTORY**.

17 Q. What body part or parts did you injure?

18 A. Pulled a muscle in my chest.

19 Q. Did you miss any time from work?

20 A. Yes.

21 Q. Did that case wind up settling? Did you
22 get any compensation for your injuries?

23 A. Yes.

24 Q. Did you go back to work at **WORK HISTORY**

25 **WORK HISTORY** after that case?

1 A. No.

2 Q. Do you have any ongoing problems as a
3 result of that accident?

4 A. No.

5 Q. Have you had any other injuries on the job
6 in the past other than the one you mentioned at
7 **WORK HISTORY** and, of course, the one we're
8 here for today in September 2014?

9 A. **WORK HISTORY**

10 Q. What happened at **WORK HISTORY**?

11 A. I want to say my neck, shoulder, or
12 something. It was neck, I think it was.

13 Q. And this is -- you mentioned **WORK HISTORY**
14 **WORK HISTORY** in Greenwood. I assume it's the same
15 company?

16 A. Yes, it is.

17 Q. Around what time was it that you worked
18 for **WORK HISTORY**? Would that have been
19 before **WORK HISTORY**?

20 A. Yes.

21 Q. And so if you worked at **WORK HISTORY** for about
22 seven years -- I think you told me their plant
23 closed in 2007?

24 A. Yes.

25 Q. So maybe this injury at **WORK HISTORY**

1 **WORK HISTORY** was sometime in the 1990s?

2 A. Possible, yes.

3 Q. And you believe this was your neck?

4 A. I can't remember what it was.

5 Q. Fair enough.

6 A. I was much younger. Don't want to say,
7 you know.

8 Q. Did you have any ongoing problems after
9 that accident?

10 A. No.

11 Q. So really, as we sit here now, you're not
12 100 percent sure about what it was that you injured
13 in that accident at **WORK HISTORY**?

14 MR. PETERS: I would object to the form.

15 THE WITNESS: I can't remember exactly,
16 I'll be honest with you.

17 EXAMINATION RESUMED BY MR. HUGHEY:

18 Q. Fair enough. Do you know if your hurt
19 your left shoulder in that accident?

20 A. No, it was my -- no, it wasn't my left
21 shoulder.

22 Q. Do you know if you hurt your right
23 shoulder?

24 A. Like I said, I know it wasn't my shoulder.
25 If I'm not mistaken, it was my neck.

1 Q. All right. Any other work injuries in the
2 past other than the one you mentioned at
3 **WORK HISTORY**; the one at **WORK HISTORY**
4 **WORK HISTORY**; and the one that we're here for today?

5 A. No.

6 Q. Those are the only three work injuries in
7 the past?

8 A. Yes.

9 Q. Had you ever injured your left shoulder --
10 work or not, had you ever injured your left shoulder
11 before September 26th, 2014?

12 A. No.

13 Q. Had you received any medical treatment for
14 your left shoulder for any left shoulder problems
15 prior to September 26th, 2014?

16 A. No.

17 Q. Fair enough. Who is your family doctor,
18 Ms. Duncan?

19 A. Patricia Goodman.

20 Q. And where is Dr. Goodman located?

21 A. Ninety Six, South Carolina. The name has
22 changed. It used to be Piedmont Health Group, so
23 they've changed it, and I haven't been in there
24 recently.

25 Q. Fair enough. When is the last time you

1 saw Dr. Goodman?

2 A. I want to say last year sometime.

3 Q. Have you seen Dr. Goodman for any of the
4 injuries that you're claiming as a result of this
5 September 26th, 2014 accident?

6 A. No.

7 Q. Do you see anyone else there other than
8 Dr. Goodman?

9 A. Well, sometimes if she's not available, I
10 see one of the doctors there.

11 Q. Do you have any chronic health conditions
12 that you treat for; high blood pressure, diabetes,
13 anything like that?

14 A. Yes, hypertension.

15 Q. Do you take medication for that?

16 A. Yes.

17 Q. Are you taking any other medication right
18 now for any reason other than your high blood
19 pressure medication?

20 A. Just over-the-counter pain reliever.

21 Q. What do you take over-the-counter?

22 A. Aleve.

23 Q. How often do you take Aleve?

24 A. Two every day -- every morning.

25 Q. Is this for your shoulder injury?

1 A. Yes.

2 Q. Ms. Duncan, do they pay you hourly at
3 Eaton?

4 A. Yes.

5 Q. How much money were you earning an hour at
6 the time of this accident in September 2014?

7 A. I'm not sure --

8 Q. Fair enough.

9 A. -- because there's been raises, you know.

10 Q. But you're a full-time employee there?

11 A. Yes.

12 Q. So you would have been working full-time
13 at the time of this injury?

14 A. Yes.

15 Q. Who was your supervisor at the time of
16 this injury back in September 2014?

17 A. Amanda Nix.

18 Q. Is Amanda still your supervisor?

19 A. No.

20 Q. Who is your supervisor now?

21 A. Lorrie Esco.

22 Q. How is your relationship with Ms. Esco?
23 Do you guys get along well?

24 A. Yes.

25 Q. Can you describe for me, in your own

1 words, Ms. Duncan, what happened to you on September
2 26th, 2014 that resulted in your injury?

3 A. Yes. I was opening a door on a job to do
4 an inspection on, and the door was jammed, so I was
5 pulling at it. And I felt something, but I didn't
6 think anything of it, you know, so I kept working,
7 you know. So as the night proceeded -- well, the
8 evening proceeded, I finished up what I was doing
9 and I left for the evening.

10 Q. All right. When did you report the
11 injury?

12 A. Monday night on September 29th, I want to
13 say.

14 Q. You didn't injure your shoulder outside of
15 work?

16 A. No.

17 Q. What is your job title at Eaton?

18 A. Final inspector.

19 Q. Final inspector?

20 A. Yes.

21 Q. And were you working as a final inspector
22 at the time of this accident?

23 A. Yes.

24 Q. At Eaton, do you guys make the -- is it
25 the panels there at the plant? What do you make

1 there?

2 A. We make the switch gear for -- to power
3 like an entire town.

4 Q. When you say that you were opening a door,
5 is this a door, like you have to a room, or is this
6 a door on one of the --

7 A. On one of the units. It's on our unit.

8 Q. And what would the purpose of opening the
9 door be? Was that part of the inspection?

10 A. Yes.

11 Q. Is a panel typically at waist height? Is
12 it higher than that? Can you describe for me what
13 the panel would be?

14 A. The panel is -- it's overhead.

15 Q. Overhead?

16 A. Overhead panel.

17 Q. How tall are you, Ms. Duncan?

18 A. Five eight.

19 Q. So you went home that night and you
20 started having more pain in the shoulder, is that
21 fair to say?

22 A. It was sore -- the next morning, it was
23 sore.

24 Q. When did you report it?

25 A. On Monday.

- 1 Q. Monday night, is that what you told me?
- 2 A. Yes.
- 3 Q. Who did you report it to?
- 4 A. Amanda Nix.
- 5 Q. What did she tell you when you reported
- 6 your shoulder injury?
- 7 A. She asked me to come in and fill the
- 8 report out the next morning, that she would speak
- 9 with the safety guy first thing that morning.
- 10 Q. Now, at some point, they sent you to the
- 11 doctor, is that correct?
- 12 A. Yes.
- 13 Q. And I believe you saw a Dr. Murphy
- 14 originally. Is that where Eaton sent you?
- 15 A. Yes.
- 16 Q. Where were you feeling pain, let's say, at
- 17 the time you reported this injury on Monday night
- 18 after your injury?
- 19 A. My shoulder.
- 20 Q. All right. This is your left shoulder?
- 21 A. Yes.
- 22 Q. Were you feeling pain anywhere else at
- 23 that time?
- 24 A. No.
- 25 Q. You did mention that they sent you -- you

1 told me they sent you to Dr. Murphy, and did he take
2 a look at your shoulder?

3 A. Yes.

4 Q. When you were treating with Dr. Murphy,
5 were you having problems anywhere other than your
6 left shoulder?

7 A. No.

8 Q. It looks like they then got you to an
9 orthopedist, Dr. Timms, who I think is in Greenwood,
10 is that correct?

11 A. Yes.

12 Q. Did Dr. Murphy refer you to Dr. Timms?

13 A. Yes.

14 Q. How did you like your treatment with Dr.
15 Timms as a doctor? How did you like him?

16 A. He was a kind of quick and fast doctor.

17 Q. All right. Meaning at the time of your
18 visits and things like that, you would have liked
19 for him to have spent more time with you?

20 A. Yes.

21 Q. It looks like according to my file, Ms.
22 Duncan, you were out of work from March 17th, 2015
23 until April 29th, 2015, so a little over a month.
24 Does that sound about right to you?

25 A. Yes.

1 Q. So after this injury, you continued
2 working for a while?

3 A. Light duty.

4 Q. Light duty?

5 A. Yes.

6 Q. What kinds of things did they have you
7 doing while you were on light duty?

8 A. Just computer work and like updating job
9 folders, stuff like that.

10 Q. Did you feel like Eaton respected and
11 accommodated your work restrictions?

12 A. Yes, to a point. I was asked on several
13 occasions to inspect jobs, which I did report to my
14 attorney and my doctor.

15 Q. Who asked you to inspect jobs?

16 A. I was asked by a supervisor to look at a
17 job.

18 Q. While you were on light duty?

19 A. Yes.

20 Q. Did you tell the supervisor you were on
21 light duty?

22 A. Yes.

23 Q. What did the supervisor tell you?

24 A. Just after I stated that, they said not to
25 do it.

1 Q. All right. So you didn't actually inspect
2 panels when you were on light duty, but you were
3 asked to do it?

4 A. Yes, I was asked to do it. Well, actually
5 I looked at them, but not to the point of going in
6 the unit, because my arm was in a sling.

7 Q. Fair enough. It looks like Dr. Timms
8 performed the surgery, and this was on your left
9 shoulder obviously. Did the surgery help you at all
10 in terms of the pain you were having?

11 A. Sometimes it helps. Most of the time I'm
12 still in pain. I'm still having problems now.

13 Q. Is your shoulder better now than it was
14 before the surgery?

15 A. No.

16 Q. Is your shoulder worse now than it was
17 before the surgery?

18 A. Yes.

19 Q. How is your shoulder worse now?

20 A. I don't have full range of motion.

21 Q. Did you have full range of motion prior to
22 the surgery?

23 A. Yes.

24 Q. It looks like he did the surgery in March,
25 and then you returned to work, like we said earlier,

1 I believe, sometime in the next month, and at some
2 point, you went back to work full duty, is that
3 correct?

4 A. Yes.

5 Q. Are you working full duty now?

6 A. Per se full duty, but I don't do the
7 lifting and pulling, I'm assisted with that.

8 Q. All right. Who helps you do that?

9 A. Co-workers.

10 Q. Is it your understanding that Dr. Timms
11 released you to work full duty?

12 A. Yes.

13 Q. Do you believe you're capable of full duty
14 work, or do you think that you ought to have some
15 restrictions?

16 A. Restrictions.

17 Q. Okay. What kind of things are you not
18 able to lift that you used to be able to lift before
19 this injury?

20 A. Within the switch gear, we will have an
21 actual drawer that will have -- sometimes it has VTs
22 in them, sometimes they have CPTs in them, which are
23 transformers pretty much, and you have to go up a
24 ladder to pull that drawer out. I'm not capable --
25 well, first of all, you have to lift rails that's

1 pretty heavy to roll the drawers out to be able to
2 inspect. So like I say, a co-worker will lift the
3 rails, and put them in, and pull the drawer out for
4 me. Now, I will go up on the ladder and look on the
5 inside to make sure everything is there as far as
6 what the customer ordered.

7 Q. So in terms of your job duties, you go up
8 a ladder and you look in there, but you're not able
9 to pull the drawers out, is that your testimony?

10 A. Exactly.

11 Q. All right. So you always have somebody
12 pulls the drawers out for you?

13 A. The only time I don't, if it's just a fuse
14 drawer, which is light.

15 Q. So the fuse drawer is the lighter one?

16 A. Yes.

17 Q. What's the other kind of drawer called?

18 A. CPT or VT, and sometimes both are in
19 there. The majority of the time both are in there.

20 Q. So the VT or the CPT will be in the
21 drawer?

22 A. Yes.

23 Q. And those are just heavier parts, I guess,
24 VTs and CPTs?

25 A. Yes, they're transformers.

1 Q. Right. Can you tell what's in a
2 particular drawer? Is it labeled a certain way?

3 A. Yes, it is.

4 Q. So you know if it's a VT or a CPT?

5 A. Yes, there's a name plate on the outside
6 of the drawer that lists or states what's in it.

7 Q. So you will open the fuse drawer, but you
8 don't open the VT or CPT drawers?

9 A. Exactly. And any rails overhead, you
10 know, if I have to go overhead to put a rail in.
11 Now, if it's lower -- you know, we have two
12 different size of rails. We have a lighter size,
13 which you use for the lower drawer. But the heavier
14 ones you put in for support, you know, and safety
15 reasons, you use the heavier rails up top.

16 Q. Are there any other types of things that
17 you can no longer do on the job that you used to be
18 able to do prior to this injury?

19 A. Mainly, it's the lifting and like the
20 crawling -- like having to be on -- you know,
21 pushing pressure down, because you have to crawl up
22 in the unit to check the VTs or what have you, you
23 know, check different things. I'll do it, but it's
24 painful, and I get a lot of swelling from it. So I
25 generally just treat -- that's why I take the two

1 Aleves every morning before work.

2 Q. Are your supervisors aware of these
3 limitations that you have?

4 A. Yes.

5 Q. And they're okay with your co-workers
6 helping you with that?

7 A. Yes.

8 Q. Have you missed any time from work due to
9 your injury since you came back in April of 2014?

10 A. Yes, but I'll use vacation.

11 Q. How much time have you missed due to your
12 injury?

13 A. Most of the time, it's around -- well, it
14 will be the first of the month, because the end of
15 the month is extremely busy for us, so I have a lot
16 of pain and swelling, so I'll use a vacation day or
17 a call-out day. So it's probably been, I want to
18 say, at least five, ten days that I've missed.

19 Q. Have you told Lorrie, your supervisor or,
20 anyone else at Eaton that you're still having
21 problems with your left shoulder?

22 A. Yes.

23 Q. Who have you told that you're still having
24 problems with your left shoulder?

25 A. My manager knows.

1 Q. Who is your manager?

2 A. Gary Shojay.

3 Q. What about Amanda? Does she know?

4 A. Amanda is no longer in the facility.

5 Q. I'm sorry.

6 A. Lorrie.

7 Q. Lorrie, does she still know that you're
8 still having problems?

9 A. Yes.

10 Q. When was the last time you told Lorrie
11 that you're still having problems with your
12 shoulder?

13 A. I don't remember the exact time, but it's
14 been within the year.

15 Q. Have you reinjured your shoulder at all
16 since September 2014?

17 A. No.

18 Q. Have you been to the emergency room for
19 any reason since this accident?

20 A. No.

21 Q. You haven't had any subsequent injuries, a
22 car wreck or anything like that?

23 A. No.

24 Q. It looks like Dr. Timms released you from
25 his care October 14, 2015. Have you been back to

1 Dr. Timms since then?

2 A. Yes.

3 Q. When is the last time you saw Dr. Timms?

4 A. I seen him a couple of times. I don't
5 remember the exact date the last time I seen him,
6 but it was last year, because I was having issues
7 with my neck because of the weakness. I seen him
8 during therapy, and then I had a follow-up with him
9 a couple of times after that, but I can't remember
10 the exact dates.

11 Q. You told him about your neck?

12 A. Yes.

13 Q. What kind of issues were you having with
14 your neck?

15 A. Painful where I couldn't hold my head up
16 at times.

17 Q. When did your neck problems start?

18 A. I want to say -- I want to say September
19 of last year, 2015.

20 Q. So that would have been about a year or so
21 after your accident?

22 A. Yes.

23 Q. You mentioned earlier that you may have
24 hurt your neck at an old work injury. Do you
25 remember having any problems with your neck, other

1 than that injury, prior to this neck pain beginning
2 in September 2015?

3 A. No.

4 Q. Were you having any neck pain in the
5 months leading up to September 2015?

6 A. No.

7 Q. Did you treat with your family doctor at
8 all for any neck pain?

9 A. No.

10 Q. Why do you believe -- or let me rephrase
11 that. Do you believe your neck pain is related to
12 your accident on September 26, 2014?

13 A. Yes.

14 Q. Why do you believe your neck pain is
15 related to that accident?

16 A. Because of the weakness. Like I said, I'm
17 very weak in this arm, so I'm favoring my right hand
18 -- I am right-handed anyway, but I favor it a whole
19 lot more. I do just about everything with it, and I
20 just feel strain and stressed, you know.

21 Q. Is there a particular side of your neck
22 that hurts you more?

23 A. Yes.

24 Q. Which side of your neck?

25 A. Left side.

1 Q. You described some weakness in your left
2 shoulder and left arm. What kind of things in your
3 day-to-day life are you having problems with due to
4 the left shoulder and left arm weakness?

5 A. At home as far as doing laundry, mopping
6 the floors. I'm the type of person, I like to clean
7 my own car, so I can't do that anymore. I do it
8 every now and again. I pay someone to do it now. I
9 usually help my husband, you know, and my son with
10 yard work. I don't do that -- well, I do that
11 periodically, you know, but there's consequences
12 afterwards.

13 Q. You mentioned some problems with your
14 range of motion in the shoulder. I don't want you
15 to hurt yourself, but can you demonstrate how high
16 you can lift your arm up without pain?

17 A. (Indicating.)

18 Q. And I don't want you to hurt yourself, Ms.
19 Duncan.

20 A. Yeah, that's (indicating) about it.

21 Q. So would you describe that as maybe right
22 at shoulder level?

23 A. Roughly, because I mean if I leave it
24 down, I have to support it with my hand -- my right
25 hand.

1 Q. Did that cause you pain just now, to lift
2 your arm out to the side?

3 A. Yes.

4 Q. Have you treated with anyone for the neck
5 problems you mentioned other than Dr. Timms?

6 A. Yes.

7 Q. Who have you treated with for that?

8 A. Pain Management, Dr. Morana, I think it
9 is.

10 Q. I know there's a Dr. Mironer that I've
11 seen before, M-i-r-o-n-e-r. Is that who you're
12 seeing?

13 A. Yes.

14 Q. And what's the name of his practice?

15 A. He's in PAIN management.

16 Q. When is the first time you saw Dr.
17 Mironer?

18 A. October 2015 -- it was either October or
19 November 2015.

20 Q. How did you come to be under Dr. Mironer's
21 care?

22 A. I was referred to Dr. -- oh, I can't think
23 of it. He's in the -- I can't think of the doctor,
24 but I was referred to him about my neck. Actually
25 to go back, my family -- I did see my family doctor.

1 She was the one who referred me to him, I think it
2 was the spine doctor, I want to say. I take that
3 back. It just now came to me. I did see my family
4 doctor for my neck, and I was referred to the spine
5 center, and he referred me to Dr. Mironer.

6 Q. Fair enough. So it sounds like, piecing
7 this back together, you did see your family doctor
8 at some point for neck pain?

9 A. Yes, I did.

10 Q. And did you tell your family doctor your
11 neck pain was due to your work accident?

12 A. Well, I told her I felt like it was,
13 because I hadn't had it -- I wasn't having an issue
14 prior to it.

15 Q. Fair enough. And she then referred you to
16 the spine clinic -- is it Greenwood Spine Clinic?

17 A. Yes, I think it is.

18 Q. Who did you see there?

19 A. I can't remember his name.

20 Q. I believe there's a Dr. Lal, L-a-l, and
21 maybe a Dr. Kilburn. Did you see one of those guys?

22 A. No, it wasn't those guys. They're in the
23 same office area, but these guys are on the opposite
24 side of the hall from them.

25 Q. Fair enough. Did you see someone that

1 gave you a surgical opinion as to whether or not you
2 needed surgery?

3 A. No, what he did was referred me to Pain
4 Management, because I had had an MRI from physical
5 therapy, and they didn't see any issue, and no one
6 could figure out why I was having these neck pains.

7 Q. Do you have health insurance?

8 A. Yes.

9 Q. Have you paid for your pain management on
10 your health insurance?

11 A. Yes.

12 Q. Are you still treating with Dr. Mironer?

13 A. No, I was sent to -- to have a nerve
14 ending done here in Greenville, and he sent my
15 results in and said I had ulnar nerve. And once
16 they received the results there, I have to go --
17 actually Friday, I have been referred to a surgeon.

18 Q. All right. And you mentioned some issues
19 with your ulnar nerve. Are you having any problems
20 with your elbow?

21 A. Yes, they seem to think that's where the
22 neck pain is coming from, so I'm not sure.

23 Q. All right. So walking back through this,
24 sometimes you will have a test called a nerve study
25 or an EMG. Do you believe that you had nerve

1 studies done in Greenville?

2 A. Yes.

3 Q. And then it sounds like they're sending
4 you to surgeon. Is this a hand and upper extremity
5 surgeon?

6 A. Yes.

7 Q. Do they believe you need surgery, as far
8 as you understand it?

9 A. I wouldn't know until Friday.

10 Q. Do you know who you're scheduled to see on
11 Friday?

12 A. Dr. King.

13 Q. And then, I believe, there's a Dr. King
14 with Lakelands Ortho. Is that who you're scheduled
15 to see?

16 A. Yes, it is.

17 Q. So they're sending you back to Greenwood
18 for treatment for that, is that right?

19 A. Yes.

20 Q. All right. How many times do you think
21 you saw Dr. Mironer, the pain doctor?

22 A. Probably 10, 12 times.

23 Q. Did he have you on any medication or
24 anything like that?

25 A. Yes.

1 Q. But you're not taking any of the
2 medication he gave you now?

3 A. Because I can't work with it. No, I'm
4 not.

5 Q. He gave you pain pills?

6 A. Yes.

7 Q. Did he do any injections or anything like
8 that?

9 A. Yes.

10 Q. How many injections did you have?

11 A. At least five, and maybe less than five.

12 Q. Do you believe the issues you're having
13 with your ulnar nerve are related to your work
14 accident in September 2014?

15 A. Yes.

16 Q. Did you tell Dr. Mironer that?

17 A. I did.

18 Q. What kinds of symptoms are you having now,
19 Ms. Duncan, anywhere that you believe are related to
20 this work accident?

21 A. Numbness in my ring and pinky; weakness in
22 my arm; shoulder pain and neck pain.

23 Q. And this neck pain, is it still mostly on
24 the left side?

25 A. It's mostly here (indicating).

1 Q. Is that the left side of your neck?

2 A. Yes, it is.

3 Q. If we used a scale of zero to ten with
4 zero being no pain at all and ten being as bad as it
5 could possibly be, how bad is the pain in your neck,
6 as we sit at the table right now?

7 A. Seven.

8 Q. Is that about normal for you when you're
9 having pain?

10 A. Normal.

11 Q. What about your shoulder? As we sit here
12 at the table right now, are you having pain in your
13 shoulder?

14 A. Yes.

15 Q. If we use that same scale of zero to ten,
16 with zero being no pain and ten being as bad as it
17 could possibly be, how bad is the pain in your
18 shoulder?

19 A. Five.

20 Q. Is that about normal for you?

21 A. Yes.

22 Q. Are there any types of things that cause
23 your left shoulder pain to increase?

24 A. High usage.

25 Q. What about your -- you mentioned the

1 weakness in your arm and you have numbness in your
2 ring and your pinky. Is that on the left side, I
3 take it?

4 A. Yes.

5 Q. Does that numbness ever go away?

6 A. No.

7 Q. When did you first experience numbness in
8 your ring and pinky fingers?

9 A. April 2014 -- 2015.

10 Q. It was right around the time you had the
11 surgery?

12 A. It was after surgery. It was during one
13 of my follow-ups, I mentioned it to Dr. Timms at
14 that point.

15 Q. Does the pain in your shoulder ever go
16 away completely?

17 A. No.

18 Q. You always have some level of pain there?

19 A. Yes.

20 Q. How about the pain in your neck? Does
21 that ever go away completely?

22 A. It does, yes.

23 Q. It does?

24 A. Yes.

25 Q. How often do you experience pain in your

1 neck?

2 A. Daily, whenever I'm up and about.

3 Q. Do you ever go a day without neck pain?

4 A. Mainly I get relief when I'm resting.

5 Q. Do you have any hobbies or things you do
6 for fun outside of work?

7 A. Clean my car, that I can't do.

8 Q. Anything -- you know, anything for
9 exercise? Any sports or things like that?

10 A. Well, I'm no longer exercising like I was,
11 because I used to use the elliptical, so it takes a
12 lot, so I just kind of do my walking now.

13 Q. Who all do you report to at work now? Is
14 that just Lorrie?

15 A. Lorrie and Gary.

16 Q. And have you ever applied for Social
17 Security disability?

18 A. Prior to the injury, I was out with a back
19 injury -- well, I had a procedure done and it --
20 yeah, prior to it, a back injury.

21 Q. So prior to this injury --

22 A. Yes.

23 Q. -- you had a back injury in the past?

24 A. Well, I was having an issue. I have
25 neuropathy.

1 Q. And is this due to a back condition?

2 A. Yes.

3 Q. Is this in your legs where you experience
4 the neuropathy?

5 A. Yes.

6 Q. Was this back condition due to a
7 particular injury or accident?

8 A. No, it was from arthritis, I think that's
9 what my doctor says, it's from arthritis, and I was
10 getting injections.

11 Q. Who gave you injections for your back?

12 A. That injection was done here in
13 Greenville. It was done at Pain Management here in
14 Greenville.

15 Q. How long ago was that?

16 A. 2012.

17 Q. And you treated with your family doctor
18 for this condition as well?

19 A. Yes.

20 Q. Did you apply for Social Security
21 disability?

22 A. Well, after I was out of work so long,
23 Eaton -- my insurance with Eaton, they initiated it,
24 so it was initiated through them.

25 Q. All right. I know they have a short- and

1 long-term disability policy. Is that what you're
2 talking about?

3 A. Yes.

4 Q. So Eaton paid you money while you were out
5 of work?

6 A. Yes, I was out. Yes.

7 Q. And I'm not trying to confuse you, but
8 Social Security disability is another type of
9 benefit. Did you apply to the government for Social
10 Security disability benefits as well?

11 A. Yes.

12 Q. Did you believe that you were going to be
13 totally disabled as a result of that back condition?

14 A. Well, I could have been, but I chose to go
15 back to work. I didn't want to get it, I wanted to
16 go back to work, so I started exercising. I found
17 out what I needed to do through my doctor to get
18 back to work.

19 Q. Was this your family doctor?

20 A. Yes.

21 Q. That is the one you mentioned to me
22 earlier?

23 A. Patricia Goodman.

24 Q. Are you still treating with anyone for
25 your back injury -- or your back condition rather

1 and the neuropathy?

2 A. No.

3 Q. When is the last time you treated with
4 anybody for your back condition?

5 A. 2012, I want to say -- maybe 2013.

6 Q. You've mentioned your neck, your left
7 shoulder, the ulnar nerve, the weakest in your arm,
8 and the numbness and tingling you've had in the
9 pinky and ring fingers. Are you having any other
10 problems that you believe are related to this
11 September 2014 work injury?

12 A. No.

13 Q. Have you had any other work injuries at
14 Eaton either before or after this September 26th,
15 2014 work injury?

16 A. I hit my knee, but it was -- I just went
17 to the doctor to make sure it wasn't broken.

18 Q. When did you hit your knee?

19 A. I want to say June, July of the same 2014.

20 Q. But nothing came out of that?

21 A. No, I was fine.

22 Q. You're not having any problems with your
23 knee now?

24 A. No.

25 Q. Do you believe you need further treatment

1 for your left shoulder injury, or do you feel like
2 your shoulder has gotten as good as it's going to
3 get?

4 A. I feel like I need more treatment.

5 MR. HUGHEY: All right. I appreciate your
6 time, Ms. Duncan. I don't have any more
7 questions for you. Please answer anything that
8 your attorney has.

9 - - -

10 EXAMINATION

11 - - -

12 BY MR. PETERS:

13 Q. Just briefly, Ms. Duncan, you had
14 previously stated the current symptoms that you have
15 and the various body parts that are still
16 experiencing pain in. Can you please state those
17 again for me, please?

18 A. Numbness in my ring and pinky finger;
19 weakness in my left arm; pain in my left shoulder;
20 and the left side of my neck.

21 Q. And the numbness in your pinky finger,
22 which hand is that?

23 A. Left hand as well.

24 Q. So all of your parts of your body that
25 you're currently experiencing pain are on your left

1 side?

2 A. Yes.

3 Q. If you don't mind, let's talk about your
4 work activities. You're not working at the previous
5 -- well, you don't have the same responsibilities
6 that you used to have before the injury, is that
7 correct?

8 A. I still have the same responsibilities.

9 Q. Are you able to perform the same tasks is
10 what I'm really asking?

11 A. No.

12 Q. Thank you. I apologize. Are there areas
13 in your work where you require help?

14 A. Yes.

15 Q. And who do you get the help from?

16 A. Co-workers.

17 Q. And what do the co-workers help you do at
18 work?

19 A. Lift the rails to put in the slots and
20 pull out the heavier drawers, and open the same
21 doors -- the art doors as well. The ones that are
22 pretty hard to open, they'll open those, too,
23 they'll pull those, too, because a lot of times they
24 come down and jam like that, so they will pull those
25 doors.

1 Q. And technically you have been released
2 back to full duty, is that correct?

3 A. Yes.

4 Q. And you had mentioned that your manager is
5 aware of the job abilities that you can no longer
6 perform by yourself?

7 A. Yes.

8 Q. And does he have any problem with that?

9 A. No.

10 Q. So you're physically listed as full duty,
11 but really it's not really full duty because you
12 have help, is that correct?

13 A. Yes, it is.

14 MR. PETERS: Thank you. I have no further
15 questions.

16 MR. HUGHEY: That will do it. Thank you.

17 MR. PETERS: What about signature?

18 MR. PETERS: We can reserve it.

19 THE COURT REPORTER: Did you want a copy?

20 MR. PETERS: Yes, please.

21 - - -

22 (Witness excused.)

23 - - -

24 (Deposition was concluded at 3:48 p.m.)

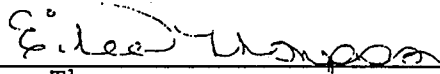
25 - - -

CERTIFICATE OF REPORTER

I, Eileen Thompson, Registered Professional Reporter and Notary Public for the State of South Carolina at Large, do hereby certify:

That the foregoing deposition was taken before me on the date and at the time and location stated on page 1 of this transcript; that the deponent was duly sworn to testify to the truth, the whole truth and nothing but the truth; that the testimony of the deponent and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed; that the foregoing deposition as typed is a true, accurate and complete record of the testimony of the deponent and of all objections made at the time of the examination to the best of my ability.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof. Witness my hand, I have hereunto affixed my official seal this 13th day of May, 2016 at Liberty, Pickens County, South Carolina.



Eileen Thompson,
Registered Professional Reporter
Notary Public
State of South Carolina at Large
My Commission expires:
October 17, 2024

SIGNATURE OF DEPONENT

I, the undersigned, KAREN MARTIN DUNCAN,
do hereby certify that I have read the foregoing
deposition transcript and find it to be a true
and accurate transcription of my testimony,
with the following corrections, if any:

PAGE	LINE	CHANGE
20	21	Should read Lori rather than Lorrie
27	21	Should read CT rather than VT
31	6	Should read Lori rather than Lorrie
31	7	Should read Lori rather than Lorrie
31	10	Should read Lori rather than Lorrie
47	21	Should read Arc Doors rather than Arc Door.

Karen Martin Duncan
KAREN MARTIN DUNCAN

6-16-16
{Date}

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE #1421162

KAREN M. DUNCAN	)	
CLAIMANT,	)	
VS.	)	SC WORKERS' COMPENSATION COMMISSION
EATON CORPORATION	)	HEARING OF
EMPLOYER,	)	KAREN M. DUNCAN
AND	)	VS
OLD REPUBLIC INS CO	)	EATON CORPORATION
<u>CARRIER.</u>	)	

This is the Transcript of the South Carolina Workers' Compensation Hearing of Karen M. Duncan versus Eaton Corporation, taken before Gloria Davis, a Court Reporter and Notary Public in and for the State of South Carolina, commencing at the hour of 11:15 A.M., Tuesday, August 30, 2016, at Laurens County Judicial Services Complex, 100 Hillcrest Square, Highway 76 By-Pass, Laurens, South Carolina.

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FOR THE EMPLOYER/CARRIER:

J. Russell Goudelock, II, Esquire
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Columbia, SC 29211

ALSO PRESENT:

Ms. Marlene Coates
Mr. Tony Waters

*Reporter's Note: -- Indicates incomplete thought or sentence, trailing off or interruption by speakers.

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I N D E X**WITNESSES**

All Witnesses:	Page
Ms. Duncan for Claimant	
Direct Examination by Mr. Peters	10:7
Cross-Examination by Mr. Goudelock	29:14
Redirect Examination by Mr. Peters	42:10
Certificate	45

STIPULATIONS

Commissioner Wilkerson: Today's date is the 30th day of August, 2016. We're here in reference to Workers' Comp file number 1421162. The Claimant in today's case is Karen Duncan and she represented by Willie Peters; is that correct?

Mr. Peters: Yes, sir.

Commissioner Wilkerson: Okay.

Mr. Peters: Thank you.

Commissioner Wilkerson: And also, Darren S. Haley is with us as well and I believe Mr. Peters going to try the case today; is that correct?

Mr. Peters: That's correct, Commissioner.

Commissioner Wilkerson: Yes, sir. Thank you. The Carrier -- oh, excuse me -- the Employer is Eaton Corporation; the Carrier is Old Republic Insurance Company represented by Rusty Goudelock. The date of accident is 9/26/2014. The average weekly wage is five forty-eight, ninety-seven (\$548.97); thus the comp rate is three hundred and sixty-six dollars (\$366.00). We're here to determine if the Employer Carrier is entitled to pay compensation to Claimant and if Employer Carrier is entitled to credit for temporary total benefits paid in excess of award, if any. Are

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1 there any objections to the APAs, jurisdiction,
2 venue or any other items by the moving party, Mr.
3 Goudelock?

4 Mr. Goudelock: None, Your Honor.

5 Commissioner Wilkerson: From Mr. Peters?

6 Mr. Peters: No objection, Your Honor.

7 Commissioner Wilkerson: Okay. Thank you
8 both. Without objection, the Commission's file
9 becomes part of the record with the exception of
10 self-serving declarations and unstipulated medical
11 reports. We did have a -- a little brief meeting
12 before we started just to make sure what I had
13 before me is what I was going to be looking at but
14 I always like for each side to put their position
15 on the record. So, at this point in time, I'm
16 going to have Mr. Goudelock put his client's
17 position on the record then, Mr. Peters; likewise,
18 we'll have you put your client's position on the
19 record. So, thank you. Please.

20 Mr. Goudelock: Commissioner, thank you. We
21 admit an injury to the left surgery, it occurred
22 on September 26, 2014; we deny any injury to any
23 other body part. She was paid temporary total for
24 -- from March 17, 2015 to April 29, 2015,
25 following surgery. So, there is no other TTD

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1 owed; I don't think there is any credit.

2 Commissioner Wilkerson: I didn't think so.

3 Mr. Goudelock: And we admit PPD, specific
4 schedule to the left shoulder, MMI, October 14,
5 2015, and we contend no future medical care is
6 owed.

7 Commissioner Wilkerson: 10/14/15, MMI?

8 Mr. Goudelock: Yes, Your Honor. And -- and
9 we would -- the -- the impairment rating from the
10 doctor is three percent (3%) to the arm, which we
11 would stipulate is --

12 Commissioner Wilkerson: Five percent (5%) to
13 the shoulder.

14 Mr. Goudelock: -- five percent (5%) to the
15 shoulder --

16 Commissioner Wilkerson: All right.

17 Mr. Goudelock: -- from Dr. Timms, who is the
18 treating physician. He returned her to work in
19 September of 2015, with no restrictions and no
20 need for future medical care according to the
21 14-B.

22 Commissioner Wilkerson: And I think I asked
23 in -- in the pre-hearing that there is no hardware
24 in Ms. Duncan's shoulder?

25 Mr. Goudelock: No, sir. Her --

1 Commissioner Wilkerson: Okay.

2 Mr. Goudelock: -- her shoulder was a
3 debridement only, there was no repair done; it was
4 arthroscopic and no hardware. And we have
5 submitted as an exhibit, Defendant's Exhibit
6 Number One, which we -- the APAS -- the AMA Guide
7 is contained in our APA submissions and all we've
8 done is highlight some portions that we want to
9 attract your attention in Exhibit Number One just
10 to -- to counter the IME rating that Ms. Duncan
11 received from Dr. De Vault and our position is
12 that -- that he combined too many different
13 conditions and erroneous calculations and that
14 type thing, which we feel are reflected by the AMA
15 Guides.

16 Commissioner Wilkerson: Okay. Anything
17 else?

18 Mr. Goudelock: Nothing further, Your Honor.

19 Commissioner Wilkerson: Okay. Thank you.
20 Mr. Peters, on behalf of your client?

21 Mr. Peters: Thank you, Your Honor. If it
22 please the tribunal. Your Honor, we would
23 stipulate to the injury and the -- the date of
24 injury that opposing counsel previously stated.
25 Ms. Duncan had a -- a surgery on her left shoulder

1 on or about March -- in or about March of 2015.
2 Your Honor, our position is that subsequent to
3 that surgery, Mrs. -- Ms. Duncan's injury did get
4 substantially worse. There was an -- an
5 impairment rating given by Dr. Timms in the amount
6 of three percent (3%) to the upper extremity;
7 however, we are of the opinion that -- that the --
8 that the evaluation done wasn't complete and we
9 got a second opinion with Dr. De Vault and we have
10 included his impairment rating as an exhibit and
11 we -- we have also -- yes, Your Honor -- we have
12 also included as an exhibit a functional capacity
13 evaluation done by Advance Physical Therapy and we
14 would note that the impairment rating disclosed by
15 -- by Dr. De Vault was fifty-three percent (53%)
16 to the left shoulder.

17 Commissioner Wilkerson: Any additional
18 medical recommended?

19 Mr. Goudelock: Dr. De Vault, I think, said
20 that she would need four (4) medical visits a year
21 --

22 Mr. Peters: Yes.

23 Mr. Goudelock: -- and sixteen (16) physical
24 therapy or something like that.

25 Mr. Peters: Yes, that's correct, Your Honor.

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Mr. Goudelock: But no other treatment.

Commissioner Wilkerson: Okay. Anything else before we get started with the Claimant's testimony?

Mr. Peters: Nothing further, Your Honor.

Commissioner Wilkerson: Okay. Anything else?

Mr. Goudelock: Nothing further, Your Honor.

Commissioner Wilkerson: Okay. Thank you. Ma'am, I'm going to get you to raise your right hand; I'm going to have the Court Reporter swear you in and we're going to take a little testimony from you.

Whereupon;

Karen M. Duncan, being duly sworn and cautioned to speak the truth, the whole truth and nothing but the truth, testified as follows:

Court Reporter: Please state your full name for the record.

Witness: Karen M. Duncan.

Court Reporter: Thank you, ma'am.

Commissioner Wilkerson: Thank you, Ms. Duncan. And I believe before we started, you're going to rely on the medical and cross; is that correct?

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1 Mr. Goude-lock: Yes, Your Honor.

2 Commissioner Wilkerson: Okay. Thank you.
3 Please, Mr. Peters, thank you.

4 Mr. Peters: Thank you, Your Honor. May it
5 please the tribunal.

6 DIRECT EXAMINATION

7 By Mr. Peters:

8 Q. Good morning, Ms. Duncan.

9 A. Good morning.

10 Q. How old are you?

11 A. Fifty (50).

12 Q. What is your date of birth?

13 A. **DOB** 65.

14 Q. Okay. And what -- where do you live?

15 A. Greenwood, South Carolina.

16 Q. How long -- how long have you lived there?

17 A. Since '84 --

18 Q. Okay.

19 A. -- 1984.

20 Q. Okay. And how far did you go in school, Mrs.

21 Duncan?

22 A. I graduated high school and started some college
23 courses.

24 Q. Please explain your college courses that you took.

25 A. I started with -- through Eaton's -- I -- Eaton's

1 they assist with going -- attending -- furthering your
2 education. So, I started business admin with an
3 emphasis in billing -- medical billing encoding. I'm
4 sorry.

5 Q. No problem. No problem. Thank you. And,
6 actually, just backtrack a little bit. Could you
7 please describe your work history after -- after high
8 school?

9 A. I started out in, like, the fast foods, then from
10 there into manufacturing around, like, the '90's. I
11 did drive a school bus during the school years. Then
12 I've just pretty much been in manufacturing since the
13 '90's.

14 Q. Okay. And when did you start working for Eaton?

15 A. I want to say it was 2008.

16 Q. Okay.

17 A. Around 2008.

18 Q. And what was your job title when you first came
19 onboard with Eaton?

20 A. I worked in the Final Assembly Department.

21 Q. Okay. And what is your current job title?

22 A. Final Inspector.

23 Q. Okay. How long have you been working in the
24 capacity as a Final Inspector with Eaton?

25 A. About three (3) -- three (3) -- a little over

1 three (3) years.

2 Q. Okay. And you -- have you been -- have you
3 consistently been employed with Eaton since you began
4 in 2008?

5 A. Yes.

6 Q. Okay. And you -- have you worked anywhere else
7 since you started working with Eaton in 2008?

8 A. No, sir.

9 Q. Do you have any other source of income other than
10 -- other than the wages that you earned at Eaton?

11 A. No other income.

12 Q. Okay. And the Commissioner previously listed a
13 date of September 26, 2014, as the date of injury; is
14 that correct?

15 A. Yes, it is.

16 Q. Okay. Please describe for the tribunal what
17 happened in the injury.

18 A. I was inspecting units, as usual. Around the end
19 of the month is pretty busy for the Inspectors because
20 we're getting all the jobs that we're trying to ship
21 for the month. So, I was working in a another
22 department, Switches, and we have -- it was called MBS
23 and then we have the MBA side, which is where I work
24 the majority of the time but I'll go over and help out
25 in another department, you know, because we have so

1 much workload. So, actually I was scheduled -- I had
2 scheduled a four (4) hour vacation that was -- that
3 particular day but when the workload became heavier my
4 supervisor walked up and asked me could I go help out
5 in the other department, which is MBA.

6 Q. And, briefly, what -- which supervisor was that?

7 A. That would be Amanda Nicks --

8 Q. Okay.

9 A. -- was my supervisor at the time.

10 Q. Okay. Go on.

11 A. And so, I walked up to help -- you know, started
12 inspecting up there, you know. Well, I looked at my --
13 checked my email and seen what jobs were ready to be
14 inspected.

15 Q. Okay.

16 A. I started inspecting, got kind of tied up because
17 they kept releasing jobs. So, rather than leave --
18 well, by the time she came up it might have been
19 probably 1:30; I was supposed to get out 1:30,
20 something to 2:00. So, I told her, I said, well, you
21 know I've got a half a day, I said, but I'll stay over
22 and go look at those jobs. So, about the time I got
23 into those jobs they started releasing the others; so,
24 I just stayed on, you know, because the workload is
25 extremely heavy during the end of the month, like I

1 said. So, I stayed on, it may have been -- I can't
2 recall -- I don't know, it -- it was somewhere between
3 6:00 and 8:00 that evening I was still there. And I
4 was inspecting the arc job, which the arc jobs are jobs
5 that design -- that if it explodes it'll go through the
6 ceiling versus not shooting the door back injuring
7 someone.

8 Q. Okay.

9 A. So, I was in -- I went to pull the door, which is
10 a much heavier gauge of steel and several devices in
11 those jobs, so.

12 Q. Okay.

13 A. The door was jammed; so, I kept trying to pull it
14 open and it wouldn't -- I felt something but, you know,
15 I didn't think nothing of it because, like I said, we
16 were extremely busy -- I -- I was, anyway. I was
17 extremely busy trying to get everything done. And I
18 just kept working, you know. So, a little later when
19 things kind of calmed down, I went and told the
20 supervisor that was on shift that I was about to leave,
21 that would be the supervisor for that particular area
22 where I was inspecting -- inspecting at because my
23 supervisor had gone for the day. So, I didn't think
24 nothing of it. Now, I went home, you know. I was
25 hurting but, you know, it wasn't nothing to make me

1 just like, okay, it's really bad, you know, I just
2 really thought I was sore because you get sore when
3 you're that busy at the end of the month; I mean, all
4 of us do. So, I went home and the next morning I got
5 up, you know, it was a bit more painful but, like I
6 said, I just thought it was a pulled muscle or
7 something; I didn't think nothing of it. So, that's
8 pretty much what happened, you know.

9 Q. Okay. You mentioned that -- that when you were
10 pulling on the door you felt something; what -- what
11 did you feel?

12 A. I felt a pop but, you know, I didn't think -- like
13 I said, I didn't think anything of it.

14 Q. Okay.

15 A. I really didn't.

16 Q. And --

17 A. Because it's just not unusual to be, you know,
18 sore, like I said, at the end of the month --

19 Q. -- okay.

20 A. -- when you're so busy.

21 Q. Okay. And this was on a Friday, correct?

22 A. Yes, sir.

23 Q. And when did you report the injury to Eaton?

24 A. That Monday --

25 Q. The Monday.

1 A. -- evening.

2 Q. The Monday when you came back?

3 A. Yes.

4 Q. Okay.

5 A. Well, actually I went back that Sunday but by the
6 time I got to work the guys had already inspected
7 everything. So, I just kind of did a little paperwork
8 and I left for the evening but I came back Monday.

9 Q. Okay. And who did you report the injury to?

10 A. Amanda Nicks.

11 Court Reporter: I'm sorry, Amanda?

12 Witness: Nicks.

13 Court Reporter: Nicks?

14 Witness: Yes.

15 Court Reporter: Thank you, ma'am.

16 Q. Okay. And subsequently, you were -- you were
17 referred to Dr. Dennis Murphy at Piedmont Health Group;
18 is that correct?

19 A. Yes, sir.

20 Q. And I have that you began treatment with Dr.
21 Murphy on or about September 30th of 2014; is that
22 correct?

23 A. Yes.

24 Q. Okay. And Dr. Murphy then referred you to
25 Lakelands Orthopedic and Sports Medicine Clinic; is

1 that correct?

2 A. Yes.

3 Q. Okay. Can you describe your regimen there,
4 basically, what -- what kind of physical therapy you
5 had to do there?

6 A. Well, initially, I didn't do any physical therapy.
7 Initially, I was sent to have an MRI --

8 Q. Okay.

9 A. -- on my shoulder and that was pushed out to,
10 like, I want to say December but then that was in the
11 Greenwood area, I think, and I called and asked could I
12 get an appointment somewhere else.

13 Q. Okay.

14 A. Which would, you know, make it -- I tried to get
15 it speeded up because the pain was really bad.

16 Q. Okay.

17 A. So, I was able to get -- obtain an appointment in
18 Lexington and the MRI was done there.

19 Q. Okay. And at some point it was recommended that
20 you undergo surgery on your left shoulder; is that
21 correct?

22 A. Yes, sir.

23 Q. Who was the attending surgeon?

24 A. Dr. Timms.

25 Q. And is that Dr. Anthony Timms?

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- 1 A. Yes, it is.
- 2 Q. And is that at Self Regional Health Care?
- 3 A. That's where the surgery was done. He's in the
- 4 office, the orthopedic.
- 5 Q. Okay. And when did that surgery take place?
- 6 A. March 17th --
- 7 Q. Okay.
- 8 A. -- 2015.
- 9 Q. Okay. And how -- how long were your out of work
- 10 after the surgery?
- 11 A. About six (6) weeks.
- 12 Q. Okay. How did you feel after the surgery?
- 13 A. Well, after the surgery I was completely numb.
- 14 Q. Okay.
- 15 A. I had a lot of pain once I, you know, got my
- 16 feeling back. I started having issues with my ring and
- 17 pinky finger that I spoke to Dr. Timms about, numbness
- 18 in my ring and pinky finger and he felt like it would
- 19 come back, you know.
- 20 Q. Okay.
- 21 A. So, just, you know, in pain, you know. Like I've
- 22 always said, I take two (2) -- I have to take two (2)
- 23 Aleves -- I was taking two (2) Aleves every morning
- 24 prior to work because I couldn't take the --
- 25 Q. All right.

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1 A. -- the harsh pain pills.

2 Q. Right. And -- and just to be clear for the
3 record, the surgery was to your left shoulder; is that
4 correct?

5 A. Yes, sir.

6 Q. Okay. And on or about April 9th of 2015, you
7 began undergoing physical therapy at -- at Genesis
8 Sports and Rehabilitation; is that correct?

9 A. Yes.

10 Q. And could you describe for us your -- your regimen
11 there?

12 A. Oh, it was -- a lot of days I went in they
13 couldn't do anything because I was having issues with
14 neck and shoulder pain. So, there was several -- on
15 several occasions I went in that the only thing they
16 could do was just treat me with ice packs and light
17 massage.

18 Q. Okay.

19 A. I didn't get a whole lot did because, you know, of
20 the pain, you know; it was just unbearable.

21 Q. Okay. And I know you previously touched on it but
22 I have that you were out of work from approximately
23 March of -- March 17th of 2015 until about April 29th;
24 does that sound about right?

25 A. Yes.

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1 Q. Okay. And after you returned to work back in late
2 April, describe the duty that -- that you were placed
3 on; was it full duty or --

4 A. Yes. I was -- I was placed on -- he said I could
5 go back to work with no restrictions but I couldn't do
6 my job in full extremity --

7 Q. Okay.

8 A. -- you know.

9 Q. And, actually, back -- when you first came back to
10 work back in late April, were you placed on light duty?

11 A. Yes. I want to say I was light duty --

12 Q. Okay.

13 A. -- for a little while.

14 Q. Could you describe exactly for the -- for the
15 tribunal what light duty is for you?

16 A. Light duty was pretty much -- we have a lot of
17 paperwork, folders that we have to prep for the jobs
18 prior to shipment. So, I did a lot of, like, the
19 paperwork. If we had any change notices. A lot of,
20 you know, mainly -- basically, computer work, paperwork
21 of that sort or anything that I could do in the office
22 area to help out.

23 Q. So, no heavy lifting --

24 A. No.

25 Q. -- pushing or pulling?

1 A. No, no.

2 Q. Okay.

3 A. No.

4 Q. Did your supervisors accommodate you while you
5 were on light duty?

6 A. Yes. For a while I didn't have a supervisor
7 because Amanda had gotten another job but -- had been
8 transferred to another facility but Gary, my Manager,
9 he had told me on several occasions to be careful and
10 not to hurt myself and he was aware that I couldn't
11 complete my job --

12 Q. Okay.

13 A. -- as needed. And the guys on the floor would,
14 you know, do the lifting or pulling out the drawers or
15 whatever I had to do as far as overhead.

16 Q. Okay. All right. Today -- excuse me. In or
17 about October of 2015, did you have an appointment with
18 Dr. Timms to obtain an impairment rating?

19 A. Yes.

20 Q. Okay. And do you remember what took place at that
21 meeting with Dr. Timms that day?

22 A. I just went in for a follow up and I was still,
23 actually, in physical therapy; I still had three (3)
24 more sessions, actually, that had -- that had been just
25 reapproved for me to continue through Workers' Comp, I

- 1 want to say. He said he was going to release me --
2 Mr. Goudelock: Object to anything the doctor
3 said.
4 Commissioner Wilkerson: You can't tell me
5 what the doctor said.
6 A. -- well, I was released to return to full duty and
7 was asked to raise my hand as high as I can get it and
8 that was just that.
9 Q. How long did that appointment take?
10 A. I want to say fifteen (15) --
11 Q. Fifteen (15) --
12 A. -- fifteen (15) minutes.
13 Q. -- fifteen (15) minutes, approximately?
14 A. Right.
15 Q. And the evaluation that was done, you only had to
16 lift your --
17 A. Left arm.
18 Q. -- left arm?
19 A. Yes. I was asked to lift my left arm.
20 Q. Okay. Was -- okay. Did you do anything else?
21 A. No, sir.
22 Q. And Dr. Timms assigned you a three percent (3%)
23 impairment rating to your upper extremity; is that
24 correct?
25 A. Yes.

- 1 Q. Did you agree with that finding then?
- 2 A. No.
- 3 Q. Do you agree with that finding now?
- 4 A. No.
- 5 Q. Why not?
- 6 A. I'm still at the point where I can't lift my arm
- 7 no higher than half way now.
- 8 Q. Okay.
- 9 A. My shoulder just -- anything over that.
- 10 Q. Okay. In or around late October to early November
- 11 of 2015, you were released to full duty without
- 12 restrictions; is that correct?
- 13 A. Yes.
- 14 Q. Were you still in pain when you were released back
- 15 to full duty?
- 16 A. Yes.
- 17 Q. Did -- did you make Dr. Timms aware that you were
- 18 still in pain?
- 19 A. Yes.
- 20 Q. Did your supervisors know that you were still in
- 21 pain when you were released to full duty?
- 22 A. Yes. My Manager, like I said.
- 23 Q. Okay.
- 24 A. But that's around that time.
- 25 Q. And -- and who was that, specifically?

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- 1 A. Gary Shojaie.
- 2 Q. Okay.
- 3 Court Reporter: Gary, I'm sorry?
- 4 Witness: Shojaie. Gary Shojaie.
- 5 Mr. Goudelock: S-H --
- 6 Court Reporter: Could you spell it?
- 7 Mr. Goudelock: -- S-H-O-J-A-I-E.
- 8 Ms. Coates: S-H-O-J-A-I-E.
- 9 Court Reporter: Thank you.
- 10 Mr. Peters: Okay.
- 11 Q. So -- okay. And subsequent to Dr. Timms -- to the
- 12 appointment with Dr. Timms where he gave you the
- 13 impairment rating, did you seek a second opinion?
- 14 A. Yes.
- 15 Q. And was that was with Dr. William De Vault?
- 16 A. Yes.
- 17 Q. Okay. And did you have an appointment with Dr. De
- 18 Vault on or about May 14th of the -- of 2016, for the
- 19 purposes of obtaining an independent medical
- 20 examination and impairment rating?
- 21 A. Yes.
- 22 Q. Okay. Please describe your meeting with Dr. De
- 23 Vault on that day.
- 24 A. I went in, we -- you know, we spoke, he asked me
- 25 what happened. Excuse me. Excuse me. He asked me

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1 what happened, I told him. He asked me, you know, what
2 were my limits or what have you; we went from there.
3 He did several measurements. He did -- you know, he
4 would lift my arm and, you know, do the measurements as
5 far as I could go. He used a few instruments to check,
6 you know, and actually we didn't even get a chance to
7 complete a lot of it because the movement was creating
8 so much pain.

9 Q. Okay. Did you give your maximum effort?

10 A. Yes.

11 Q. Okay. Did Dr. De Vault assign to you an
12 impairment rating to your left shoulder?

13 A. Yes.

14 Q. What -- what was that rating?

15 A. Fifty-three percent (53%).

16 Q. Okay. Now, back to your work with Eaton. So,
17 technically, you've been on full work duty without
18 restrictions since approximately late October to early
19 November of 2015; is that correct?

20 A. Yes.

21 Q. Are you still in pain today?

22 A. Yes.

23 Q. How are you able to perform your -- your full job
24 duties while still being in pain?

25 A. As I stated before, the guys that I work with,

1 they'll do the lifting and pulling out the drawers.

2 Q. Okay.

3 A. You know, any lifting, pulling, anything that's --
4 I can't -- I can't reach high enough to pull out the
5 drawer; so, the thing is they'll -- they will do it.

6 Q. Now, this lifting and -- and pulling that you just
7 mentioned, is that something that you would normally be
8 required to do on full duty?

9 A. Yes.

10 Q. Okay.

11 A. Yes.

12 Q. Have you missed any time from work due to your
13 injury since you came back to work in April of 2015?

14 A. Yes, I have.

15 Q. Approximately how much time have you missed?

16 A. I can't recall. Probably anywhere from ten (10)
17 -- maybe ten (10) to twelve (12) days. It would mainly
18 be at the end of the month, like I said, when we -- we
19 get -- whenever we've got a lot on us. Any time of the
20 month that we get a great deal of work --

21 Q. Okay.

22 A. -- you know, I have called in or used vacation
23 just to kind of recoup.

24 Q. Okay. So, are your supervisors aware of this?

25 A. Yes.

1 Q. Okay. Are your supervisors aware that you require
2 help from co-workers to do job tasks that you would
3 normally be expected to do on full duty but -- but
4 aren't able to do?

5 A. Yes.

6 Q. Okay. Have you ever received medical treatment
7 for your left shoulder prior to the injury in question
8 on September -- in September 26th of 2014?

9 A. No.

10 Q. Have you re-injured your shoulder -- your shoulder
11 at all since September 26th, 2014?

12 A. No.

13 Q. Okay. Now, we've previously talked about how the
14 injury has affected your work; how has your injury
15 affected your day-to-day life?

16 A. Like doing a lot of stuff in the yard, I'm -- I'm
17 the type I -- like I said, I like cleaning my own cars,
18 mowing the lawn; I help out a good bit around the house
19 because it's just my husband, myself and my youngest
20 son. So, we kind of team up but most of it now my son
21 has to do or -- like, I have a bike; I haven't ridden
22 it -- I rode it once since I had the surgery and I
23 couldn't hold it up. So, I figured it was best I park
24 it before I get hurt or whatever. Grandkids, I can't
25 lift them, you know, do -- if I do it's one-handed, you

1 know. So, I mostly use -- just about everything I do I
2 -- I have to use -- I have to use my one hand, my right
3 hand and kind of juggle everything I do. I mean, I use
4 my left hand some but not to the full extremities and
5 that I could prior to hurting myself.

6 Q. Okay. Are you -- and are you currently taking any
7 -- any over the counter medications for your pain?

8 A. Yes. I take Aleves --

9 Q. Okay.

10 A. -- every day for pain.

11 Q. How often during the day?

12 A. I take two (2) every morning when I get up.

13 Q. Okay. And is your shoulder -- is your left
14 shoulder, does it feel better or worse than it did
15 prior -- than it did prior to the surgery in March of
16 2015?

17 A. It's worse.

18 Q. It's worse now?

19 A. It's worse now.

20 Q. Explain that please. How?

21 A. I -- weakness in it. I -- like I say, I can't
22 lift my hand -- my arm no higher than shoulder length.
23 I'm in pain, you know. I take the two (2) Aleves every
24 morning to stay on top of the pain. And when I do
25 work, I mean, it's -- it's pretty bad; it gets pretty

1 bad sometimes. When the weather changes up, I'm
2 hurting. I still get swelling. So, it's worse than
3 what it was. I didn't have any issue with my shoulder
4 prior to this.

5 Q. Okay.

6 Mr. Peters: Excuse me. Thank you,
7 Commissioner; I have no further questions. Ms.
8 Duncan, please answer any questions that the
9 Commissioner or opposing counsel may have.

10 Witness: Okay.

11 Commissioner Wilkerson: Mr. Goudelock:

12 Mr. Goudelock: Thank you, Commissioner.

13 CROSS-EXAMINATION

14 By Mr. Goudelock:

15 Q. Ms. Duncan, good morning.

16 A. Good morning.

17 Q. You described your work history and you said you'd
18 been in fast foods and in manufacturing since the
19 '90's; part of that time in manufacturing you worked
20 for -- as a team lead and a -- and a Manager, didn't
21 you?

22 A. Yes.

23 Q. How many years was that?

24 A. I worked as a lead for about three (3) years.

25 Q. Okay. And in that position you would supervise

1 anywhere from nine (9) to maybe twenty (20) people?

2 A. Yes, depending on the shift.

3 Q. Okay. And you'd be responsible for the shift and
4 scheduling the shift and performance evaluations and
5 all that type thing that a Manager would have for that
6 many people you oversaw, correct?

7 A. Yes.

8 Q. Okay. And you described some of your duties with
9 Eaton, you use a computer?

10 A. Yes.

11 Q. And you can read and write?

12 A. Yes.

13 Q. Do math?

14 A. Yes.

15 Q. Okay. And with Eaton, for I think you said the
16 last three (3) years, you've been in a position as an
17 Inspector?

18 A. Yes.

19 Q. And that was the position you were working in when
20 you -- when your injury occurred and you got hurt?

21 A. Yes.

22 Q. Okay. You all -- what Eaton makes at that
23 facility is -- is large switch gear, correct?

24 A. Exactly.

25 Q. Sometimes as big as a small car?

- 1 A. Yes.
- 2 Q. And your job in doing that is, the switch gear
- 3 will have various panels or doors around it --
- 4 A. Yes.
- 5 Q. -- and you will -- you'll open those doors and the
- 6 doors are probably, what, half the height of a regular
- 7 door, maybe?
- 8 A. It's about mid -- about --
- 9 Q. Basically?
- 10 A. -- probably about -- about -- about -- well, the
- 11 height of the door is about waist but when you have to
- 12 -- you have to reach up --
- 13 Q. Right.
- 14 A. -- for the handles --
- 15 Q. Right.
- 16 A. -- yes.
- 17 Q. Because they -- the door may be about waist height
- 18 in --
- 19 A. Yes.
- 20 Q. -- in tallness but it may be situated up higher --
- 21 A. Yes.
- 22 Q. -- on the --
- 23 A. Yes.
- 24 Q. -- on the switch gear?
- 25 A. Yes.

- 1 Q. And you might occasionally have to get on a
2 step-ladder to --
- 3 A. Yes.
- 4 Q. -- to open the door and inspect things? Some of
5 those doors -- now, the door you were working on was a
6 -- was an arc door --
- 7 A. Yes.
- 8 Q. -- or the switch gear at the time you got hurt you
9 were working on or inspecting was -- had an arc; was it
10 an arc door?
- 11 A. Yes.
- 12 Q. Which is a heavier door --
- 13 A. Yes, it is.
- 14 Q. -- is that right? All of them aren't made that
15 way, though, right? Some of them have different doors
16 that aren't as -- as robust as an arc door?
- 17 A. Correct.
- 18 Q. Okay. And you'll open the doors and inspect.
19 Sometimes there will be a piece of equipment on the
20 door or sometimes you have to pull out drawers that
21 have equipment in it and that type of thing, right?
- 22 A. Right.
- 23 Q. Some of those drawers are heavier than others to
24 pull out?
- 25 A. Yes.

- 1 Q. Some drawers you don't have any problems pulling
2 out?
- 3 A. Exactly.
- 4 Q. And some you do and you've testified occasionally
5 you'll get some help doing?
- 6 A. Yes.
- 7 Q. Okay. In the course of a day, how many drawers do
8 you inspect, four (4) or five (5)?
- 9 A. It depends on the switch gear.
- 10 Q. Okay. But is that probably an average or is that
11 high or low?
- 12 A. It's -- on a daily basis, it -- it just depends on
13 the gear, I mean, sometimes you'll get them and you
14 don't have any.
- 15 Q. Okay.
- 16 A. Sometimes you'll get them and they'll have one or
17 two (2) drawers; sometimes you may have a drawer in
18 every compartment, so.
- 19 Q. Okay. And so, some days you don't have any
20 drawers and some days you'll have -- I mean, the most
21 you would inspect in a day on a worst day would be how
22 many?
- 23 A. It all depends on --
- 24 Q. Less than ten (10)?
- 25 A. -- yeah. Less than ten (10) --

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- 1 Q. Okay.
- 2 A. -- but it depends on the, you know --
- 3 Q. Right.
- 4 A. -- the build, how quick --
- 5 Q. And that's during an eight (8) hour shift?
- 6 A. -- yes.
- 7 Q. Okay. And different -- different types of switch
- 8 gear will come through on different days, like you
- 9 said, depending on the order, right? So, some days
- 10 you've got heavier pieces that you're dealing with;
- 11 other days it's not like that at all, right?
- 12 A. Correct.
- 13 Q. And some days that you've described you've got
- 14 some people that will help you open a drawer; other
- 15 days you don't have anybody that you need help from
- 16 when you -- when you're inspecting; so, would that be
- 17 fair?
- 18 A. If it's no drawers.
- 19 Q. Okay. You had -- you had surgery on March the
- 20 17th of last year, right?
- 21 A. 20 --
- 22 Q. 2015.
- 23 A. -- 15, yes.
- 24 Q. And you had worked light duty up until you went
- 25 out for surgery?

1 A. Yes.

2 Q. And then, during your surgery Dr. Timms didn't
3 have to do any type of repair or anything on you. So,
4 he didn't put any bolts or screws or anchors or
5 anything like that in there; he just debrided out some
6 stuff that was frayed in there, didn't he?

7 A. Yes. And then, he also released tendons.

8 Q. Okay. And so, you were out of work from -- I
9 think you've already testified, from March 17th to
10 April 29th of last year, correct?

11 A. Yes.

12 Q. And you came back at light duty initially?

13 A. Yes.

14 Q. And described -- and did some of the work that you
15 described. And then, you went back to full duty, I had
16 on September 2nd of 2015, before Dr. Timms finally
17 released you. Did you go back to full duty at an
18 earlier visit before he finally released you in
19 October; do you remember?

20 A. I can't remember.

21 Q. Okay. If the medical records say that it was the
22 visit just before that, that you went back to full
23 duty, have you got any reason to disagree with that?
24 It would have been in September.

25 A. I'm not --

1 Q. You just don't remember?

2 A. -- I don't -- I don't remember the dates.

3 Q. Okay. But, anyway, by the time he released you,
4 you would have been released at full duty, correct?

5 A. Yes.

6 Q. And Dr. Timms, your treating doctor, hadn't given
7 you any restrictions, had he?

8 A. No.

9 Q. Okay. And you described your evaluation by Dr.
10 Timms but you had also been evaluated and -- and
11 treated regularly with a Physical Therapist, hadn't
12 you?

13 A. Yes.

14 Q. You'd seen a Physical Therapist multiple times?

15 A. Yes.

16 Q. And they did all kind of different movements and
17 measurements and things like that with you and charted
18 it down, didn't they?

19 A. Yes.

20 Q. Okay. And Dr. Timms had access to those records,
21 as well, because he sent you there, didn't he?

22 A. Yes.

23 Q. Now, you -- you had a -- you saw Dr. De Vault in
24 May of this year?

25 A. Yes.

1 Q. So, what about eight (8) -- or eight (8) months or
2 so after you had gone back to work at full duty?

3 A. Yes.

4 Q. All right. You hadn't seen any doctor since Dr.
5 Timms in October of 2015, and going to Dr. De Vault in
6 May of 2016, had you --

7 A. Huh-uh.

8 Q. -- for your shoulder?

9 A. No.

10 Q. Okay. You had seen one for something else I'm
11 going to talk about --

12 A. Yeah.

13 Q. -- but not for your shoulder, right?

14 A. Yes.

15 Q. Okay. You hadn't been to any emergency room --

16 A. No.

17 Q. -- during that time?

18 A. Huh-uh.

19 Q. You hadn't asked anybody at the plant to send you
20 back to a doctor during that time for your shoulder,
21 had you?

22 A. No.

23 Q. Your attorney hadn't sent you to any doctor during
24 that time for your shoulder, had he?

25 A. No.

1 Q. Okay. Dr. De Vault was a visit arranged by your
2 attorney, wasn't it?

3 A. Yes.

4 Q. And just prior to seeing Dr. De Vault, your
5 attorney had you go for a functional capacity
6 evaluation testing, didn't he?

7 A. Yes.

8 Q. Now, during that time you had functional capacity
9 testing and you saw Dr. De Vault, you were having elbow
10 problems on your left side, weren't you?

11 A. Yes.

12 Q. You described earlier you had some neck pain and
13 things like that, ultimately they determined that that
14 was coming from a cubital tunnel and ulnar nerve type
15 of condition, didn't they?

16 A. Yes.

17 Q. And, in fact, you had that condition on both --
18 both sides, from the testing --

19 A. Uh-huh.

20 Q. -- the left was worse than the right but it
21 existed actually on both sides, didn't it?

22 A. Exactly.

23 Q. And the doctor said it didn't have anything to do
24 with your shoulder injury, didn't he?

25 A. Yes.

1 Q. Okay. Now, you had -- so, the problems you were
2 having with your left elbow, you had actually seen Dr.
3 King for that the day before you saw Dr. De Vault,
4 didn't you?

5 A. It may have been. I'm not for sure. I don't
6 remember.

7 Q. But you were having problems with it by the time
8 you had your functional capacity evaluation and you saw
9 Dr. De Vault and they did the testing you've described,
10 you were already having elbow problems at that point,
11 weren't you?

12 A. Well, at that point I didn't know it was elbow. I
13 just knew I had -- I was complaining of numbness in my
14 ring and pinky finger.

15 Q. Right.

16 A. Yes.

17 Q. It was affecting your arm?

18 A. Yes.

19 Q. You were having pain in your arm --

20 A. Yes.

21 Q. -- and you were having numbness in your fingers --

22 A. Yes.

23 Q. -- and that type of thing at the time --

24 A. Yes. I had --

25 Q. -- you had your functional capacity evaluation and

1 you saw Dr. De Vault, right?

2 A. -- yes.

3 Q. Okay. And then ultimately you actually had
4 surgery on that elbow in June of this year, didn't you?

5 A. Yes.

6 Q. All right. You're right handed, aren't you?

7 A. Yes.

8 Q. Now, the elbow treatment that you had was paid for
9 under your group health?

10 A. Yes.

11 Q. Any time you lost for work for that has been under
12 group short term disability or long term disability,
13 right?

14 A. Yes.

15 Q. And you've got all those benefits for you, you
16 described education benefits, group disability
17 benefits, group health benefits; you still have all
18 those, correct?

19 A. Yes.

20 Q. And you've been working full time since October of
21 -- you've been working full time since, I guess, the
22 beginning of May of last year, full time; not full
23 duty, full time?

24 A. Full time, yes.

25 Q. Yes.

- 1 A. Okay.
- 2 Q. And then, full duty since -- since at least
- 3 October --
- 4 A. Yes.
- 5 Q. -- of last year?
- 6 A. Yes.
- 7 Q. So, for almost eleven (11) months, you've been at
- 8 full duty, right?
- 9 A. Yes.
- 10 Q. You haven't had any treatment since you saw Dr. De
- 11 Vault, other than your attorney had you evaluated by
- 12 doctor -- I mean, since you saw Dr. Timms, other than
- 13 your attorney had you evaluated by Dr. De Vault, right?
- 14 A. Right.
- 15 Q. No prescriptions medications for your shoulder;
- 16 you take only Aleve?
- 17 A. Yes.
- 18 Q. You haven't been to any emergency rooms for
- 19 anything related to your shoulder, have you?
- 20 A. No.
- 21 Q. Okay. And you testified earlier that you had
- 22 missed some days for your shoulder since you went back
- 23 to work in April of last year but you didn't tell
- 24 anybody those days were for your shoulder, did you?
- 25 You turned them in under vacation or a call-in day; is

1 that right?

2 A. Yes.

3 Q. Okay.

4 Mr. Goudelock: One second, Your Honor.

5 Commissioner Wilkerson: Okay.

6 Mr. Goudelock: Nothing further, Your Honor.

7 Mr. Peters: Just -- just briefly, Your
8 Honor.

9 REDIRECT EXAMINATION

10 By Mr. Peters:

11 Q. Ms. -- Mrs. Duncan, did you previously need help
12 with your job responsibilities before your injury?

13 A. No.

14 Q. You were able to do that by yourself?

15 A. Exactly.

16 Q. How did you get assigned to Dr. Timms; who made
17 the -- the referral?

18 A. Dr. Murphy.

19 Q. Okay. And who made the -- who made the referral
20 to Dr. Murphy?

21 A. Tony.

22 Q. Tony?

23 A. Yes.

24 Q. Okay. And who is that?

25 A. Mr. Waters, yeah.

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1 Q. okay. So -- so, Eaton did that?

2 A. Eaton did, yes.

3 Q. okay. Why -- why can't you take prescription
4 drugs?

5 A. I -- they make me drowsy. I couldn't do my job
6 plus driving to work on them. So, that's my last
7 alternative, you know, to take the Aleve.

8 Q. okay.

9 Mr. Peters: Thank you, Your Honor. I have
10 no -- no further questions.

11 Mr. Goudelock: Nothing further, Your Honor.

12 Commissioner Wilkerson: Okay. Any other
13 witnesses from the Claimant's perspective?

14 Mr. Peters: That -- that'll be our case,
15 Your Honor.

16 Commissioner Wilkerson: Okay. Thank you.
17 Any witnesses from the Defense?

18 Mr. Goudelock: No witnesses, Your Honor.

19 Commissioner Wilkerson: Okay.

20 Court Reporter: The Court Reporter has a
21 question. You all are saying door -- is it art or
22 arc? I can't tell which one you're saying.

23 Mr. Haley: I believe it's A-R-C.

24 Mr. Goudelock: A-R-C.

25 Court Reporter: Thank you.

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Commissioner Wilkerson: A-R-C, I think.

Court Reporter: That's what I needed to know.

Commissioner Wilkerson: And that's fine.

Court Reporter: Thank you, very much.

Commissioner Wilkerson: Okay. Thank you.

This concludes the hearing. I thank everybody for being here. Let me meet with the attorneys for a few minutes. Thank you all.

(THERE BEING NO FURTHER QUESTIONS, THE HEARING CONCLUDED AT
11:57 A.M.)

STATE OF SOUTH CAROLINA)

COUNTY OF LAURENS)

CERTIFICATE

Be it known that I took the foregoing South Carolina Workers' Compensation Commission Hearing of Karen M. Duncan, vs. Eaton Corporation;

That I was then and there a Notary Public in and for the State of South Carolina-At-Large;

That by virtue thereof I was duly authorized to administer an oath;

That the witness was first duly sworn to testify the truth, the whole truth, and nothing but the truth, concerning the matter in controversy aforesaid;

The foregoing transcript of 44 typewritten pages represents a true, accurate and complete transcription of the testimony so given at the time and place aforesaid to the best of my skill and ability;

That I am not related to nor an employee of any of the parties hereto, nor a relative or employee of any attorney or counsel employed by the parties hereto, nor interested in the outcome of this action;

Witness my hand and seal this 7th Day of January, 2017.

Gloria G. Davis

Gloria G. Davis
Notary Public for South Carolina
My Commission Expires 12/21/21

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Transcript of the Testimony of
DUNCAN V. EATON CORP., ET AL.

Date: March 21, 2017



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STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC No. 1421162

Karen Duncan,)
)
Claimant,)
)
v.)
)
Eaton Corporation,)
)
Employer,)
)
and)
)
Old Republic,)
)
Carrier/Defendants.)
)

FULL COMMISSION HEARING

Tuesday, March 21, 2017
10:14 a.m. - 10:26 a.m.

The Full Commission Hearing was heard before Commissioners Melody L. James, T. Scott Beck, and Susan S. Barden, at the Workers' Compensation Commission, 1333 Main Street, Suite 500, Columbia, South Carolina, on the 21st day of March, 2017, before Sonia D. Wallace-Sanders, Court Reporter and Notary Public in and for the State of South Carolina.

APPEARANCES

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EXHIBITS

(There were no exhibits marked during the hearing.)

1 CALL TO ORDER:

2 COURT REPORTER: Today is March 21st, 2017. This is
3 South Carolina's Workers' Compensation Case
4 Number 1421162. This is the case of Karen
5 Duncan, claimant, v. Eaton Corporation,
6 employer, and Old Republic, carrier. The
7 Appellant is the Claimant/Defendant represented
8 by Darren S. Haley. The Respondent is
9 represented by J. Russell Goudelock. Each side
10 is allowed 10 minutes for oral argument and the
11 Appellant three minutes in reply. You are
12 requested to argue the grounds of exception and
13 stay within the record.

14 COMMISSIONER BARDEN: Mr. Haley?

15 ARGUMENT BY MR. PETERS:

16 MR. PETERS: Thank you. May it please ---

17 COMMISSIONER BARDEN: And you may take the podium.

18 MR. PETERS: Okay.

19 COMMISSIONER BARDEN: And you may take your papers
20 up there with you. Thank you so much.

21 MR. PETERS: Thank you, and may it please the
22 tribunal. And actually I am Willie Peters
23 standing for Darren Haley. I am an associate
24 from the firm ---

25 COMMISSIONER BARDEN: All right. Mr. Peters, I

1 apologize.

2 MR. PETERS: No problem. Thank you. Your Honor,
3 again, I am Willie Peters, attorney for Ms.
4 Duncan, the Appellant in this case, who is an
5 employee with Eaton Corporation. Your Honor,
6 we're here today to -- because we are appealing
7 the Commissioner's decision to award a 10
8 percent impairment rating to Ms. Duncan's left
9 shoulder.

10 COMMISSIONER BARDEN: Did the Commissioner award a
11 10 percent disability award instead of an
12 impairment rating?

13 MR. PETERS: Yes, yes, Your Honor. I apologize.
14 That's correct. Yes, that -- the 10 percent to
15 Ms. Duncan's shoulder.

16 COMMISSIONER BARDEN: Right.

17 MR. PETERS: And we believe that the APAs and the
18 testimony submitted at the hearing do not
19 warrant that percentage rate, but warrant a
20 higher rating. Specifically, the reports by
21 Mr. Jason Embler and Dr. Devault, which show
22 that a higher impairment rating is warranted.
23 Specifically, in Mr. Embler's findings he, in
24 his reports, states that Ms. Duncan is able to
25 perform light work with occasional lifting

1 below the waist of 10 pounds. Zero pounds at
2 shoulder height and zero pounds overhead. And
3 that she could push 15 pounds and pull 21
4 pounds. I believe this finding alone shows
5 that Ms. Duncan should not have been assigned
6 to full work duty, which she was, by her
7 treating physician, Dr. Timms, as her job often
8 required her to lift above -- to reach above
9 her head and move objects that are well above
10 20 pounds. The testimony at the hearing, which
11 was undisputed, showed that Ms. Duncan has
12 required and still does require a -- assistance
13 from her employ- -- her coworkers to perform
14 her full job duties. It's also undisputed that
15 the sup- -- that her supervisors are aware of
16 this and that they take no issue with this. So
17 she is technically on full work duty, but she
18 has not been able to do full work duty since
19 she's been released. Your Honor, also in Dr.
20 Devault's findings, he used all of the APAs and
21 ---

22 COMMISSIONER MCCASKILL: Let me ask you a question
23 about Dr. Devault's ---

24 MR. PETERS: Yeah.

25 COMMISSIONER MCCASKILL: --- rating, which I

1 understand is 53 percent?

2 MR. PETERS: Yes. Yes.

3 COMMISSIONER MCCASKILL: What treatise and or
4 methodology did he use to arrive at 53 percent?

5 MR. PETERS: And I would consent that I believe that
6 that amount -- that that rating is a bit high,
7 but -- and I think he calculated out in the --
8 in his report, which we have submitted in our
9 APAs, where he did utilize the manual, the 5th
10 Edition. But we believe that at the very least
11 ---

12 COMMISSIONER MCCASKILL: You believe the manual,
13 utilizing the 5th Edition and the methodology
14 incorporated therein, arrives at 53 percent?

15 MR. PETERS: I think that it does not arise at the
16 10 percent rating. I think at the very least
17 splitting the difference between ---

18 COMMISSIONER MCCASKILL: That's not my question. Do
19 you think it arrives at 53 percent?

20 MR. PETERS: I think that 53 percent is a bit high,
21 but I do -- but I also think that the 10
22 percent rating is grossly low.

23 COMMISSIONER MCCASKILL: I get that. Thank you.

24 MR. PETERS: Thank you. But in Mr. Devault's
25 findings, he also found that Ms. Duncan could

1 reach waist high, with no overhead reaching, to
2 the upper left extremity. He also found that
3 in order to maintain Ms. Duncan's level of
4 function, she would need four physician visits
5 per year with 16 therapy visits per year for
6 treatment. Also, Your Honor, we believe that
7 the functional capacity evaluation performed by
8 her treating physician, Dr. Timms, was rushed,
9 was done very quickly and was not a complete
10 functional capacity evaluation as it only
11 lasted a mere few minutes. And I believe the
12 only question that was asked of Ms. Duncan was
13 to lift her arm, which she was unable to do
14 above her head. And that's how Mr. -- Dr.
15 Timms reached his body impairment rating of,
16 which I believe was three percent. In short,
17 Your Honor, we believe that the Commissioner
18 disregarded the findings of Ms. Duncan's APAs
19 and reached an arbitrary amount of -- in
20 awarding that -- the 10 percent award. So what
21 we would ask, that the Commissioner re-access
22 the APAs of Ms. Duncan's injury and award an
23 impairment rating that accurately reflects her
24 injury.

25 COMMISSIONER BARDEN: Thank you ---

1 COMMISSIONER MCCASKILL: Thank you.

2 MR. PETERS: Thank you.

3 COMMISSIONER BARDEN: --- Mr. Peters. All right,
4 Mr. Goudelock?

5 ARGUMENT BY MR. GOUDELOCK:

6 MR. GOUDELOCK: Good morning, may it please the
7 Commission. I represent Eaton Corporation and
8 its insurance carrier. Ms. Duncan is a 50 year
9 old high school graduate. She's been working
10 with Eaton since 2008. She had an admitted
11 left shoulder injury that occurred on September
12 26th of 2014. She missed about six weeks from
13 work in March. In April of 2015, she went back
14 to work at light duty initially and then back
15 at full duty early September of 2015. Dr.
16 Timms, her treating orthopedist, released her
17 October 14th of 2015 at maximum medical
18 improvement. He gave her a three percent
19 rating to the arm, which we stipulated at the
20 hearing was equivalent to five percent to the
21 shoulder. He said she didn't need any future
22 medical care and she had no restrictions. Mr.
23 Peters' appeal is essentially that Commissioner
24 Wilkerson ignored Dr. Devault's rating of 53
25 percent, which he's acknowledged here today as

1 high. Defendant's Exhibit Number 1 are
2 excerpts from the AMA Guide which address that
3 rating. Dr. Devault stacked a bunch of
4 different things to arrive at that rating, both
5 range of motion part and a loss of strength,
6 which you're not supposed to use in the
7 presence of both pain or other things, in
8 addition to range of motion ---

9 COMMISSIONER JAMES: Mr. Goudelock, I hate to
10 interrupt your train of thought, would you mind
11 pausing the button for a moment?

12 (Off the Record)

13 COMMISSIONER BARDEN: Mr. Goudelock?

14 MR. GOUDELOCK: Thank you. The first page of that
15 Exhibit is the calculation of what the
16 impairment would be using Dr. Devault's
17 measurements, which we don't submit are right,
18 but his rating would be either 10 or 13 percent
19 under the AMA guides if you stacked them like
20 he did but use the proper measurements.

21 COMMISSIONER JAMES: And you said under the AMA the
22 strength is not included with the shoulder
23 evaluation?

24 MR. GOUDELOCK: Correct.

25 COMMISSIONER JAMES: But that would be included in a

1 disability determination?

2 MR. GOUDELOCK: It could be included in disability
3 determination. And I will address those in
4 just a second too because that's a good
5 question. Dr. Timms gave her three percent to
6 the arm, no restrictions. She has no hardware
7 in her shoulder and no future medical care.
8 Again, six weeks out of work. Been at full
9 duty, by the time of the hearing, for pretty
10 much 12 months that she had been back at work.
11 She sought no further medical care. She filed
12 no 50 seeking any further medical care. She
13 takes two Aleve a day, no prescription pain
14 medications. The only doctor she saw was Dr.
15 Devault, who her attorney sent her to in May
16 prior to the original hearing in this case,
17 which was ultimately -- ultimately took place
18 in August. The part that's interesting about
19 Dr. Devault's rating as well, if you want to
20 assume his measurements are accurate. At that
21 time, Ms. Duncan was having problems with her
22 left arm that were unrelated to this and it's
23 undisputed. Her testimony said it's unrelated,
24 the doctor said it's unrelated. She was
25 diagnosed with cubital tunnel syndrome.

1 Interestingly, she had seen Dr. King the day
2 before she saw Dr. Devault for cubital tunnel
3 syndrome in her left arm. And ultimately had
4 surgery the following month after she saw Dr.
5 King. So when Dr. Devault saw her, she was
6 having unrelated left arm problems, that by all
7 accounts don't have anything to do with her
8 shoulder surgery. And Dr. King, I mean Dr.
9 Timms' final report of October 14th, which is
10 Defendant's APA Number 1, Page 27, he reflects
11 her comments. It says, Claimant states her
12 shoulder -- I use the term claimants, but Ms.
13 Duncan states her shoulder is probably the
14 least of the problems that she is having now.
15 To your point, Commissioner James, on the
16 disability aspects of it, she has -- Dr. Timms,
17 who was her treating physician, Mr. Peters said
18 that his evaluation on the final day didn't
19 take long. Keep in mind, and you all know
20 this, he'd been her treating physician all
21 along. He had seen her multiple times. She --
22 she'd undergone physical therapy. He had
23 physical therapy records and had followed her,
24 so he was familiar with her condition. He
25 found no restrictions. He didn't give her any

1 future medical care. She'd been working full
2 duty for 12 months. While the Clements case
3 would suggest to you that maybe those things
4 don't matter, we do submit to you that they do
5 matter in identifying what someone's function
6 is when they're able to engage in certain
7 activities versus not engage in certain
8 activities. So we would submit to you that
9 Commissioner Wilkerson adequately considered
10 the treating physician's comments, treating
11 physician's treatment, the treating physician's
12 rating. He did disregard Dr. Devault's rating
13 in large part, but we think there are reasons
14 for that and we will submit that his decision
15 should be affirmed. Thank you.

16 COMMISSIONER BARDEN: All right. Thank you, Mr.
17 Goudelock. Mr. Peters, you have three minutes
18 to reply.

19 REPLY BY MR. PETERS:

20 MR. PETERS: Thank you, Your Honor. Just briefly.
21 Just briefly. Opposing counsel has stated that
22 Ms. Duncan has not sought any future treatment
23 after she was released to full time duty, but
24 that was because she was, in fact, released to
25 full work duty. And she did not have the means

1 to pay for that as it would not come out of the
2 workers' compensation. Your Honor, and lastly,
3 to go again, we believe that Commissioner did
4 -- Commissioner Wilkerson did disregard Ms.
5 Duncan's APAs and did not provide a sufficient
6 basis for reaching the impairment rating that
7 he did reach. If he stated in his Order that
8 Dr. Devault's findings were based upon an
9 erroneous combination of multiple medical
10 conditions and erroneous calculations, and as
11 Mr. Goudelock has stated correct, a correct
12 impairment rating would be 13 percent.
13 However, the Commissioner did not specifically
14 state why the findings were erroneous and did
15 not provide methods for reaching the 13 percent
16 rating or the 10 percent rating that he
17 ultimately did find was appropriate. So we
18 would, again, just ask that the Commissioners
19 just reassess the APAs and the injury to find
20 an impairment rating that accurately reflects
21 Ms. Duncan's injury. Thank you.

22 COMMISSIONER BARDEN: All right. Thank you, sir.

23 COMMISSIONER JAMES: Thank you.

24 COMMISSIONER BARDEN: That concludes this
25 proceeding. Y'all have a good rest of the day.

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1 COMMISSIONER MCCASKILL: Thank y'all.
2 (There being no further questions, the hearing
3 concluded at 10:26 a.m.)

1

The Orthopedic Center
William DeVault, M.D.
206 Wall Street
Piedmont, South Carolina
29673

Karen Duncan

Karen Duncan, by report, was working for Eaton Electrical and had the injury to her left shoulder pulling on heavy doors and drawers to move them. The injury was reported to have occurred on September 26, 2014.

Karen Duncan was evaluated on October 7, 2014 by Dennis Murphy, M.D. of Tower Pointe Family Medicine in Greenwood, South Carolina. She was having a follow-up for her left shoulder injury. The injury resulted from repetitive activity. She had to pull hard on heavy doors and drawers to move them. Pain came on while she was working a harder than usual shift. Symptoms included pain with swinging her arm when walking. Her symptoms had worsened. The pain was sharp and radiating to the left shoulder and subacromial area. Her current treatment included an exercise regimen, nonsteroidal anti-inflammatory medications and oral corticosteroids. On physical examination, the left shoulder had decreased range of motion passively with significant pain with any movement. She had decreased strength with the arms suspended. The assessment was joint pain in the shoulder and clavicle region and weakness of the shoulder. An orthopedic referral was recommended. She was continued on restricted duty with no use of the left arm.

On October 29, 2014, Karen Duncan was evaluated by Anthony Timms, M.D. Of Lakelands Orthopedic Clinic in Greenwood, South Carolina for her left shoulder pain that was running into the upper arm area. She had a previous humerus fracture on that side. On physical examination, there was some difficulty moving the shoulder. She had positive impingement discomfort, positive apprehension and O'Brien's sign. X-rays of left shoulder showed minimal arthritic changes at the acromioclavicular joint with slight anterior lateral acromion impingement changes. She had a healed humerus fracture with displacement in the proximal one third distal one third junction.

Karen Duncan is an MRI arthrogram of the left shoulder on December 11, 2014 at Palmetto Imaging in West Columbia, South Carolina. The conclusion was an inflamed acromioclavicular joint with the rim

rent tear of the distal anterior supraspinatus with superior labrum fraying and the nondisplaced split tear of the biceps tendon.

On December 31, 2014, Karen Duncan was evaluated by Dr. Timms. The MRI scan of left shoulder revealed a biceps tendon tear with tendinosis, probably a type I labrum tear, and an inflamed acromioclavicular joint. Dr. Timms recommended the left shoulder arthroscopy. Alternatives, risks and benefits were discussed.

Karen Duncan was rechecked by Dr. Anthony Timms on March 2, 2015. He noted that her shoulder continued to do poorly with weakness, pain and popping. Dr. Timms reviewed the MRI scan and plain x-rays. Left shoulder arthroscopy was recommended.

On March 17, 2015, Karen Duncan had a left shoulder arthroscopic subacromial decompression, distal clavicle excision, biceps tenotomy, labrum debridement and rotator cuff debridement by Dr. Anthony Timms at Self Regional Healthcare.

Ms. Duncan was rechecked by Dr. Timms on April 29, 2015, six weeks post left shoulder arthroscopy. She was not getting into her active and passive motion in the office visit. There was a lot of guarding. X-rays "look good". There were no fractures and no loss of position of the acromioclavicular joint. Dr. Timms recommended taking the sling off and start using her shoulder more in the house. He recommended physical therapy to be extremely aggressive. Ms. Duncan was rechecked on June 10, 2015, 2 ½ months post left shoulder arthroscopy. She still complained of pain and swelling in the shoulder. She had some numbness and the therapist was concerned there may be cervical issues. On exam, there was no loss of sensation to pin wheeling. The Tinel's was negative at the cubital tunnel, carpal tunnel and Guyon's canal. Her neck motion was a little bit restricted. She had left sided trapezius and levator muscle spasm. Karen Duncan was rechecked by Dr. Timms on July 13, 2015, four months post left shoulder surgery. She had a steroid injection in the shoulder that helped some. She was complaining of neck pain and upper extremity tingling. Dr. Timms gave her a Steripred dose pack and continued restricted duty at work with no lifting over 20 pounds. He recommended that she "otherwise really try to push it as hard as she can". There was still some restricted motion the shoulder. Dr. Timms noted that things are coming along slow. He recommended that she keep pushing things as hard as she can. He recommended continuing therapy. He did injections of the left shoulder in both the glenohumeral and subacromial spaces. She was put on light duty with the left upper extremity.

Physical therapy records were reviewed from Genesis Sports and Rehabilitation Services in Greenwood, South Carolina, outlining treatment for Ms. Duncan for her left shoulder.

On March 9, 2016, Karen Duncan had a functional capacity evaluation at Align Networks. Ms. Duncan had consistent effort and appropriate pain behaviors. The results noted that she was able to perform light work with occasional lifting below waist height of 10 pounds, 0 pounds at shoulder height and 0 pounds overhead. She carried 15 pounds. She could push 15 pounds and pull 21 pounds. She demonstrated that she could sit, stand, do dynamic and static bending, dynamic squatting and kneeling and walk for continuous intervals. She could occasionally reach at waist height with no overhead reaching. She could perform continuous hand tasks. She could stair climb and ladder climb continuously. Sensory testing was normal for two-point discrimination. She demonstrated limited strength during manual muscle testing.

Karen Duncan reported that she was working for Eaton Electrical and was pulling on doors with her left arm. She heard a pop in her left shoulder. She had the onset of pain and discomfort in the left shoulder and had the treatment for her left shoulder as outlined above. She reported that she is now continuing to work. She reported that she takes Aleve anti-inflammatory medications and hydrocodone pain medications from time to time. She reported that she has difficulty doing overhead lifting and she has pain in her left shoulder when trying to lift.

On physical examination, Karen Duncan had active assisted left shoulder range of motion of flexion to 105°, extension to 35°, abduction to 115°, adduction of 45°, internal rotation 80° and external rotation to 30°. She had audible popping of the left shoulder with these ranges of motion. Her right upper arm diameter measured 34.5 cm and her left upper arm diameter measured 33.5 cm. Right forearm diameter measured 29.0 cm and her left forearm diameter measured 29.5 cm. Motor strength examination against the examiner resistance revealed 4/5 strength to left shoulder flexion, extension, abduction, internal rotation and external rotation. She demonstrated 5/5 strength to left shoulder adduction. She had palpable left trapezius muscle spasm. She had decreased sensation to the left hand little and ring fingers with widened two-point discrimination of 10 to 12 mm on the radial and ulnar aspect of the little finger and the ulnar aspect of the ring finger. She demonstrated 5/5 left hand grip strength against examiner resistance.

Within a reasonable degree of medical certainty, Karen Duncan sustained injuries to her left shoulder and left upper extremity in the accident described above as occurring on September 26, 2014 while she was working for Eaton Electrical. Within a reasonable degree of medical certainty, Karen Duncan has reached maximum medical improvement for her left shoulder and left upper extremity injuries. Based

on the American Medical Association Guides to the Evaluation of Permanent Impairment, Fifth Edition, Karen Duncan has 53 % left shoulder permanent and partial impairment based on shoulder range of motion figure 16 – 40, page 476, figure 16 – 43, page 477, figure 16 – 46, page 479 and motor strength examination table 16 – 35, page 510 with impairment of upper extremity after arthroplasty table 16 – 27, page 506. Based on her functional capacity evaluation, Karen Duncan is suitable for light duty work activity with occasional lift below waist height of 10 pounds. She was not able to demonstrate lifting to shoulder height with her left shoulder. She could push 15 pounds and pull 21 pounds. Continuously, Karen Duncan could stand, sit, walk, do static and dynamic bending, dynamic squatting, kneeling, ladder climbing and stair climbing and perform hand tasks. On an occasional basis she could reach at waist height with no overhead reaching with the left upper extremity. In order to maintain her current level of function, Karen Duncan will need four physician visits per year and 16 physical therapy visits per year for treatment of acute exacerbations of her left shoulder conditions.

I have discussed with the examinee that the independent medical evaluation does not constitute the establishment of a physician-patient relationship. This independent medical evaluation is based on the physical exam findings at the time of this evaluation and the medical records available at the time of this evaluation with the assumption that the medical records are true and correct. If additional information becomes available in the future, then the independent medical evaluation can be revised. There is a possibility of undetected illnesses or injuries at the time of this evaluation. This independent medical evaluation should not be construed as endorsing or criticizing the medical care provided. This independent medical evaluation is the opinion of William L. DeVault, M.D.

William L. DeVault, MD

William L. DeVault, M.D.
206 Wall Street
Piedmont, SC 29673

May 14, 2016

Haley Law Firm, LLC

1007 Pendleton St.

Greenville, SC 29601

864-235-6638

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2

**FUNCTIONAL CAPACITY EVALUATION**Karen Duncan

A functional capacity evaluation was conducted on 3/9/16 to determine this client's tolerance to perform work tasks.

Results obtained indicate this client performed with determined consistent effort and demonstrated appropriate pain behaviors.

Based on results obtained the client is able to perform light PDC work with occasional lifting below waist height to 10#. The client lifted 0# to shoulder height and 0# overhead. The client carried 15#. Push and pull strengths were measured statically and tested at 15# and 21# respectively.

Non-material handling testing indicates the client can sit for continuous intervals, stand for continuous intervals and walk for continuous intervals. The client can dynamic bend for continuous intervals and static bend for continuous intervals. The client can dynamic squat continuously. The client can kneel continuously. The client can perform occasional reaching at waist height and no overhead reaching. The client can perform continuous hand tasks. The client can stair climb continuously and ladder climb continuously.

Musculoskeletal exam demonstrated within functional limits bilateral upper and lower extremity active range of motion (AROM) Except L UE limitations noted in report. Spinal AROM was limited for cervical area as noted in report. Sensory testing was normal for two point discrimination. The client demonstrated limited strength during manual muscle testing. Balance and gait testing were functional.

Thank you for this referral. Should you have any future questions or concerns please do not hesitate to contact us at 864-343-2650.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jason Embler'. Below the signature is the printed name 'Jason Embler, PT, SCS'.

Jason Embler, PT, SCS

3/9/16

FUNCTIONAL CAPACITIES EVALUATION

Demographics:

Patient: Karen Duncan	Evaluation Date: 3/9/2016	Diagnosis: L shoulder pain
Physician: Dr. Timms	Next MD Appl: Unknown	Date of Surgery: 3/17/15
Employer: Eaton Electrical	Occupation: Inspector	Work Status: Full time/duty

Past Medical/Occupational History:

Comments:	Pt had L RTC repair and is unable to elevate L UE.
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Validity Profile:

Maximum Effort Demonstrated	YES	☒	NO	☐
Appropriate Pain Behaviors Demonstrated	YES	☒	NO	☐

Physical Demand Classification:

Sedentary ☐ Light ☒ Light-Medium ☐ Medium ☐ Medium-Heavy ☐ Heavy ☐ Very Heavy ☐

Worker Can:

	Occasional 1-33% per day	Frequent 34-66% per day	Continuous 67-100% day	Meets Job Demands
Lift Floor to Knuckle	10			N/A
Lift 12 inch off floor to knuckle	10			N/A
Lift waist to shoulder height	0			N/A
Lift waist to overhead	0			N/A
Two Hand Carry	15			N/A
Static Push	15.3			N/A
Static Pull	21			N/A
Sit			X	N/A
Stand			X	N/A
Walk			X	N/A
Repetitive Stooping (Bending)			X	N/A
Sustained Stooping (Bending)			X	N/A
Repetitive Crouching (Squatting)			X	N/A
Sustained Crouching (Squatting)			X	N/A
Climb Stairs			X	N/A
Climb Ladders			X	N/A
Kneel			X	N/A
Crawl			X	N/A
Reach above Shoulder Height				N/A
Reach Repetitively Waist Height		X		N/A
Operate Hand Controls			R/L	N/A
Operate Foot Controls			R/L	N/A

Summary/Recommendations:

Pt has limited L UE ROM and is unable to reach above shoulder height.

VALIDITY TEST RESULTS

Static Strength Tests

	Arm Test	Push Test R	Push Test L	Pull Test R	Pull Test L	Overhead R	Overhead L	Smoot
Trial 1	0	39	11	52	18	0	0	0
Trial 2	0	40	20	54	14	0	0	0
Trial 3	0	38	15	40	16	0	0	0

	Consistent Effort
Coefficient of Variance	YES
Heart Rate	YES
Correlation to Dynamic Testing	N/A

Jamar Dynamometer

Pressure	Force	GRV	Valid	Len	GRV	Valid
1	41	5.27	Y	20	6.12	Y
2	48	6.61	Y	21	7.09	Y
3	57	17.13	N	21	8.59	Y
4	47	6.84	Y	21	13.91	N
5	51	6.62	Y	24	6.92	Y

Pressure	Force	GRV	Valid	Len	GRV	Valid
1	41	5.27	Y	20	6.12	Y
2	48	6.61	Y	21	7.09	Y
3	57	17.13	N	21	8.59	Y
4	47	6.84	Y	21	13.91	N
5	51	6.62	Y	24	6.92	Y

	Consistent Effort
Coefficient of Variance	YES
Rapid Exchange Grip	YES
Bell Shaped Curve	YES

Whole Test Validity Criteria

	Consistent Effort
Heart Rate	YES
Dissimulation	YES
Test-Retest	YES
Manual Muscle Testing	YES

Pain Evaluation

	Appropriate	Inappropriate	Not Tested
Pain Behaviors	YES		☐
Ransford Pain Drawing	YES		☐
Visual Analog Scale	YES		☐
McGill Pain Questionnaire			☒
Dallas Pain Questionnaire			☒
Waddell's Non-Organic Signs	YES		☐
Inappropriate Illness Questionnaire			☒

MUSCULOSKELETAL TEST RESULTS

Strength Assessment

RIGHT		5/5	4/5	3/5	1-2/5	Cogwheel	No Test
STOIC C- JOM	Flexion	☒	☐	☐	☐	☐	☐
	Extension	☒	☐	☐	☐	☐	☐
	Abduction	☒	☐	☐	☐	☐	☐
	Adduction	☒	☐	☐	☐	☐	☐
	Internal Rotation	☒	☐	☐	☐	☐	☐
	External Rotation	☒	☐	☐	☐	☐	☐
STOIC C- JOM	Flexion	☒	☐	☐	☐	☐	☐
	Extension	☒	☐	☐	☐	☐	☐
	Supination	☒	☐	☐	☐	☐	☐
	Pronation	☒	☐	☐	☐	☐	☐
STOIC C- JOM	Flexion	☒	☐	☐	☐	☐	☐
	Extension	☒	☐	☐	☐	☐	☐
	Ulnar Deviation	☒	☐	☐	☐	☐	☐
	Radial Deviation	☒	☐	☐	☐	☐	☐
STOIC C- JOM	Abduction	☒	☐	☐	☐	☐	☐
	Adduction	☒	☐	☐	☐	☐	☐
	Flexion	☒	☐	☐	☐	☐	☐
	Extension	☒	☐	☐	☐	☐	☐
STOIC C- JOM	Abduction	☒	☐	☐	☐	☐	☐
	Adduction	☒	☐	☐	☐	☐	☐
	Flexion	☒	☐	☐	☐	☐	☐
	Extension	☒	☐	☐	☐	☐	☐
STOIC C- JOM	Flexion	☒	☐	☐	☐	☐	☐
	Extension	☒	☐	☐	☐	☐	☐
	Internal rotation	☒	☐	☐	☐	☐	☐
	External Rotation	☒	☐	☐	☐	☐	☐
STOIC C- JOM	Abduction	☒	☐	☐	☐	☐	☐
	Adduction	☒	☐	☐	☐	☐	☐
	Flexion	☒	☐	☐	☐	☐	☐
	Extension	☒	☐	☐	☐	☐	☐
STOIC C- JOM	Dorsiflexion	☒	☐	☐	☐	☐	☐
	Plantarflexion	☒	☐	☐	☐	☐	☐
	Invertors	☒	☐	☐	☐	☐	☐
	Evertors	☒	☐	☐	☐	☐	☐

Comments: The client demonstrated functional extremity strength

LEFT		5/5	4/5	3/5	1-2/5	Cogwheel	No Test
STOIC C- JOM	Flexion	☐	☐	☐	☒	☐	☐
	Extension	☐	☒	☐	☐	☐	☐

W R I S T E R L E F T L O W E R E X T R E M I T Y	Abduction	☐	☐	☐	☒	☐	☐
	Adduction	☐	☐	☐	☐	☐	☒
	Internal Rotation	☐	☐	☒	☐	☐	☐
	External Rotation	☐	☐	☐	☒	☐	☐
W R I S T E R L E F T U P P E R E X T R E M I T Y	Flexion	☐	☒	☐	☐	☐	☐
	Extension	☐	☒	☐	☐	☐	☐
	Supination	☐	☒	☐	☐	☐	☐
	Pronation	☐	☒	☐	☐	☐	☐
W R I S T E R L E F T M I D D L E E X T R E M I T Y	Flexion	☐	☒	☐	☐	☐	☐
	Extension	☐	☒	☐	☐	☐	☐
	Ulnar Deviation	☐	☒	☐	☐	☐	☐
	Radial Deviation	☐	☒	☐	☐	☐	☐
W R I S T E R L E F T D I S T A L E X T R E M I T Y	Abduction	☐	☒	☐	☐	☐	☐
	Adduction	☐	☒	☐	☐	☐	☐
	Flexion	☐	☒	☐	☐	☐	☐
	Extension	☐	☒	☐	☐	☐	☐
W R I S T E R L E F T P R O X I M A L E X T R E M I T Y	Abduction	☐	☒	☐	☐	☐	☐
	Adduction	☐	☒	☐	☐	☐	☐
	Flexion	☐	☒	☐	☐	☐	☐
	Extension	☐	☒	☐	☐	☐	☐
W R I S T E R L E F T M E D I O D I S T A L E X T R E M I T Y	Flexion	☒	☐	☐	☐	☐	☐
	Extension	☒	☐	☐	☐	☐	☐
	Internal rotation	☒	☐	☐	☐	☐	☐
	External Rotation	☒	☐	☐	☐	☐	☐
W R I S T E R L E F T P R O X I M A L M E D I O D I S T A L E X T R E M I T Y	Abduction	☒	☐	☐	☐	☐	☐
	Adduction	☒	☐	☐	☐	☐	☐
	Flexion	☒	☐	☐	☐	☐	☐
	Extension	☒	☐	☐	☐	☐	☐
W R I S T E R L E F T D I S T A L M E D I O D I S T A L E X T R E M I T Y	Dorsiflexion	☒	☐	☐	☐	☐	☐
	Plantarflexion	☒	☐	☐	☐	☐	☐
	Invertors	☒	☐	☐	☐	☐	☐
	Evertors	☒	☐	☐	☐	☐	☐

Comments:

The client demonstrated functional left lower extremity strength. L UE strength is limited.

Range of Motion:

Body Part	NORMS	Right	Left
Shoulder Flexion	180	WFL	88
Shoulder Extension	60	WFL	38
Shoulder Abduction	180	WFL	79
Shoulder Int. Rotation	70	WFL	42
Shoulder Ext. Rotation	90	WFL	42
Elbow Flexion	0 - 150	WFL	WFL
Forearm Pronation	0 - 80	WFL	WFL
Forearm Supination	0 - 90	WFL	WFL
Wrist Flexion	80	WFL	WFL
Wrist Extension	70	WFL	WFL
Wrist Ulnar Deviation	30	WFL	WFL
Wrist Radial Deviation	20	WFL	WFL
Thumb CM Flexion	15	WFL	WFL
Thumb CM Extension	20	WFL	WFL
Thumb MP Flexion	50	WFL	WFL
Thumb IP Flexion	80	WFL	WFL
Thumb Abduction	70	WFL	WFL
Knee Flexion	0 - 135	WFL	WFL

Body Part	NORMS	Right	Left
Index MP Flexion	0-90	WFL	WFL
Index PIP Flexion	0-100	WFL	WFL
Index DIP Flexion	0-90	WFL	WFL
Middle MP Flexion	0 - 90	WFL	WFL
Middle PIP Flexion	0 - 100	WFL	WFL
Middle DIP Flexion	0 - 90	WFL	WFL
Ring MP Flexion	0 - 90	WFL	WFL
Ring PIP Flexion	0 - 100	WFL	WFL
Ring DIP Flexion	0 - 90	WFL	WFL
Little MP Flexion	0 - 90	WFL	WFL
Little PIP Flexion	0 - 100	WFL	WFL
Little DIP Flexion	0 - 90	WFL	WFL
Hip Flexion	120	WFL	WFL
Hip Extension	30	WFL	WFL
Hip Abduction	45	WFL	WFL
Hip Adduction	30	WFL	WFL
Ankle Dorsiflexion	20	WFL	WFL
Ankle Plantar Flexion	50	WFL	WFL

Comments:

The client has limited lumbar ROM to WFL. Cervical ROM: Flex 100%, Ext 22°, Rotation L 68° R 81°, Sidebending L 22° R 46°.

Sensation:

Two Point Discrimination			
RIGHT HAND		LEFT HAND	
Thumb	5 / 5 mm	Thumb	5 / 5 mm
Index	5 / 5 mm	Index	5 / 5 mm
Long	5 / 5 mm	Long	5 / 5 mm
Ring	5 / 5 mm	Ring	5 / 5 mm
Small	5 / 5 mm	Small	5 / 5 mm

Normal: 5 mm (2-12 mm) 12-25 mm (10-30 mm) 25-50 mm (20-60 mm) 50-100 mm (40-120 mm) 100-150 mm (80-180 mm) 150-200 mm (120-250 mm) 200-250 mm (150-300 mm) 250-300 mm (200-350 mm) 300-350 mm (250-400 mm) 350-400 mm (300-450 mm) 400-450 mm (350-500 mm) 450-500 mm (400-550 mm) 500-550 mm (450-600 mm) 550-600 mm (500-650 mm) 600-650 mm (550-700 mm) 650-700 mm (600-750 mm) 700-750 mm (650-800 mm) 750-800 mm (700-850 mm) 800-850 mm (750-900 mm) 850-900 mm (800-950 mm) 900-950 mm (850-1000 mm) 950-1000 mm (900-1050 mm) 1000-1050 mm (950-1100 mm) 1050-1100 mm (1000-1150 mm) 1100-1150 mm (1050-1200 mm) 1150-1200 mm (1100-1250 mm) 1200-1250 mm (1150-1300 mm) 1250-1300 mm (1200-1350 mm) 1300-1350 mm (1250-1400 mm) 1350-1400 mm (1300-1450 mm) 1400-1450 mm (1350-1500 mm) 1450-1500 mm (1400-1550 mm) 1500-1550 mm (1450-1600 mm) 1550-1600 mm (1500-1650 mm) 1600-1650 mm (1550-1700 mm) 1650-1700 mm (1600-1750 mm) 1700-1750 mm (1650-1800 mm) 1750-1800 mm (1700-1850 mm) 1800-1850 mm (1750-1900 mm) 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Pinch Strength		
	Right	Left
Tip to tip	9	1
Palmar	2	1
Lateral	17	5

Upper Extremity Endurance

	Occasional 1-33% per day 0.1-2.5 hrs/day 1-100 Reps/Day	Frequent 34-66% per day 2.6-5.5 hours/day 101-500 Reps/Day	Continuous 67-100% day 5.6-8 hours/day > 500 Reps/Day	Meets Job Demands
Repetitive Grasping Right	☐	☐	☒	N/A
Repetitive Grasping Left	☒	☐	☐	N/A
Repetitive Fingering Right	☐	☐	☒	N/A
Repetitive Fingering Left	☐	☐	☒	N/A
Repetitive Torquing Right	☐	☐	☐	N/A
Repetitive Torquing Left	☐	☐	☐	N/A
Repetitive Linear Reaching Right	☐	☐	☒	N/A
Repetitive Linear Reaching Left	☐	☒	☐	N/A
Repetitive Above Shoulder Reach Right	☐	☐	☐	N/A
Repetitive Above Shoulder Reach Left	☐	☐	☐	N/A

Edema

	Pre-Test Right	Pre-Test Left	Post-Test Right	Post-Test Left
Volumetrics				
Circumferential				

Inflammatory Response to Exercise N/A

Comments: Pt unable to reach overhead.

Balance/Gait Testing

Client demonstrated functional gait testing

Special Testing

Cardiovascular Endurance

Testing Protocol:	Treadmill ☒	YMCA Bike ☐	9-Inch Step Stool ☐
Gender:	Male: ☐	Female ☒	
Age: 50	Resting Blood Pressure: 124/89	Resting Heart Rate: 59	
Predicted Maximum Heart Rate: 170	85% Predicted Maximum Heart Rate: 145		
Maximum Met Level: METS	Safe Work Level: PDC		

Comments:

3

Lakelands Orthopaedic & Sports Medicine Clinic, PA

102 Gregor Mendel Circle • Greenwood, SC 29646 • (864)229-2663 • (864)223-5694 fax

ACCOUNT NUMBER: [REDACTED]
 DATE OF BIRTH: [REDACTED] DOB 1963
 PATIENT NAME: DUNCAN, KAREN
 REFERRING PHYSICIAN:
 DATE OF VISIT: 06/10/2015

Karen Duncan is 2.5 months out from left shoulder arthroscopic biceps tenotomy, subacromial decompression, cuff and labral debridement and distal clavicle excision. The incisions are clean and without signs of infection. She still complains of pain and swelling in the shoulder. She is complaining of some numbness and the therapist is concerned there may be a cervical issue here. There are no signs of infection and no signs of DVT. Today there is no loss of sensation to pin wheeling. Tinell's is negative at the cubital tunnel, Guyon's canal and carpal tunnel. Her neck motion is a little bit restricted. This seems to be mostly trapezial and levator or left-sided muscle spasm causing the issue. The spinous process and ^^ are nontender.

ASSESSMENT: Again, things in general at 2.5 months are coming along slow for not having had a cuff repair or a labral repair.

PLAN: She just needs to kind of keep pushing things as hard as she can. I think we do need to continue therapy. At my recommendation and her request under sterile conditions, we have injected the left shoulder both in the glenohumeral and subacromial spaces. I want her to push it as hard as she can and continue therapy. We will check her back in about 6 weeks. We will put her on light duty with this left upper extremity at this point in time.

Anthony R. Timms, MD

ART/wz985ny
 D: 06/10/2015 T: 06/21/2015
 Job ID:57234

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102 Gregor Mendel Circle • Greenwood, SC 29646 • (864)229-2663 • (864) 223-5694 fax

ACCOUNT NUMBER: ACCT #
DATE OF BIRTH: DOB/1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 04/28/2015

The patient is six weeks out left shoulder arthroscopic biceps tenotomy, SAD, cuff and labral debridement, and distal clavicle excision. She is really not getting into her active and passive motion here in the office with clear restriction. There is a lot of guarding just really would not let me loosen her up.

No signs of infection. No swelling in the arm. Radial pulse is good.

Gone ahead and x-rayed. Just not doing great. X-rays look good. Resection level looks go with both the distal clavicle and the acromioplasty. No signs of loss of position of the "AC joint". No signs of fracturing of the bone.

I am not quite sure why she cannot get things going. I discussed with her that she needs to take the sling off and start using it more in the house. The dos and don'ts in terms of activities are gone over. I am going to try to get physical therapy to be extremely aggressive with her. We are just a little bit behind at six weeks we did not expect from a debridement as oppose to a repair and this was carefully discussed with her. Work duties are outlined, see report. Again, x-rays left shoulder AC joint and outlet have been taken and the results are as above in the body.

Anthony R. Timms, MD

ART/wz984dj
D: 05/04/2015 T: 05/11/2015
Job ID:53735



☒ 102 Gregor Mendel Cir
Greenwood, SC 29646
864-223-8110

☐ 234 Birchtree Dr.
Greenwood, SC 29649
864-223-0900

PHYSICAL THERAPY REFERRAL

Patient's Name: Karen Duncan Date: 4-1-15

Diagnosis: D Shoulder Scope SAID, RCR, debridement, DCE

Procedure: biceps tenotomy

Frequency _____ # of visits for _____ weeks

MODALITIES:

☒ Modalities as needed
☐ Iontophoresis
☐ Electrical Stimulation

STRENGTHENING:

☐ Isometrics
☐ PRT's
☐ Open Chain Exercise
☐ Closed Chain Exercise

RANGE OF MOTION:

☐ Active
☐ Active-Assisted
☐ Passive
☐ Evaluate & Treat

PROGRAM/PROTOCOLS (TO INCLUDE EXERCISE, MODALITIES & PROCEDURE PLAN)
EVALUATE & TREAT

☐ Cervical Program
☐ Spinal Stabilization Program
☐ Back Rehabilitation Program
☐ SI Stabilization
☐ Shoulder Program
☐ Elbow Program
☐ Hand Program
☐ Total Joint Program
☐ Hip Program

☐ Knee Program
☐ Foot/Ankle Program
☐ TMJ Program
☐ Headache Treatment
☐ Work Conditioning
☐ Functional Capacity Evaluation
☐ Aerobic Conditioning
☐ Wound Care
☐ Other

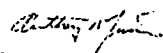
Comments:

Modalities
Full PROM
LAAROM

2x wk

M.D. Signature _____

This prescription also serves as a letter of medical necessity.

☐ John A. King, M.D. ☐ Richard M. Christian, Jr., M.D. ☐ Charles D. Gray, M.D. ☐ John H. Cathcart, III, M.D. ☒ Anthony K. Timony, M.D. ☐ Douglas F. Powell, M.D. ☐ Lou A. Patterson, M.D.		☐ Jonico S. Willard, P.A.-C
PATIENT WORK / SCHOOL STATUS REPORT		
Patient Name: <u>DUNKAN, KAREN</u>		Account No. <u>ACCT #</u>
Today's Date: <u>4/1/2015</u>		Date of Injury / Illness: _____
This Injury / Illness Is: ☒ Work Related ☐ School Related ☐ Personal		
Diagnosis: _____		
Follow-Up Appointment (date): _____		(time): _____
Please excuse this absence. Patient had/had an appointment on: <u>4/1/2015</u>		
PHYSICIAN COMMENTS:		
Patient is unable to drive, & will need transportation to/from work.		
WORK STATUS		
☐ Patient may return to work/school with NO RESTRICTIONS on (date): _____ ☐ Patient is OFF WORK/SCHOOL until (date): _____ ☒ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): <u>4/2/2015</u> If unavailable per employer, out until next appointment. Restrictions are as follows:		
RESTRICTIONS		
☐ Restricted lifting ☐ No lifting above 20 pounds ☐ No lifting above 10 pounds ☐ Sit down work only ☒ One-handed duty only. No use of the <u>left</u> arm. ☐ Avoid constant repetitive use of hands ☐ No twisting ☐ No bending ☐ No pulling ☐ No pushing ☐ No climbing ☐ Do not drive or operate heavy / hazardous equipment ☐ Return from all athletic activities until approximately _____ ☐ Other (please be specific): _____		
DURATION OF RESTRICTIONS		
☒ Until next appointment ☐ Until (date): <u>4/29/2015</u>		
TREATMENTS		
☐ Prescription medications: _____ ☐ Referred to (PT, OT, etc.): _____ ☐ _____		
Physician Signature: 		
		Date: <u>4/1/2015 12:29</u>

3/19/2015 7:03 AM FROM: Van Self Regional Healthcare TO: 221-9781 PAGE: 002 OF 004

Self Regional Healthcare
1325 Spring Street
Greenwood, SC 29646
Phone (864) 725-4111
Fax (864) 725-4810

PATIENT: DUNCAN, KAREN M
PHYSICIAN: ANTHONY R TIMMS, MD
DOB: [REDACTED] 1965
ACCT: [REDACTED] #
ROOM: 127
D-DATE: 03/17/2015
12:12
T-DATE: 03/19/2015

OPERATIVE REPORT

DATE: March 17, 2015

DATE OF BIRTH:
[REDACTED] 1965.

PREOPERATIVE DIAGNOSES:

1. Left shoulder impingement.
2. Biceps tendon tear proximally.
3. Labral tear.
4. Partial versus full-thickness cuff tear.

POSTOPERATIVE DIAGNOSES:

1. Left shoulder impingement.
2. Biceps tendon tear proximally.
3. Labral tear.
4. Partial versus full-thickness cuff tear.
5. Acromioclavicular (AC) joint arthritic changes were significant. It did not appear that bad radiographically, but clinically total arthroscopy was bad.

PROCEDURES:

- Left shoulder arthroscopic:
1. Subacromial decompression.
 2. Biceps tenotomy.
 3. Rotator cuff debridement, bursal side.
 4. Labral debridement.
 5. Distal clavicle excision.

SURGEON:
Anthony R Timms, MD.

Copy For: Copy For: Anthony R Timms, MD

PATIENT: DUNCAN, KAREN M
PHYSICIAN: ANTHONY R TIMMS, MD

ACCT: ACCT #
ROOM: 127

PAGE 2

ASSISTANT:
Childress, scrub technician.

ANESTHESIA:
General and regional for postoperative pain control.

ESTIMATED BLOOD LOSS:
10 mL.

DRAINS:
None used.

COMPLICATIONS:
None noted.

SPECIMENS:
No specimen.

DETAILS OF PROCEDURE:

After an adequate level of anesthesia was obtained, the patient was carefully positioned in the beach chair position. The left shoulder area was scrubbed and sterilely prepped and draped. A standard posterior soft spot portal incision was made and standard lateral portal incision was made. Via the posterior portal, camera cannula placed in over blunt trocar. Trocar was removed. Camera was inserted and inflow started from the lateral portal. Shaver and cautery was used to perform a very extensive bursectomy; bursitis was very bad here. The bursal side of the cuff was frayed. This was smoothed off with the shaver as well. Probing did not suggest anything deep at all in terms of cuff tear. Acromioplasty was initiated with the bur laterally and the camera remaining posteriorly. The initial inferior distal clavicle was excised in this manner as well. The portals were then switched and the acromioplasty was completed by planing it off and the remaining distal clavicle was removed with a bur from the posterior portal as well. General irrigation and shaving was carried out to remove debris. Hand rasping was used to smooth off the acromioplasty and distal clavicle excision. An additional debridement with shaver was carried out. The subacromial space was copiously irrigated. All instruments except 1 cannula were removed. The subacromial space was then bilged.

At this point in time, a glenohumeral arthroscopy was initiated via the posterior portal; 60 mL of saline were injected in the

Copy For: Copy For: Anthony R Timms, MD

3/19/2015 7:03 AM FROM: Van Self Regional Healthcare TO: 227-9707 PAGE: 004 OF 004

PATIENT: DUNCAN, KAREN M
PHYSICIAN: ANTHONY R TIMMS, MD

ACCT: ACCT.#
ROOM: 127

PAGE 3

glenohumeral joint. Camera cannula was placed into the glenohumeral joint over blunt trocar via the posterior portal. Trocar was removed. Camera was inserted. Inflow was started. A very complex tearing of the biceps tendon in the labrum appeared to be present. Visualization on the articular side of the cuff looked okay. A portal was established just above the subscapularis. Extensive synovitis was debrided back with cautery. The labrum was probed and did appear to be a type 1 tear. The labrum was smoothed off. One portion of it did kind of come up into the biceps, and this was debrided back, and what was remaining of the biceps was insufficient so the biceps were released. General smoothing off with cautery was carried out. On probing of the remaining labrum revealed it to be very stable and probing of the rotator cuff articular side revealed no tear. The glenohumeral joint was copiously irrigated. All instruments except 1 cannula were removed. The glenohumeral joint was bilged and the final cannula was removed. The 3 portals were closed with 3-0 nylon. Sterile bulky dressings and sling were applied.

ART/sc
Job #: 993986/647814057

Copy For: Copy For: Anthony R Timms, MD

Lakelands Orthopaedic & Sports Medicine Clinic, PA
102 Gregor Mondel Circle • Greenwood, SC 29646 • (864) 229-2663 • (864) 223-5694 fax

ACCOUNT NUMBER: ACCT #
DATE OF BIRTH: DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 03/02/2015

Karen Duncan comes in. The shoulder continues to do very, very, very poorly, with left shoulder weakness, pain, and popping, at this point in time.

All alternatives, risks and benefits were discussed with her at length. She does wish to proceed with left shoulder arthroscopic acromioplasty, biceps tenotomy, debridement and/or repair of the labrum, and likely debride the cuff with the outside chance we might have to repair it; I do not think the AC joint.

I reviewed the MRI and plain x-rays. There is some inflammation there, but I do not think it warrants distal clavicle excision and this discussed with her, her husband, and the caseworker. A complete evaluation was done. See written note on the chart. Everything looks good to proceed with above recommendations pending Anesthesia evaluation.

Anthony R. Timms, MD

ART/vz903lh
D: 03/02/2015 T: 03/10/2015
Job ID: 48159

Lakelands Orthopaedic & Sports Medicine Clinic, PA

102 Gregor Mendel Circle • Greenwood, SC 29646 • (864)229-2663 • (864) 223-5694 fax

ACCOUNT NUMBER: [REDACTED]
DATE OF BIRTH: [REDACTED] 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN: Dennis Murphy, MD
DATE OF VISIT: 12/31/2014

MRI arthrogram of the left shoulder does reveal a biceps tendon tear, probably type I labral tear, significant biceps ^^ tendinosis, may be partial tear, type II acromion. AC joint does not show any marked stenosis which is consistent with the regular x-rays. AC joint is inflamed but not particularly arthritic.

All alternatives, risks, and benefits were discussed with her. My recommendations are to proceed with left shoulder arthroscopic acromioplasty, cuff debridement and/or repair, labral debridement and/or repair, and biceps tenotomy. Implications of the appearance of the humerus permanently are discussed as opposed to scarring of the ^^ interval repair. Alternatives, risks, and benefits discussed at great length. She is leaning toward the above recommendation. She is going to consider things and let us know what she would like to do.

Anthony R. Timms, MD

ART/wz957dg
D: 01/02/2015 T: 01/05/2015
Job ID:43224

cc: Dennis Murphy, MD



SOUTH CAROLINA DIAGNOSTIC IMAGING

Palmetto Imaging West Columbia
2997 Sunset Boulevard, W. Columbia, SC 29169
p: (803) 934-0223 f: (803) 934-0229

PATIENT: DUNCAN, KAREN
DOB: 1965
MRN: MRN #
PHONE: 864- PHONE (Home)
PHYSICIAN: ANTHONY TIRMS, MD
EXAM DATE: 12/11/2014

EXAM: MR Left Shoulder With Contrast

REASON FOR EXAM: left shoulder pain /access of rot

TECHNIQUE: Written informed consent was obtained from the patient prior to the procedure. A 25-gauge needle was advanced into the left glenohumeral joint utilizing local anesthesia, sterile technique and fluoroscopic guidance. A small amount of nonionic contrast was injected to confirm needle tip placement. Subsequently, an admixture containing 10 mL of normal saline, 4 mL of nonionic contrast, and 0.1 mL of gadolinium was injected. There were no acute complications. Total fluoroscopy time was less than 0.1 minutes.

ARTHROGRAM FINDINGS: There is no evidence of rotator cuff tear by fluoroscopy.

IMPRESSION:
Successful left shoulder arthrogram. The patient proceeded to MRI for further imaging.

MRI OF THE LEFT SHOULDER (POST ARTHROGRAPHY)

TECHNIQUE: The following images were performed in a 1.5 Tesla magnet: Axial, coronal and sagittal T1-weighted fast spin-echo, oblique coronal and sagittal fat-saturated T2-weighted spin-echo, and oblique coronal fat-saturated T1-weighted spin-echo through the left shoulder. There are no priors for comparison.

FINDINGS: Hypertrophic and edematous A-C arthropathy is present and while there is no significant medial arch stenosis, this can very well contribute to patients pain syndrome given the edematous and erosive change. The patient has a type II acromion but no significant outlet stenosis.

Abnormal contrast accumulation is noted within the distal anterior insertion of the supraspinatus even though there is no gadolinium accumulation in this tear. Findings are in keeping with the combination of a developing Rim-Rent tear with a small delaminating component best depicted on the coronal images. The Rim-Rent portion of the tear measures 9 mm in width. The Rim-Rent portion is favored to propagate from the bursal side given the lack of contrast accumulation. There is minimal distal insertional fraying of the subscapularis, but the rotator cuff is otherwise intact.

There is a non-displaced split tear of the horizontal segment of the biceps long head tendon best depicted on sagittal images #8 and #9. The arcuate and vertical segments are intact.

PATIENT: DUNCAN, KAREN
 DOB: **DOB** 1965
 EXAM: MR Left Shoulder With Contrast
 EXAM DATE: 12/11/2014

There is also abnormal signal within the superior and posterior superior labrum in keeping with a non-displaced tear here.

Glenohumeral ligaments are intact. No significant articular disorder is noted.

CONCLUSION:

1. Inflamed A-C joint.
2. Variation of a Rim-Rent tear propagating from the bursal side noted at the distal anterior insertion of the supraspinatus. A miniscule delaminating intrasubstance component is also present.
3. Superior labral fraying, as above.
4. Non-displaced split tear of the horizontal segment of biceps long head tendon.

Zachary Kilpatrick, MD

ZK/bar

DD: 12/11/2014 01:42 P

DT: 12/11/2014 05:52 P

Accession#: 08-1972601 VS#: 120132164 CS#: 1154143

CC:

Electronically Signed and Reviewed by Zachary Kilpatrick, MD 12/11/2014 10:50 P

Lakelands Orthopaedic & Sports Medicine Clinic, PA

102 Gregor Mendel Circle • Greenwood, SC 29646 • (864)229-2663 • (864) 223-5694 fax

ACCOUNT NUMBER: [REDACTED]
DATE OF BIRTH: [REDACTED] 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 10/29/2014

RADIOGRAPHS: True AP, AC joint and outlet reveal minimal arthritic changes at the AC joint. The inferior glenohumeral line looks good. Glenohumeral joint looks good. There are some slight anterolateral acromial impingement changes. She does have a healed humerus fracture with displacement at the proximal one-third/distal one-third junction. The outlet view reveals a probable Type 1.5 acromion. It is a little bit curved, but it does not seem to be real displaced. I do not see any acute fracture or dislocation.

Anthony R. Timms, MD

ART/wz985ny
D: 10/31/2014 T: 11/12/2014
Job ID:38526a

Lakelands Orthopaedic & Sports Medicine Clinic, PA

102 Gregor Mendel Circle • Greenwood, SC 29646 • (864)229-2663 • (864) 223-5694 fax

ACCOUNT NUMBER: [REDACTED]
DATE OF BIRTH: [REDACTED] DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN: Dennis Murphy, MD
DATE OF VISIT: 10/29/2014

Thank you, Dr. Murphy, for sending Ms. Karen Duncan for evaluation.

HISTORY: She comes in complaining of left shoulder pain running into the upper arm area. She states it really does not go down below the elbow. She has had a previous humerus fracture on this side.

PAST MEDICAL HISTORY: The past, social, and family history form has been completed by the patient and reviewed by me with the patient, and there are no further comments or issues to be added.

PHYSICAL EXAM: Examination reveals some difficulty moving the shoulder in general. If I can get her to relax with the elbow at the side, it seems to be not too bad range of motion, so I do not think frozen shoulder is an issue, but it could be. She has a very, very positive impingement sign. She also has a positive apprehension and O'Brien's sign. These do appear to be legitimately positive. Cervical exam is good without any pain elicited. I do not detect any decreased sensation of the digits on the left. She does admit to some popping on use. I cannot get anything to pop real great in our office here today.

RADIOGRAPHS: See report

ASSESSMENT: It does appear that this probably is a cuff tear or labral tear. It seems probably a little bit more likely that it is the labrum, but she is having enough weakness upon exam that a cuff tear is concerning.

PLAN: At this point in time, we need to go ahead and proceed with an MR arthrogram of her left shoulder and check her back after that is done.

Anthony R. Timms, MD

ART/wz985ny
D: 10/31/2014 T: 11/12/2014
Job ID:38526

cc: Dennis Murphy, MD

4

Self Regional Healthcare
1325 Spring Street
Greenwood, SC 29646
Phone (864) 725-4111
Fax (864) 725-4810

PATIENT: DUNCAN, KAREN M
PHYSICIAN: ANTHONY R TIMMS, MD
DOB: [REDACTED] 1965
ADMITTED: 03/17/2015

ACCT: [REDACTED] ACCT #
ROOM: 127
D-DATE: 03/17/2015 12:12
T-DATE: 03/19/2015

OPERATIVE REPORT

DATE: March 17, 2015

DATE OF BIRTH:
[REDACTED] 1965.

PREOPERATIVE DIAGNOSES:

1. Left shoulder impingement.
2. Biceps tendon tear proximally.
3. Labral tear.
4. Partial versus full-thickness cuff tear.

POSTOPERATIVE DIAGNOSES:

1. Left shoulder impingement.
2. Biceps tendon tear proximally.
3. Labral tear.
4. Partial versus full-thickness cuff tear.
5. Acromioclavicular (AC) joint arthritic changes were significant.
It did not appear that bad radiographically, but clinically total
arthroscopy was bad.

PROCEDURES:

Left shoulder arthroscopic:

1. Subacromial decompression.
2. Biceps tenotomy.
3. Rotator cuff debridement, bursal side.
4. Labral debridement.
5. Distal clavicle excision.

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PATIENT: DUNCAN, KAREN M
PHYSICIAN: ANTHONY R TIMMS, MD

ACCT: ACCT #
ROOM: 127

PAGE 2

SURGEON:
Anthony R Timms, MD.

ASSISTANT:
Childress, scrub technician.

ANESTHESIA:
General and regional for postoperative pain control.

ESTIMATED BLOOD LOSS:
10 ml.

DRAINS:
None used.

COMPLICATIONS:
None noted.

SPECIMENS:
No specimen.

DETAILS OF PROCEDURE:

After an adequate level of anesthesia was obtained, the patient was carefully positioned in the beach chair position. The left shoulder area was scrubbed and sterily prepped and draped. A standard posterior soft spot portal incision was made and standard lateral portal incision was made. Via the posterior portal, camera cannula placed in over blunt trocar. Trocar was removed. Camera was inserted and inflow started from the lateral portal. Shaver and cautery was used to perform a very extensive bursectomy; bursitis was very bad here. The bursal side of the cuff was frayed. This was smoothed off with the shaver as well. Probing did not suggest anything deep at all in terms of cuff tear. Acromioplasty was initiated with the bur laterally and the camera remaining posteriorly. The initial inferior distal clavicle was excised in this manner as well. The portals were then switched and the acromioplasty was completed by planing it off and the remaining distal clavicle was removed with a bur from the posterior portal as well. General irrigation and shaving was carried out to remove debris. Hand rasping was used to smooth off the acromioplasty and distal clavicle excision. An additional debridging

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PATIENT: DUNCAN, KAREN M
PHYSICIAN: ANTHONY R TIMMS, MD

ACCT: ACCT #
ROOM: 127

PAGE 3

with shaver was carried out. The subacromial space was copiously irrigated. All instruments except 1 cannula were removed. The subacromial space was then bilged.

At this point in time, a glenohumeral arthroscopy was initiated via the posterior portal; 60 ml. of saline were injected in the glenohumeral joint. Camera cannula was placed into the glenohumeral joint over blunt trocar via the posterior portal. Trocar was removed. Camera was inserted. Inflow was started. A very complex tearing of the biceps tendon in the labrum appeared to be present. Visualization on the articular side of the cuff looked okay. A portal was established just above the subacromial. Extensive synovitis was debrided back with cautery. The labrum was probed and did appear to be a type 1 tear. The labrum was smoothed off. One portion of it did kind of come up into the biceps, and this was debrided back, and what was remaining of the biceps was insufficient so the biceps were released. General smoothing off with cautery was carried out. On probing of the remaining labrum revealed it to be very stable and probing of the rotator cuff articular side revealed no tear. The glenohumeral joint was copiously irrigated. All instruments except 1 cannula were removed. The glenohumeral joint was bilged and the final cannula was removed. The 3 portals were closed with 3-0 nylon. Sterile bulky dressings and sling were applied.

ART/so

Job #: 993906/647814057

Authenticated by Anthony R Timms, MD On 03/19/2015 07:34:50 AM

PRINTED BY: C92190

5



Tower Pointe Family Medicine
105 Vine Crest Court, Suite 600
Greenwood, SC, 29646
(864) 227-2900

MRN
MRN #

Encounter Date
10/07/2014 10:15AM

Patient Information
Karen M. Duncan
ADDRESS

49 years old
DOB - DOB 1965
(H) (864) PHONE
(W)(864) 229-3006

Greenwood, SC 29646

Reason For Visit

PHG WC Reason for Visit:
The patient is being seen for a routine clinic follow-up of a workplace injury.

Employment:

The patient is employed by Eaton Hydro.
Person authorizing treatment is Marlene Coats.
Drug screen has been requested and has been done.

Date of Injury/Illness:

Date of injury was 9/26/14.
Date of symptom onset was 9/26/14.
Date reported: 9/29/14.
Date of first treatment: 9/30/14.
Location of first treatment: PHG.
Visit number: 2.

History of Present Illness

PHG WC Workplace Injury: The injury involved the left shoulder. The injury resulted from repetitive activity and she has two pull hard on heavy doors and drawers to move them. No specific injury noted the pain came on while she was doing a harder than usual shift. The patient was not treated for this problem at the workplace. Symptoms include no localized swelling, no localized bruising and just the movement from arm swing when walking is painful. Symptoms have worsened since her previous visit. The patient presents with complaints of frequent episodes of localized pain, described as sharp, radiating to the left shoulder (in the anterior shoulder in the subacromial area). Current treatment includes an exercise regimen, nonsteroidal anti-inflammatory drugs and oral corticosteroids. By report, there is good adherence with treatment, good tolerance of treatment and poor symptom control.

Review of Systems

Constitutional: negative.
ENT: negative.
Cardiovascular: negative.

Vitals

Recorded by : Tuman, Rhonda at
07Oct2014 10:13AM
08.2 F

Temperature

Printed By: Sheenu Foster

1 of 3

1/19/15 10:29:59 AM

Patient: Karen M. Duncan
Encounter: Oct 7 2014 10:15AM

MRN: **MRN #**

Heart Rate	72
Respiration	16
Systolic	146
Diastolic	90
Height	5 ft 6 in
Weight	198 lb
BMI Calculated	31.96
BSA Calculated	1.90

Physical Exam

Constitutional
General appearance: No acute distress, well appearing and well nourished.

Neck
Neck: Supple, symmetric, trachea midline, no masses.

Chest
Chest: Abnormal. Tender over the left proximal pectoralis muscle in the anterior shoulder joint.

Musculoskeletal
Joints, bones, and muscles: Abnormal. Right shoulder has normal range of motion without pain. Left shoulder has decreased range of motion passively, with significant pain with any movement. Decreased strength with arms suspended. Left arm drifts down with arms suspended, eyes closed.

Range of motion: Normal.
Stability: Abnormal.

Assessment

1. Joint pain in the shoulder/clavicle region (719.41)
2. Weakness of shoulder (719.81)

Plan

- Orthopedic Referral Evaluation and Treatment W.Comp - Evaluate / Treat Status: Hold
For - Scheduling Requested for: 07Oct2014

Discussion/Summary

Occupational status of Injury: This injury/illness is work related.
Symptoms began during the performance of normal job duties, but without any recognized trauma or injury.

Work Status:
Employee may return to ALTERNATE/RESTRICTED DUTIES on 10/07/2014.
Restrictions: Restrictions apply until released by consultant.
One handed duty only with no use of the LEFT arm.
Orders Completed in Office:
X-ray/Image(s) Done Today: No.
Rx Medication(s) Given: No.

Recommendations/Orders:
Referral(s) Ordered: Orthopedic Surgery.

Patient Discussion: Discussed with the patient.
Maximum Medical Improvement: MMI has not been reached.

Past medical history, allergies to medications, and current medical treatments were obtained and reviewed. All of the above stated information is documented in the confidential medical record.
Information regarding vital signs and review of systems documented in the confidential medical record.

ABSTRACT

Printed By: Sheena Foster

2 of 3

1/19/15 10:29:59 AM

Patient: Karen M. Duncan
Encounter: Oct 7 2014 10:15AM

MRN: MRN #

Signatures

Electronically signed by : Dennis Murphy, M.D.; Oct 12 2014 10:00PM EST (Author)

Printed By: Sheena Foster

3 of 3

1/19/15 10:29:59 AM

Lakelands Orthopaedic & Sports Medicine Clinic, PA

102 Gregor Mendel Circle • Greenwood, SC 29646 • (864)229-2663 • (864) 223-5694 fax

ACCOUNT NUMBER: [REDACTED]
DATE OF BIRTH: [REDACTED] DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN: Dennis Murphy, MD
DATE OF VISIT: 10/29/2014

Thank you, Dr. Murphy, for sending Ms. Karen Duncan for evaluation.

HISTORY: She comes in complaining of left shoulder pain running into the upper arm area. She states it really does not go down below the elbow. She has had a previous humerus fracture on this side.

PAST MEDICAL HISTORY: The past, social, and family history form has been completed by the patient and reviewed by me with the patient, and there are no further comments or issues to be added.

PHYSICAL EXAM: Examination reveals some difficulty moving the shoulder in general. If I can get her to relax with the elbow at the side, it seems to be not too bad range of motion, so I do not think frozen shoulder is an issue, but it could be. She has a very, very positive impingement sign. She also has a positive apprehension and O'Brien's sign. These do appear to be legitimately positive. Cervical exam is good without any pain elicited. I do not detect any decreased sensation of the digits on the left. She does admit to some popping on use. I cannot get anything to pop real great in our office here today.

RADIOGRAPHS: See report

ASSESSMENT: It does appear that this probably is a cuff tear or labral tear. It seems probably a little bit more likely that it is the labrum, but she is having enough weakness upon exam that a cuff tear is concerning.

PLAN: At this point in time, we need to go ahead and proceed with an MR arthrogram of her left shoulder and check her back after that is done.

Anthony R. Timms, MD

ART/wz985ny
D: 10/31/2014 T: 11/12/2014
Job ID:38526

cc: Dennis Murphy, MD

Lakelands Orthopaedic & Sports Medicine Clinic, PA

102 Gregor Mendel Circle • Greenwood, SC 29646 • (864)229-2663 • (864) 223-5694 fax

ACCOUNT NUMBER: ACCT #
DATE OF BIRTH: DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 10/29/2014

RADIOGRAPHS: True AP, AC joint and outlet reveal minimal arthritic changes at the AC joint. The inferior glenohumeral line looks good. Glenohumeral joint looks good. There are some slight anterolateral acromial impingement changes. She does have a healed humerus fracture with displacement at the proximal one-third/distal one-third junction. The outlet view reveals a probable Type 1.5 acromion. It is a little bit curved, but it does not seem to be real displaced. I do not see any acute fracture or dislocation.

Anthony R. Timms, MD

ART/wz985ny
D: 10/31/2014 T: 11/12/2014
Job ID:38526a

Lakelands
Orthopaedic
& Sports Medicine Clinic, PA

102 GREGOR MENDEL CIRCLE
GREENWOOD, SC 29840
(854) 225-BONE (2663)
TOLL FREE (877) 229-BONE (2663)
FAX (854) 223-5694

103 COMMERCIAL DRIVE
ABBEVILLE, SC 29820
(854) 366-8332

300 RIDGE MEDICAL PLAZA
EDGEFIELD, SC 29824

SAVANNAH LAKES
McCORMICK, SC 29835

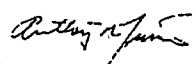
Name: Karen Duncan DOB **DOB** 10-29-14
Address: _____ Date: 10-29-14

MRI Arthrogram (L) Shoulder
(L) Shoulder pain
access for RCT

Anthony R. Timms

John A. King, M.D. • Richard M. Christian, Jr., M.D. • Charles D. Gray, M.D. • John H. Cathcart, III, M.D. • Anthony R. Timms, M.D.
Douglas F. Powell, M.D. • Lee A. Patterson, M.D. • Jessica S. Willard, P.A.-C

F-36 4-07

☐ John A. King, M.D. ☐ Richard M. Christian, Jr., M.D. ☐ Charles D. Gray, M.D. ☐ John H. Cathcart, III, M.D. ☒ Anthony R. Lumis, M.D. ☐ Douglas F. Powell, M.D. ☐ Lee A. Patterson, M.D.		☐ Jessica S. Willard, P.A.-C
PATIENT WORK / SCHOOL STATUS REPORT		
Patient Name: <u>DUNCAN, KAREN</u>		Account No. <u>ACCT #</u>
Today's Date: <u>10/29/2014</u>		Date of Injury / Illness: _____
This Injury / Illness is, ☒ Work Related ☐ School Related ☐ Personal		
Diagnosis (): <u>840.4 / 840.7</u>		
Follow-Up Appointment (date): _____ (time): _____		
Please excuse this absence. Patient had/has an appointment on: <u>10/29/2014</u>		
PHYSICIAN COMMENTS:		
WORK STATUS		
☐ Patient may return to work/school with NO RESTRICTIONS on (date): _____		
☐ Patient is OFF WORK/OUT OF SCHOOL until (date): _____		
☒ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): <u>10/29/2014</u> If unavailable per employer, out until next appointment Restrictions are as follows		
RESTRICTIONS		
☐ Restricted lifting		
☐ No lifting above 20 pounds ☐ No lifting above 10 pounds		
☐ Sit down work only		
☒ One-handed duty only. No use of the <u>left</u> arm.		
☐ Avoid constant repetitive use of hands		
☐ No twisting		
☐ No bending		
☐ No pulling		
☐ No pushing		
☐ No climbing		
☐ Do not drive or operate heavy / hazardous equipment		
☐ Refrain from all athletic activities until approximately _____		
☐ Other (please be specific): _____		
DURATION OF RESTRICTIONS		
☐ Until next appointment		
☒ Until (date): <u>follow up pending work comp approval for MRI</u>		
TREATMENTS		
☐ Prescription medications: _____		
☐ Referred to (PT, OT, etc.): _____		
☐ _____		
Physician Signature  Date <u>10/29/2014 14:38</u>		

Attachment for claim 251659V1515

12/1/2014

201410038507

5120141201045478

Lakelands
Orthopaedic
& Sports Medicine Clinic, PA

102 GREGOR MENDEL CIRCLE
GREENWOOD, SC 29645
(854) 229-3096 (2663)
TOLL FREE (877) 229-BONE (2663)
FAX (854) 223-5094

103 COMMERCIAL DRIVE
ABBEVILLE, SC 29520
(854) 366-8332

300 RIDGE MEDICAL PLAZA
EDGEFIELD, SC 29824

SAVANNAH LAKES
McCORMICK, SC 29835

Name: Karen Duncan DOB 125
Address: _____ Date: 12-12-14

MRI Arthrogram (L) Shoulder
(L) Shoulder pain/access for RCT

pt. needs copy of
images on a disc !!

Anthony Timms

John A. King, M.D. • Richard M. Christian, Jr., M.D. • Charles D. Gray, M.D. • John H. Cathcart, III, M.D. • Anthony R. Timms, M.D.
Douglas F. Powell, M.D. • Lee A. Patterson, M.D. • Jessica S. Wilbard, P.A.-C
Please fax report to 804-229-9902

F-38 4-07

Lakelands Orthopaedic & Sports Medicine Clinic, PA

102 Gregor Mendel Circle • Greenwood, SC 29646 • (864)229-2663 • (864) 223-5694 fax

ACCOUNT NUMBER: **ACCT #**
DATE OF BIRTH: **DOB 1965**
PATIENT NAME: **DUNCAN, KAREN**
REFERRING PHYSICIAN: **Dennis Murphy, MD**
DATE OF VISIT: **12/31/2014**

MRI arthrogram of the left shoulder does reveal a biceps tendon tear, probably type I labral tear, significant biceps ^^ tendinosis, may be partial tear, type II acromion. AC joint does not show any marked stenosis which is consistent with the regular x-rays. AC joint is inflamed but not particularly arthritic.

All alternatives, risks, and benefits were discussed with her. My recommendations are to proceed with left shoulder arthroscopic acromioplasty, cuff debridement and/or repair, labral debridement and/or repair, and biceps tenotomy. Implications of the appearance of the humerus permanently are discussed as opposed to scarring of the ^^ interval repair. Alternatives, risks, and benefits discussed at great length. She is leaning toward the above recommendation. She is going to consider things and let us know what she would like to do.

Anthony R. Timms, MD

ART/wz957dg
D: 01/02/2015 T: 01/05/2015
Job ID:43224

cc: Dennis Murphy, MD

Timms

W/C - Sedgwick
CLAIM #

PATIENT Karen Duncan SURGERY DOB 65 ACCT # 12-31-14
ACCOUNT # 12-31-14
DATE 12-31-14

1. TO SC X SMH
2. OP SAME DAY (in the hospital days)
3. LOCAL LOCAL/IV SEDATION IV REG BIER BLOCK
AXILLARY EPIDURAL SPINAL GENERAL

4. DIAGNOSIS ① biceps tear, Labral tear, ICD9 840.4
Partial RCT, Impingement 840.7
5. PLANNED PROCEDURE ① Shoulder scope, SAD, 726.2
biceps tenotomy, Cuff debridement vs. repair, CPT 29826
labral debridement vs repair 29828
6. EQUIPMENT 29827
29823
29807

7. TIME 15 MIN 1 HR 15 MIN 2 HR 15 MIN
30 MIN 1 HR 30 MIN 2 HR 30 MIN
45 MIN 1 HR 45 MIN 2 HR 45 MIN
1 HOUR 2 HOURS 3 HOURS

8. ASSISTANT NEEDED TECH PA DOCTOR

9. PRE-OP SURGICAL CLEARANCE WITH DR.

10. OTHER

11. DONATE UNITS

12. PROCRIT INJECTIONS YES or NO
remember hemoglobin needs to be done today

13. PATIENT WILL BE OUT OF WORK: now, until surgery and days or weeks post op
 days or weeks post op

SCHEDULED FOR

PATIENT REQUEST ANESTHESIOLOGIST

P10F-1 REVISED 4-08

12/31/2014

201410038507

5220141231003542

- ☐ John A. King, M.D.
- ☐ Richard M. Christian, Jr., M.D.
- ☐ Charles D. Gray, M.D.
- ☐ John H. Cathcart, III, M.D.
- ☒ Anthony R. Timms, M.D.
- ☐ Douglas F. Powell, M.D.
- ☐ Lee A. Patterson, M.D.

☐ Jessica S. Willard, P.A.

Lakelands Orthopaedic

& Sports Medicine Clinic, PA

PATIENT WORK / SCHOOL STATUS REPORT

Patient Name: DUNCAN, KAREN Account No. ACCT #

Today's Date: 12/31/2014 Date of Injury / Illness: _____

This Injury / Illness is: ☒ Work Related ☐ School Related ☐ Personal

Diagnosis (_____):

Follow-Up Appointment (date): _____ (time): _____

Please excuse this absence. Patient had/has an appointment on: 12/31/2014

PHYSICIAN COMMENTS:

WORK STATUS

- ☐ Patient may return to work/school with NO RESTRICTIONS on (date): _____
- ☐ Patient is OFF WORK/OUT OF SCHOOL until (date): _____
- ☒ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): _____ If unavailable per employer, out until next appointment
Restrictions are as follow:

RESTRICTIONS

- ☐ Restricted lifting
 - ☐ No lifting above 20 pounds
 - ☐ No lifting above 10 pounds
- ☐ Sit down work only
- ☒ One-handed duty only. No use of the left arm.
- ☐ Avoid constant repetitive use of hands
- ☐ No twisting
- ☐ No bending
- ☐ No pulling
- ☐ No pushing
- ☐ No climbing
- ☐ Do not drive or operate heavy / hazardous equipment
- ☐ Refrain from all athletic activities until approximately _____
- ☐ Other (please be specific): _____

DURATION OF RESTRICTIONS

- ☐ Until next appointment
- ☐ Until (date): _____

TREATMENTS

- ☐ Prescription medications: _____
- ☐ Referred to (PT, OT, etc.): _____
- ☐ _____: _____

Physician Signature: _____

Date: 12/31/2014 9:57

12/31/2014

201410038507

5220141231003876

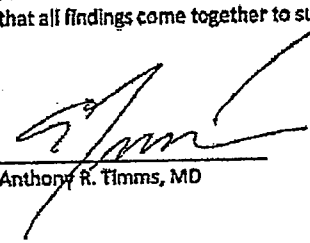
Lakelands Orthopaedic & Sports Medicine Clinic, PA
102 Gregor Mendel Circle - Greenwood, SC 29646 • (864) 229-2663 • (864) 223-5694 fax

January 30, 2015

RE: KAREN DUNCAN
DOB: DOB1965
Claim no: CLAIM #

To Whom It May Concern:

I have reviewed Ms. Duncan's job description along with the notes, and findings on the MRI and I feel that all findings come together to support that this injury occurred from her work.


Anthony R. Timms, MD

2/2/2015

201410038507

5220150202014693

Lakelands Orthopaedic & Sports Medicine Clinic, PA
102 Gregor Mendel Circle · Greenwood, SC 29646 · (864)229-2663 · (864) 223-5694 fax

ACCOUNT NUMBER: ACCT #
DATE OF BIRTH: DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 03/02/2015

Karen Duncan comes in. The shoulder continues to do very, very, very poorly, with left shoulder weakness, pain, and popping, at this point in time.

All alternatives, risks and benefits were discussed with her at length. She does wish to proceed with left shoulder arthroscopic acromioplasty, biceps tenotomy, debridement and/or repair of the labrum, and likely debride the cuff with the outside chance we might have to repair it; I do not think the AC joint.

I reviewed the MRI and plain x-rays. There is some inflammation there, but I do not think it warrants distal clavicle excision and this discussed with her, her husband, and the caseworker. A complete evaluation was done. See written note on the chart. Everything looks good to proceed with above recommendations pending Anesthesia evaluation.

Anthony R. Timms, MD

ART/wz903lh
D: 03/02/2015 T: 03/10/2015
Job ID:48159

L. J. Landels Orthopaedic

& Sports Medicine Clinic, PA

SURGICAL HISTORY AND PHYSICAL

(/ If Normal, X if Abnormal, del if deferred)

PATIENT NAME: Karen Duncan DATE: 3-2-15
 DATE OF BIRTH: DOB 1/5 (49) SURGERY DATE: 3/17/15

HISTORY OF PRESENT ILLNESS/CHIEF COMPLAINT _____

DIAGNOSIS: (L) bicep tear, labral tear, partial RCT, impingement
 PLANNED SURGERY: (L) shoulder scope, SAD bicep tenotomy, cuff debridement
 vs. repair, labral debridement vs. repair
 SOCIAL HISTORY: tobacco use: 0 alcohol use: 0
 FAMILY HISTORY: bleeding disorders: 0 anesthesia complications: N+V

PAST SURGERY: GB hysterectomy, Achilles

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

☒ HEENT glasses
☒ CARDIOVASCULAR HTN
☐ PULMONARY
☐ GU/RENAL
☐ GI
☒ MUSCULOSKELETAL Shoulder
☐ NEUROLOGICAL
☐ DIABETES/OTHER ENDOCRINE
☐ BLOOD DYSCRASIAS

☐ PROSTATE
☐ BLOOD CLOTS
 ANTICOAGULANT THERAPY:
☐ PREVIOUS
☐ CURRENT
☐ ASPIRIN, PLAVIX, COUMADIN

COMMENTS: _____ DOCTOR: P. Apodman - PHG 96

CURRENT MEDICATIONS:

HCTZ
tramadol

ALLERGIES: Std. d. 12/05/05
Lisinopril

LATEX ALLERGIES: NKA
 BANDAIDS? NKA
 TAPE: rash

PHYSICAL EXAM: vital signs: BP _____ PULSE _____ RESP _____ TEMP _____

☒ HEENT
☒ CARDIOVASCULAR
☒ CHEST
☒ ABDOMEN
☒ PELVIS
☒ EXTREMITIES

Left shoulder
hard Biceps
+ infra, pink
2.5 p.p.m. above 22 p.m.
NKA

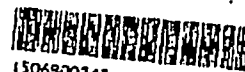
☒ MRI
☒ CT
☒ XRAY

Catallbriaps 10mg
pink 100g

COMMENTS: _____

FAU APPOINTMENT: 15 days
NO RX given (Wed) 4/1/15
10:30

PHYSICIAN SIGNATURE _____



1506900242 000005994
 DUNCAN, KAREN M
 Rm: DOB

FORM #F-15 REV. 02/08

PRINTED BY: C92198

5/6/2015

201410038507

5120150506080520

- ☐ John A. King, M.D.
☐ Richard M. Christian, Jr., M.D.
☐ Charles D. Gray, M.D.
☐ John H. Cathcart, III, M.D.
☒ Anthony R. Timms, M.D.
☐ Douglas F. Powell, M.D.
☐ Lee A. Patterson, M.D.

☐ Jessica S. Willard, P.A.

Lakelands Orthopaedic

& Sports Medicine Clinic, PA

PATIENT WORK / SCHOOL STATUS REPORT

Patient Name: DUNCAN, KAREN Account No. ACCT #
 Today's Date: 3/2/2015 Date of Injury / Illness: _____
 This Injury / Illness is: ☒ Work Related ☐ School Related ☐ Personal
 Diagnosis (): _____
 Follow-Up Appointment (date): 4/1/2015 (time): 10:30am
 Please excuse this absence. Patient had/has an appointment on: 3/2/2015

PHYSICIAN COMMENTS:

Scheduled for surgery on 3/17/2015.

WORK STATUS

- ☐ Patient may return to work/school with NO RESTRICTIONS on (date): _____
☒ Patient is OFF WORK/OUT OF SCHOOL until (date): 3/17/2015 to 4/2/2015
☒ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): _____ If unavailable per employer, out until next appointment
 Restrictions are as follow

RESTRICTIONS

- ☐ Restricted lifting
☐ No lifting above 20 pounds
☐ No lifting above 10 pounds
☐ Sit down work only
☒ One-handed duty only. No use of the left arm.
☐ Avoid constant repetitive use of hands
☐ No twisting
☐ No bending
☐ No pulling
☐ No pushing
☐ No climbing
☐ Do not drive or operate heavy / hazardous equipment
☐ Refrain from all athletic activities until approximately _____
☐ Other (please be specific): _____

DURATION OF RESTRICTIONS

- ☐ Until next appointment
☐ Until (date): _____

TREATMENTS

- ☐ Prescription medications: _____
☐ Referred to (PT, OT, etc.): _____
☐ _____

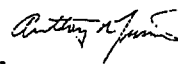
Physician Signature: _____

Date: 3/2/2015 10:16

3/24/2015

201410038507

5220150324003598

☐ John A. King, M.D. ☐ Richard M. Christian, Jr., M.D. ☐ Charles D. Gray, M.D. ☐ John H. Cathcart, III, M.D. ☒ Anthony R. Timms, M.D. ☐ Douglas F. Powell, M.D. ☐ Lee A. Patterson, M.D.		☐ Jessica S. Willard, P.A.-C
PATIENT WORK / SCHOOL STATUS REPORT		
Patient Name: <u>DUNCAN, KAREN</u>		Account No. XXXX ACCT # XXXX
Today's Date: <u>4/1/2015</u> Date of Injury / Illness: _____		
This Injury / Illness is: ☒ Work Related ☐ School Related ☐ Personal		
Diagnosis (): _____		
Follow-Up Appointment (date): _____ (time): _____		
Please excuse this absence. Patient had/has an appointment on: <u>4/1/2015</u>		
PHYSICIAN COMMENTS:		
Patient is unable to drive, & will need transportation to/from work		
WORK STATUS		
☐ Patient may return to work/school with NO RESTRICTIONS on (date): _____		
☐ Patient is OFF WORK/OUT OF SCHOOL until (date): _____		
☒ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): <u>4/2/2015</u> If unavailable per employer, out until next appointment. Restrictions are as follows:		
RESTRICTIONS		
☐ Restricted lifting		
☐ No lifting above 20 pounds		
☐ No lifting above 10 pounds		
☐ Sit down work only		
☒ One-handed duty only. No use of the <u>left</u> arm.		
☐ Avoid constant repetitive use of hands		
☐ No twisting		
☐ No bending		
☐ No pulling		
☐ No pushing		
☐ No climbing		
☐ Do not drive or operate heavy / hazardous equipment		
☐ Refrain from all athletic activities until approximately _____		
☐ Other (please be specific): _____		
DURATION OF RESTRICTIONS		
☒ Until next appointment		
☒ Until (date): <u>4/29/2015</u>		
TREATMENTS		
☐ Prescription medications: _____		
☐ Referred to (PT, OT, etc.): _____		
☐ _____		
Physician Signature: 		Date: <u>4/1/2015 12:27</u>

Lakelands Orthopaedic & Sports Medicine Clinic, PA
102 Gregor Mendel Circle • Greenwood, SC 29646 • (864)229-2663 • (864) 223-5694 fax

ACCOUNT NUMBER: ACCT #
DATE OF BIRTH: DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 04/29/2015

The patient is six weeks out left shoulder arthroscopic biceps tenotomy, SAD, cuff and labral debridement, and distal clavicle excision. She is really not getting into her active and passive motion here in the office with clear restriction. There is a lot of guarding just really would not let me loosen her up.

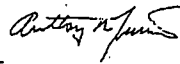
No signs of infection. No swelling in the arm. Radial pulse is good.

Gone ahead and x-rayed. Just not doing great. X-rays look good. Resection level looks go with both the distal clavicle and the acromioplasty. No signs of loss of position of the "AC joint". No signs of fracturing of the bone.

I am not quite sure why she cannot get things going. I discussed with her that she needs to take the sling off and start using it more in the house. The dos and don'ts in terms of activities are gone over. I am going to try to get physical therapy to be extremely aggressive with her. We are just a little bit behind at six weeks we did not expect from a debridement as oppose to a repair and this was carefully discussed with her. Work duties are outlined, see report. Again, x-rays left shoulder AC joint and outlet have been taken and the results are as above in the body.

Anthony R. Timms, MD

ART/wz984dj
D: 05/04/2015 T: 05/11/2015
Job ID:53735

☐ John A. King, M.D. ☐ Richard M. Christian, Jr., M.D. ☐ Charles D. Gray, M.D. ☐ John H. Cathcart, III, M.D. ☒ Anthony R. Timms, M.D. ☐ Douglas F. Powell, M.D. ☐ Lee A. Patterson, M.D.		☐ Jessica S. Willard, P.A.-C
PATIENT WORK / SCHOOL STATUS REPORT		
Patient Name: <u>DUNCAN, KAREN</u>		Account No. <u>ACCT #</u>
Today's Date: <u>4/29/2015</u> Date of Injury / Illness: _____		
This Injury / Illness is: ☒ Work Related ☐ School Related ☐ Personal		
Diagnosis (): _____		
Follow-Up Appointment (date): _____ (time): _____		
Please excuse this absence. Patient had/has an appointment on: <u>4/29/2015</u>		
PHYSICIAN COMMENTS:		
WORK STATUS		
☐ Patient may return to work/school with NO RESTRICTIONS on (date): _____		
☐ Patient is OFF WORK/OUT OF SCHOOL until (date): _____		
☒ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): <u>4/30/2015</u> If unavailable per employer, out until next appointment. Restrictions are as follows:		
RESTRICTIONS ☐ Restricted lifting ☐ No lifting above 20 pounds ☐ No lifting above 10 pounds ☐ Sit down work only ☒ One-handed duty only. No use of the <u>left</u> arm. ☐ Avoid constant repetitive use of hands ☐ No twisting ☐ No bending ☐ No pulling ☐ No pushing ☐ No climbing ☐ Do not drive or operate heavy / hazardous equipment ☐ Refrain from all athletic activities until approximately _____ ☐ Other (please be specific): _____		
DURATION OF RESTRICTIONS ☒ Until next appointment ☒ Until (date): <u>6/10/2015</u>		
TREATMENTS		
☐ Prescription medications: _____		
☐ Referred to (PT, OT, etc.): _____		
☐ _____		
Physician Signature:  Anthony Timms, M.D.		Date: <u>4/29/2015 9:31</u>

Lakelands Orthopaedic & Sports Medicine Clinic, PA

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ACCOUNT NUMBER: ACCT #
DATE OF BIRTH: DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 06/10/2015

Karen Duncan is 2.5 months out from left shoulder arthroscopic biceps tenotomy, subacromial decompression, cuff and labral debridement and distal clavicle excision. The incisions are clean and without signs of infection. She still complains of pain and swelling in the shoulder. She is complaining of some numbness and the therapist is concerned there may be a cervical issue here. There are no signs of infection and no signs of DVT. Today there is no loss of sensation to pin wheeling. Tinel's is negative at the cubital tunnel, Guyon's canal and carpal tunnel. Her neck motion is a little bit restricted. This seems to be mostly trapezial and levator or left-sided muscle spasm causing the issue. The spinous process and ^{AA} are nontender.

ASSESSMENT: Again, things in general at 2.5 months are coming along slow for not having had a cuff repair or a labral repair.

PLAN: She just needs to kind of keep pushing things as hard as she can. I think we do need to continue therapy. At my recommendation and her request under sterile conditions, we have injected the left shoulder both in the glenohumeral and subacromial spaces. I want her to push it as hard as she can and continue therapy. We will check her back in about 6 weeks. We will put her on light duty with this left upper extremity at this point in time.

Anthony R. Timms, MD

ART/wz985ny
D: 06/10/2015 T: 06/21/2015
Job ID:57234

☐ John A. King, M.D.
☐ Richard M. Christian, Jr., M.D.
☐ Charles D. Gray, M.D.
☐ John H. Cuthbert, III, M.D.
☒ Anthony R. Timms, M.D.
☐ Douglas P. Powell, M.D.
☐ Lee A. Pusterson, M.D.

☐ Jessica S. Willard, P.A.-C

Lakelands Orthopaedic

& Sports Medicine Clinic, PA

PATIENT WORK / SCHOOL STATUS REPORT

Patient Name: DUNCAN, KAREN Account No. ACCT #
 Today's Date: 6/10/2015 Date of Injury / Illness: _____
 This Injury / Illness is: ☐ Work Related ☐ School Related ☐ Personal
 Diagnosis (): _____ (time): _____
 Follow-Up Appointment (date): _____ (time): _____
 Please excuse this absence. Patient had/has an appointment on: 6/10/2015

PHYSICIAN COMMENTS:

please excuse patient for absence on 06/09/2015

WORK STATUS

☐ Patient may return to work/school with NO RESTRICTIONS on (date): _____
☐ Patient is OFF WORK/OUT OF SCHOOL until (date): _____
☒ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): 6/10/2015 If unavailable per employer, out until next appointment.
 Restrictions are as follows:

RESTRICTIONS

☒ Restricted lifting
☒ No lifting above 20 pounds
☐ No lifting above 10 pounds
☐ Sit down work only
☐ One-handed duty only. No use of the _____ arm.
☐ Avoid constant repetitive use of hands
☐ No twisting
☐ No bending
☐ No pulling
☐ No pushing
☐ No climbing
☐ Do not drive or operate heavy / hazardous equipment
☐ Refrain from all athletic activities until approximately _____
☒ Other (please be specific): no over chest height lifting

DURATION OF RESTRICTIONS

☒ Until next appointment
☒ Until (date): 07/22/15 @ 8:00

TREATMENTS

☐ Prescription medications: _____
☐ Referred to (PT, DT, etc.): _____
☐ _____: _____

Physician Signature: Anthony Timms Date: 6/10/2015 9:37
 Anthony Timms, M.D.

Lakelands Orthopaedic & Sports Medicine Clinic, PA

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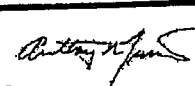
ACCOUNT NUMBER: ACCT #
DATE OF BIRTH: DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 07/13/2015

The patient comes in four months out from left shoulder tenotomy, SAD, cuff and labral debridement, distal clavicle excision. Again, this is the left side. Things just in general come around a little bit slower. Steroid injection in the shoulder has helped some. She has been complaining of neck pain and left upper extremity tingling. So, there may be some cervical issues going on as well.

We are going to go ahead and give her a Sterapred dose pack, continue restricted duty at work, no lifting over 20 pounds, but otherwise really try to push it as hard as she can. There is still some restriction of motion in the shoulder, but no real specific positive exam, supraspinatus, O'Brien's or apprehension. Will check her in two months.

Anthony R. Timmis, MD

ART/wz984dJ
D: 07/13/2015 T: 07/22/2015
Job ID:59963

☐ John A. King, M.D. ☐ Richard M. Christian, Jr., M.D. ☐ Charles D. Grey, M.D. ☐ John H. Cathcart, III, M.D. ☒ Anthony R. Thoms, M.D. ☐ Douglas F. Powell, M.D. ☐ Leo A. Patterson, M.D.		☐ Jessica S. Willard, P.A.-C
PATIENT WORK / SCHOOL STATUS REPORT		
Patient Name: <u>DUNCAN, KAREN</u>		Account No. <u>ACCT #</u>
Today's Date: <u>7/13/2015</u>		Date of Injury / Illness: _____
This Injury / Illness is: ☒ Work Related ☐ School Related ☐ Personal		
Diagnosis (): _____		
Follow-Up Appointment (date): _____ (time): _____		
Please excuse this absence. Patient had/had an appointment on: <u>7/13/2015</u>		
PHYSICIAN COMMENTS:		
WORK STATUS		
☐ Patient may return to work/school with NO RESTRICTIONS on (date): _____ ☐ Patient is OFF WORK/OUT OF SCHOOL until (date): _____ ☒ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): _____ If unavailable per employer, out until next appointment. Restrictions are as follows:		
RESTRICTIONS		
☒ Restricted lifting ☒ No lifting above 20 pounds ☐ No lifting above 10 pounds ☐ Sit down work only ☐ One-handed duty only. No use of the _____ arm. ☐ Avoid constant repetitive use of hands ☐ No twisting ☐ No bending ☐ No pulling ☐ No pushing ☐ No climbing ☐ Do not drive or operate heavy / hazardous equipment ☐ Refrain from all athletic activities until approximately _____ ☐ Other (please be specific): _____		
DURATION OF RESTRICTIONS		
☒ Until next appointment ☒ Until (date): <u>9/14/2015</u>		
TREATMENTS		
☐ Prescription medications: _____ ☐ Referred to (PT, OT, etc.): _____ ☐ _____: _____		
Physician Signature: 		Date: <u>7/13/2015 15:55</u>

Lakelands Orthopaedic & Sports Medicine Clinic, PA

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ACCOUNT NUMBER: ACCT #
DATE OF BIRTH: DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 08/12/2015

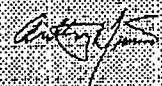
Karen Duncan comes in almost five months out from left shoulder surgery. In general, it has been coming along a little slow. We gave her a steroid pack and things just do not seem to be turning the corner. She has limited motion of her cervical spine, lots of complaints of pain in her neck. The pain does seem to radiate into both trapezii bilaterally. She does not seem to have any numbness in the hands.

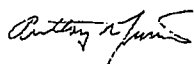
ASSESSMENT: Continued neck pain despite shoulder treatment, possibly just a cervical sprain or possible aggravation of some underlying arthritic degenerative changes in the neck from the injury that she had.

PLAN: At this point in time, the cervical issue seems to be a limiting factor so we need to go ahead and get an MRI of the cervical spine. We will check her back after that is done.

Anthony R. Timms, MD

ART/wz985ny
D: 08/29/2015 T: 09/08/2015
Job ID: 64271

Lakelands Orthopaedic Sports Medicine Clinic, PA		
181 GREGORY MONDEL CIRCLE GREENWOOD, SC 29615 (803) 228-8000 (FAX) TOLL FREE (877) 228-8000 (FAX) FAX (803) 228-8000	101 COMMERCIAL DRIVE ANDERSON, SC 29621 (803) 228-8000	100 PINEHURST MEDICAL PLAZA EDENHURST, SC 29617 SAVANNAH LANE ANDERSON, SC 29621
Patient Name: <u>haren Dragan Dori</u> DOB: <u>6/5</u>		
Claim # <u>CLAIM #</u> Date: <u>8/13/15</u>		
Cervical MRI DX: Assess for Spinal Stenosis		
		
John A. King, M.D. • Richard M. Christen, Jr., M.D. • Charles D. Gray, M.D. • John H. Gannon, III, M.D. • Anthony D. Thomas, M.D. Douglas F. Powell, M.D. • Lee A. Patterson, M.D. • Jessica S. Wilford, P.A.-C		

☐ John A. King, M.D. ☐ Richard M. Christian, Jr., M.D. ☐ Charles D. Gray, M.D. ☐ John H. Cathcart, III, M.D. ☐ Anthony R. Timms, M.D. ☐ Douglas F. Powell, M.D. ☐ Lee A. Patterson, M.D.	 Lakelands Orthopaedic & Sports Medicine Clinic, PA	☐ Jessica S. Willard, P.A.-C
PATIENT WORK / SCHOOL STATUS REPORT		
Patient Name: <u>DUNCAN, KAREN</u>		Account No. <u>ACCT #</u>
Today's Date: <u>8/12/2015</u>		Date of Injury / Illness: _____
This Injury / Illness is: ☐ Work Related ☐ School Related ☐ Personal		
Diagnosis (): _____		
Follow-Up Appointment (date): _____		(time): _____
Please excuse this absence. Patient had/has an appointment on: <u>8/12/2015</u>		
PHYSICIAN COMMENTS:		
WORK STATUS		
☐ Patient may return to work/school with NO RESTRICTIONS on (date): _____ ☐ Patient is OFF WORK/OUT OF SCHOOL until (date): _____ ☒ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): <u>8/12/2015</u> If unavailable per employer, out until next appointment. Restrictions are as follows:		
RESTRICTIONS ☒ Restricted lifting ☒ No lifting above 20 pounds ☐ No lifting above 10 pounds ☐ Sit down work only ☐ One-handed duty only. No use of the _____ arm. ☐ Avoid constant repetitive use of hands ☐ No twisting ☐ No bending ☐ No pulling ☐ No pushing ☐ No climbing ☐ Do not drive or operate heavy / hazardous equipment ☐ Refrain from all athletic activities until approximately _____ ☐ Other (please be specific): _____		
DURATION OF RESTRICTIONS ☒ Until next appointment ☒ Until (date): <u>pending MRI approval</u>		
TREATMENTS		
☐ Prescription medications: _____ ☐ Referred to (PT, OT, etc.): _____ ☐ _____: _____		
Physician Signature:  _____ Anthony Timms, M.D.		Date: <u>8/12/2015 16:01</u>

Lakelands Orthopaedic & Sports Medicine Clinic, PA

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ACCOUNT NUMBER: ACCT #
DATE OF BIRTH: DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 08/19/2015

This is a patient of Dr. Timms who presents from physical therapy in a lot of neck pain. The therapist was concerned about the amount of radicular pain she is having in the left upper extremity when she is trying to rehab her shoulder. The pain reports having a lot of muscle spasm and pain in her neck and radiating down her arm, down into the ulnar side of her hand consistent more with a region of ulnar neuropathy.

PHYSICAL EXAM: She sits with her head tilted to the right. In checking her neck range of motion with the muscle spasm she can only get the neck to neutral. She cannot rotate the head to turn to the left side. I tested this by sitting to her left side when I was speaking to her and she moves her eyes without moving her neck to focus on me. She can move her head to the right in rotation and tilt but will not tilt it to the left. She is tender in the trapezius muscle and the neck muscles. She denies having any fall or any injury to the neck.

ASSESSMENT: Patient rehabbing shoulder after surgery, now with acute neck spasm with radicular symptoms in left upper extremity.

PLAN: I am recommending a cervical spine MRI, patient be out of work until this is addressed, and we have given her a prescription for Flexeril to help with the muscle spasm.

Lee A. Patterson, MD

LAP/wz938rp
D: 08/22/2015 T: 08/24/2015
Job ID: 63535

BROWN AND RADIOLOGY ASSOCIATES

PATIENT: DUNCAN, KAREN
DOB: [REDACTED] 1965 **MR#:** [REDACTED] **MRN #**
EXAM DATE: 08/19/2015
PROCEDURE: MRI OF THE CERVICAL SPINE
FACILITY: LAKELANDS ORTHOPAEDIC & SPORTS MEDICINE CLINIC
PHYSICIAN: DR. PATTERSON

CLINICAL HISTORY:
Neck pain, cervical radiculopathy.

FINDINGS:
The visualized prevertebral and retrospinal soft tissue structures are unremarkable.

The craniocervical junction is unremarkable. The cervical spinal cord demonstrates normal caliber, without signal alteration.

C2-3, C3-4, C4-5, C5-6, C6-7, C7-T1, T1-2, T2-3, T3-4, and T4-5 demonstrated no compressive disc disease. No high-grade spondylosis.

CONCLUSION:
Unremarkable MRI of the cervical spine without contrast.

PRELIMINARY REPORT UNLESS APPROVED BY PHYSICIAN

H. BRADFORD JONES, JR., M.D.

HBJ/mh
Dict: 08/19/2015
Trans: 08/20/2015
Job#: 1160080

fcc: Lakelands Orthopaedic & Sports Medicine Clinic (Fax: 864-229-9902)

Lakelands Orthopaedic & Sports Medicine Clinic, PA

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ACCOUNT NUMBER: [REDACTED]
DATE OF BIRTH: [REDACTED] 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 09/02/2015

Karen Duncan comes in. Cervical MRI was reported as completely normal. The nerve testing has suggested a little bit of maybe cubital tunnel syndrome but no cervical issues are noted. The ulnar finding ^^ is very mild. This is discussed with her carefully. I do not think this has anything to do with the neck tightness or the shoulder problems that she has been having. I am not sure why she has all of the spasm that she is having. Will continue to treat that medically. Have her continue exercises at home for both the shoulder and the neck, active as tolerated. We will check her back in about 6 weeks. Would expect her to be at MMI at that time, but cervical evaluation, both imaging and nerve testing are completely normal by reports.

Anthony R. Timms, MD

ART/wz957dg
D: 09/04/2015 T: 09/15/2015
Job ID: 64791

☐ John A. King, M.D. ☐ Richard M. Christman, Jr., M.D. ☐ Charles D. Gray, M.D. ☐ John H. Lehnert, M.D. ☒ Anthony R. Thomas, M.D. ☐ Douglas P. Powell, M.D. ☐ Lee A. Patterson, M.D.	Lakelands Orthopaedic & Sports Medicine Clinic, PA	☐ Joseph S. Wollard, P.A. C.
PATIENT WORK / SCHOOL STATUS REPORT		
Patient Name: <u>DUNNAN, KAREN</u>		Account No. <u>ACCT #</u>
Today's Date: <u>9/2/2015</u>		Date of Injury / Illness: _____
Injury / Illness is: ☐ Work Related ☐ School Related ☐ Personal		
Diagnosis: _____		
Follow-Up Appointment (date): _____ (time): _____		
Please excuse this absence. Patient has/had an appointment on: <u>9/2/2015</u>		
PHYSICIAN COMMENTS:		
WORK STATUS		
☒ Patient may return to work/school with NO RESTRICTIONS by (date): <u>9/2/2015</u>		
☐ Patient is OFF WORK/SCHOOL until (date): _____		
☐ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): _____ If unavailable per employer, use next appointment. Restrictions are as follows:		
RESTRICTIONS:		
☐ Restricted lifting: ☐ No lifting above 20 pounds ☐ No lifting above 10 pounds		
☐ Sit down work only		
☐ One-handed only, no use of the _____ arm		
☐ Avoid constant repetitive use of hands		
☐ No twisting		
☐ No bending		
☐ No pushing		
☐ No climbing		
☐ Do not drive or operate heavy / large equipment		
☐ Refrain from all athletic activities until appointment		
☐ Other (please be specific): _____		
DURATION OF RESTRICTIONS:		
☐ Until next appointment		
☐ Until (date): _____		
TREATMENTS:		
☐ Prescription medications: _____		
☐ Referred to (PT, OT, etc.): _____		
☐ _____		
Physician Signature:		Date: <u>9/2/2015 13:34</u>
Anthony Thomas, M.D.		

Lakelands Orthopaedic & Sports Medicine Clinic, PA

102 Gregor Mendel Circle · Greenwood, SC 29646 · (864)229-2663 · (864) 223-5694 fax

ACCOUNT NUMBER: [REDACTED]
DATE OF BIRTH: [REDACTED] DOB 1965
PATIENT NAME: DUNCAN, KAREN
REFERRING PHYSICIAN:
DATE OF VISIT: 10/14/2015

HISTORY: Karen Duncan comes in complaining of left little finger numbness, some left shoulder soreness and a lot of neck pain. She states her shoulder is probably the least of the problems that she is having now.

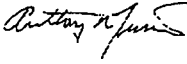
PAST MEDICAL HISTORY: The past, social, and family history form has been completed by the patient and reviewed by me with the patient, and there are no further comments or issues to be added.

PHYSICAL EXAM: She has a lot of guarding on her elbow and her neck, but appears the best I can tell that the shoulder itself has pretty good range of motion. There is glenohumeral abduction to about 100 degrees with external rotation to about 30 degrees. Forward flexion and internal rotation look good. There is a negative supraspinatus, negative impingement, negative O'Brien's sign, just some general tenderness, but again it is mostly referred back to the elbow and the neck.

PLAN: She had an MRI of the cervical spine which was normal. She apparently has been to the Spine Center now and they are doing things for her neck. I am not sure what they are doing, but it is discussed with her that the neck looked okay from the MRI standpoint. I do not believe this is related to the injury to her left shoulder that she had. She has had some nerve testing that showed some cubital tunnel, but it was very mild and I do not think this is related to the left shoulder in any way. It seems to be getting a little bit better, but the persistent numbness is bothering her. Again I do not think either one of these is related to the left shoulder. I think as far as her left shoulder is concerned, she is at maximal medical improvement. She may be released to full activities without restriction and she has a 3% impairment of the left upper extremity due to slight restriction of abduction and external rotation. We will check her back as needed.

Anthony R. Timms, MD

ART/wz985ny
D: 10/14/2015 T: 10/26/2015
Job ID:68519

☐ John A. King, M.D. ☐ Richard M. Christian, Jr., M.D. ☐ Charles D. Gray, M.D. ☐ John H. Cathcart, III, M.D. ☒ Anthony R. Timms, M.D. ☐ Douglas F. Powell, M.D. ☐ Lee A. Patterson, M.D.	 Lakelands Orthopaedic & Sports Medicine Clinic, PA	☐ Jessica S. Willard, P.A.-C
PATIENT WORK / SCHOOL STATUS REPORT		
Patient Name: <u>DUNCAN, KAREN</u>		Account No. <u>ACCT #</u>
Today's Date: <u>10/14/2015</u>		Date of Injury / Illness: _____
This Injury / Illness is: ☐ Work Related ☐ School Related ☐ Personal		
Diagnosis (): _____		
Follow-Up Appointment (date): _____ (time): _____		
Please excuse this absence. Patient had/has an appointment on: <u>10/14/2015</u>		
PHYSICIAN COMMENTS:		
WORK STATUS		
☒ Patient may return to work/school with NO RESTRICTIONS on (date): <u>10/15/2015</u> ☐ Patient is OFF WORK/OUT OF SCHOOL until (date): _____ ☐ Patient may return to ALTERNATIVE WORK / SCHOOL on (date): _____ If unavailable per employer, out until next appointment. Restrictions are as follows:		
RESTRICTIONS ☐ Restricted lifting ☐ No lifting above 20 pounds ☐ No lifting above 10 pounds ☐ Sit down work only ☐ One-handed duty only. No use of the _____ arm. ☐ Avoid constant repetitive use of hands ☐ No twisting ☐ No bending ☐ No pulling ☐ No pushing ☐ No climbing ☐ Do not drive or operate heavy / hazardous equipment ☐ Refrain from all athletic activities until approximately _____ ☐ Other (please be specific): _____		
DURATION OF RESTRICTIONS ☐ Until next appointment ☐ Until (date): _____		
TREATMENTS		
☐ Prescription medications: _____ ☐ Referred to (PT, OT, etc.): _____ ☐ _____: _____		
Physician Signature:  Date: <u>10/14/2015 17:14</u> Anthony Timms, M.D.		

South Carolina Workers' Compensation Commission
1612 Marion Street • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wccsc.gov



Physician's Statement

Claimant's Name: Karen Duncan
Physician's Name: Anthony Timmons
Practice/Clinic: Lakelands Ortho.
Preparer's Name: SA
Phone: PHONE

Employer's Name: _____
Insurance Carrier: _____
SCWC 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: 10/29/14 Date of last visit: 10/14/15

Diagnosis or nature of injury or illness: OB left shoulder

Body part(s) injured: left shoulder Body part(s) affected: LUE

Date of Maximum Medical Improvement: 10/14/15

Based on the AMA Guidelines, the claimant has sustained a three (3) % medical impairment to ONE injured body part(s) and a 0 % medical impairment to whole body other affected body part(s).

☒ The claimant is able to return to work without restriction.

☐ The claimant is able to return to work with the following restrictions:

☐ The claimant is unable to return to work at his or her current employment.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

☒ will not need future medical care related to his or her work related injury or illness, based on a reasonable degree of medical certainty (more likely than not).

☐ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Treating Physician: [Signature]

Date: 11-2-15

9/07

14B

Physician's Statement

3/19/2015 7:03 AM FROM: Fax Self Regional Healthcare TO: 227-9707 PAGE: 002 OF 004

Self Regional Healthcare
1325 Spring Street
Greenwood, SC 29646
Phone (864) 725-4111
Fax (864) 725-4810

PATIENT:	DUNCAN, KAREN M	ACCT:	ACCT #
PHYSICIAN:	ANTHONY R TIMMS, MD	ROOM:	127
DOB:	DOB 1965	D-DATE:	03/17/2015
		12:12	
ADMITTED:	03/17/2015	T-DATE:	03/19/2015

OPERATIVE REPORT

DATE: March 17, 2015

DATE OF BIRTH:
DOB 1965.

PREOPERATIVE DIAGNOSES:

1. Left shoulder impingement.
2. Biceps tendon tear proximally.
3. Labral tear.
4. Partial versus full-thickness cuff tear.

POSTOPERATIVE DIAGNOSES:

1. Left shoulder impingement.
2. Biceps tendon tear proximally.
3. Labral tear.
4. Partial versus full-thickness cuff tear.
5. Acromioclavicular (AC) joint arthritic changes were significant. It did not appear that bad radiographically, but clinically total arthroscopy was bad.

PROCEDURES:

Left shoulder arthroscopic:

1. Subacromial decompression.
2. Biceps tenotomy.
3. Rotator cuff debridement, bursal side.
4. Labral debridement.
5. Distal clavicle excision.

SURGEON:

Anthony R Timms, MD.

Copy For: Copy For: Anthony R Timms, MD

3/19/2015 7:03 AM FROM: Fax Self Regional Healthcare TO: 227-9707 PAGE: 003 OF 004

PATIENT: DUNCAN, KAREN M
PHYSICIAN: ANTHONY R TIMMS, MD

ACCT: ACCT #
ROOM: 127

PAGE 2

ASSISTANT:
Childress, scrub technician.

ANESTHESIA:
General and regional for postoperative pain control.

ESTIMATED BLOOD LOSS:
10 mL.

DRAINS:
None used.

COMPLICATIONS:
None noted.

SPECIMENS:
No specimen.

DETAILS OF PROCEDURE:

After an adequate level of anesthesia was obtained, the patient was carefully positioned in the beach chair position. The left shoulder area was scrubbed and sterilely prepped and draped. A standard posterior soft spot portal incision was made and standard lateral portal incision was made. Via the posterior portal, camera cannula placed in over blunt trocar. Trocar was removed. Camera was inserted and inflow started from the lateral portal. Shaver and cautery was used to perform a very extensive bursectomy; bursitis was very bad here. The bursal side of the cuff was frayed. This was smoothed off with the shaver as well. Probing did not suggest anything deep at all in terms of cuff tear. Acromioplasty was initiated with the bur laterally and the camera remaining posteriorly. The initial inferior distal clavicle was excised in this manner as well. The portals were then switched and the acromioplasty was completed by planing it off and the remaining distal clavicle was removed with a bur from the posterior portal as well. General irrigation and shaving was carried out to remove debris. Hand rasping was used to smooth off the acromioplasty and distal clavicle excision. An additional debridement with shaver was carried out. The subacromial space was copiously irrigated. All instruments except 1 cannula were removed. The subacromial space was then bilged.

At this point in time, a glenohumeral arthroscopy was initiated via the posterior portal; 60 mL of saline were injected in the

Copy For: Copy For: Anthony R Timms, MD

3/19/2015 7:03 AM FROM: Fax Self Regional Healthcare TO: 227-9707 PAGE: 004 OF 004

PATIENT: DUNCAN, KAREN M
PHYSICIAN: ANTHONY R TIMMS, MDACCT: ACCT #
ROOM: 127

PAGE 3

glenohumeral joint. Camera cannula was placed into the glenohumeral joint over blunt trocar via the posterior portal. Trocar was removed. Camera was inserted. Inflow was started. A very complex tearing of the biceps tendon in the labrum appeared to be present. Visualization on the articular side of the cuff looked okay. A portal was established just above the subscapularis. Extensive synovitis was debrided back with cautery. The labrum was probed and did appear to be a type 1 tear. The labrum was smoothed off. One portion of it did kind of come up into the biceps, and this was debrided back, and what was remaining of the biceps was insufficient so the biceps were released. General smoothing off with cautery was carried out. On probing of the remaining labrum revealed it to be very stable and probing of the rotator cuff articular side revealed no tear. The glenohumeral joint was copiously irrigated. All instruments except 1 cannula were removed. The glenohumeral joint was bilged and the final cannula was removed. The 3 portals were closed with 3-0 nylon. Sterile bulky dressings and sling were applied.

ART/se
Job #: 993986/647814057

Copy For: Copy For: Anthony R Timms, MD



SOUTH CAROLINA DIAGNOSTIC IMAGING

Palmetto Imaging West Columbia
2997 Sunset Boulevard, W. Columbia, SC 29169
p: (803) 936-0223 f: (803) 936-0229

PATIENT: DUNCAN, KAREN
DOB: 1965
MRN: [REDACTED]
PHONE: 864- [REDACTED] (Home)
PHYSICIAN: ANTHONY TIMMS, MD
EXAM DATE: 12/11/2014

EXAM: MR Left Shoulder With Contrast

REASON FOR EXAM: left shoulder pain /access of rct

TECHNIQUE: Written informed consent was obtained from the patient prior to the procedure. A 25-gauge needle was advanced into the left glenohumeral joint utilizing local anesthesia, sterile technique and fluoroscopic guidance. A small amount of nonionic contrast was injected to confirm needle tip placement. Subsequently, an admixture containing 10 mL of normal saline, 4 mL of nonionic contrast, and 0.1 mL of gadolinium was injected. There were no acute complications. Total fluoroscopy time was less than 0.1 minutes.

ARTHROGRAM FINDINGS: There is no evidence of rotator cuff tear by fluoroscopy.

IMPRESSION:

Successful left shoulder arthrogram. The patient proceeded to MRI for further imaging.

MRI OF THE LEFT SHOULDER (POST ARTHROGRAPHY)

TECHNIQUE: The following images were performed in a 1.5 Tesla magnet: Axial, coronal and sagittal T1-weighted fast spin-echo, oblique coronal and sagittal fat-saturated T2-weighted spin-echo, and oblique coronal fat-saturated T1-weighted spin-echo through the left shoulder. There are no priors for comparison.

FINDINGS: Hypertrophic and edematous A-C arthropathy is present and while there is no significant medial arch stenosis, this can very well contribute to patients pain syndrome given the edematous and erosive change. The patient has a type II acromion but no significant outlet stenosis.

Abnormal contrast accumulation is noted within the distal anterior insertion of the supraspinatus even though there is no gadolinium accumulation in this tear. Findings are in keeping with the combination of a developing Rim-Rent tear with a small delaminating component best depicted on the coronal images. The Rim-Rent portion of the tear measures 9 mm in width. The Rim-Rent portion is favored to propagate from the bursal side given the lack of contrast accumulation. There is minimal distal insertional fraying of the subscapularis, but the rotator cuff is otherwise intact.

There is a non-displaced split tear of the horizontal segment of the biceps long head tendon best depicted on sagittal images #8 and #9. The arcuate and vertical segments are intact.

PATIENT: DUNCAN, KAREN
DOB: [REDACTED] 1965
EXAM: MR Left Shoulder With Contrast
EXAM DATE: 12/11/2014

There is also abnormal signal within the superior and posterior superior labrum in keeping with a non-displaced tear here.

Glenohumeral ligaments are intact. No significant articular disorder is noted.

CONCLUSION:

1. Inflamed A-C joint.
2. Variation of a Rim-Rent tear propagating from the bursal side noted at the distal anterior insertion of the supraspinatus. A miniscule delaminating intrasubstance component is also present.
3. Superior labral fraying, as above.
4. Non-displaced split tear of the horizontal segment of biceps long head tendon.

Zachary Kilpatrick, MD

ZK/bar

DD: 12/11/2014 01:42 P

DT: 12/11/2014 05:52 P

Accession#: 08-1972601 VS#: 120132164 CS#: 1154143

cc:

Electronically Signed and Reviewed by Zachary Kilpatrick, MD 12/11/2014 10:50 P



☒ 102 Gregor Mendel Cir
Greenwood, SC 29646
864-229-8110

☐ 234 Birchtree Dr.
Greenwood, SC 29649
864-223-0900

PHYSICAL THERAPY REFERRAL

Patient's Name: Karen Duncan Date: 4-1-15
Diagnosis: D Shoulder Scope SAID, RCR debridement, DCE
Procedure: biceps tenotomy
Frequency: _____ # of visits for _____ weeks

MODALITIES:

☒ Modalities as needed
☐ Iontophoresis
☐ Electrical Stimulation

STRENGTHENING:

☐ Isometrics
☐ PRE's
☐ Open Chain Exercise
☐ Closed Chain Exercise

RANGE OF MOTION:

☐ Active
☐ Active-Assisted
☐ Passive
☐ Evaluate & Treat

PROGRAM/PROTOCOLS (TO INCLUDE EXERCISE, MODALITIES & PROCEDURE PLAN)
EVALUATE & TREAT

☐ Cervical Program
☐ Spinal Stabilization Program
☐ Back Rehabilitation Program
☐ SI Stabilization
☐ Shoulder Program
☐ Elbow Program
☐ Hand Program
☐ Total Joint Program
☐ Hip Program

☐ Knee Program
☐ Foot/Ankle Program
☐ TMJ Program
☐ Headache Treatment
☐ Work Conditioning
☐ Functional Capacity Evaluation
☐ Aerobic Conditioning
☐ Wound Care
☐ Other

Comments:

Modalities
Full PROM
AAROM

2X wk

M.D. Signature _____

This prescription also serves as a letter of medical necessity.

Patient Name: Karen Duncan	DOB: DOB 65	Date: 4-9-15
----------------------------	-------------	--------------

Today's Treatment:

PROM - ① shoulder sup. flex, ER, $\frac{1}{2}$ IR. ② GHs distraction

TS: seated flexion stretch on table x 10; pendulums x 20 - written HEP given

Assessment:

Pt is 49 yof plw @ shoulder scope SAR, PCR, debridement, DCA, & biceps tenotomy.
Pt very sore throughout eval but admitted decreased pain @ end of eval.
Pt would benefit from skilled PT for stretching, Rom, strengthening, pain.
Help w/ functional activities-

_Prognosis for return to previous level of activity: Good

Short Term Goals:

To be met in 3-4 weeks.

1. Pt. to be Independent with HEP for flexibility/strength/stability of left/right shoulder/scapular complex
2. Pt. to have pain no greater than 5 out of 10 with ADLs/work/sports/sleep in left/right UE
- 3.

Long Term/Functional or Work Related Goals: To be met in 8-10 weeks.

1. Pt. to have pain no greater than 3 out of 10 with ADLs/work/sports/sleep in left/right UE
2. Pt. to have left/right AROM flexion shoulder greater than 150° and IR AROM to 41 for reaching ADLs
3. Pt. to have 4+ out of 5 strength left/right shoulder/elbow for return to work/ADLs/sports
- 4.

Plan Patient is to receive physical therapy 2 days per week for 8-10 weeks.

- | | |
|--|--|
| ☒ Manual Therapy — PROM | ☐ Traction (Lumbar/ Cervical) |
| ☒ Therapeutic Exercise (AAROM/Isometrics) | ☒ Ultrasound/Phonophoresis/Iontophoresis |
| ☒ Therapeutic Exercise (AROM/PRES) | ☒ Electrical Stimulation |
| ☒ Manual Therapy (Myofascial/Trigger Point/
Joint Mobs) | ☒ Kinesiotaping |
| ☐ Neuromuscular Re-education | ☒ Hot Pack/ Cold Pack |
| ☐ Gait/Stair Training | ☒ Home Exercise Program |
| | ☐ Other _____ |

If you have any questions or comments concerning this patient's plan of care or goals,

please feel free to contact me at 864-229-8110. Thank you for your referral.

Therapist Name: Tina Pausinger Monaghan

Signature: Max Mart Lic # 495

I certify the medical necessity of services furnished under this plan of care.

Physician signature:



102Gregor Mendel Cir Greenwood, SC 29646 854-229-8120

Daily Progress Note

Patient Name: Karen Duncan Date: 4-13-15 Total Visits: 1

Diagnosis: ① Shoulder xage

Precautions:

SUBJECTIVE: Pain Rating: 7/10 Functional Changes: It still hurts. It's hard to rotate

OBJECTIVE: Measurements:

Treatment Today:

2 min ☒ Therapeutic Exercise for ☒ flexibility ☐ strength ☒ per flowsheet

15 min ☒ Manual Therapy for soft tissue stretching PROM as follows: supine Plev. ER IR stretching. ①
② biceps v. ext. p.m./sup

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar _____

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Gait/Stair training: _____

____ min ☐ Manual attended estim: _____

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for iontophoresis _____ mA/min to _____

____ min ☐ Therapeutic Activity: _____ ☐ per flowsheet

____ min ☐ Other timed treatment: _____

23 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☒ Unattended estim IFC sinusoidal 1-8 CV 15 min

☐ Hot ☒ Cold pack ice collar → 7-8 CV

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

40 min: TOTAL TREATMENT TIME

ASSESSMENT: Pt very guarded & protective. ① shoulder & pain = approx.
PROB. No noticeable change - PROB. per visual assessment.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☒ correct technique

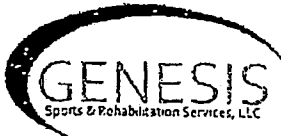
☒ correct progression

PLAN: Cont per POC.

Therapist Signature: DP N. DT

License Number: 4967

7/1/2015 3:14 PM FROM FAX TO MAILING PAGE 005 OF 011



102Gregor Mendel Cir Greenwood, SC 29646 864-229-8120

Daily Progress Note

Patient Name: Karen Duncan

Date: 4-16-15 Total Visits: 1

Diagnosis: ⑥ Shoulder surgery

Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: I was able to move until the morning. I tried to move but a hour later it was bad again. The electric felt like a shock. I think.

OBJECTIVE: Measurements: ✓ 82" 12.5" 8"

Treatment Today:

6 min ☒ Therapeutic Exercise for ☒ flexibility ☐ strength ☒ per flowsheet

15 min ☒ Manual Therapy for soft tissue stretching PROM as follows: Supine Flex, ER, IR, Abduction
(DGH) distract

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

 min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

 min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture
☐ proprioception ☐ movement ☐ per flowsheet

 min ☐ Gait/Stair training: _____

 min ☐ Manual attended estim: _____

 min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

 min ☐ Set up time for Iontophoresis _____ mA/min to _____

 min ☐ Therapeutic Activity: _____ ☐ per flowsheet

 min ☐ Other timed treatment: _____

 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar: mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☒ Unattended estim 13.5V-15.5V IFC to shoulder 13 min

☐ Hot ☒ Cold pack IFC

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

35 min: TOTAL TREATMENT TIME

ASSESSMENT: Pt very painful & all movement & needs crutch & verbal cues not to "guard" shoulder & to "relax." Pt reported nausea during tx but relieved abit & calm & less

Goals met: Pt. requires continued skilled intervention for exercises for ☐ safety ☒ correct technique ☒ correct progression

PLAN: Cont per ADC

Therapist Signature: _____

License Number: 4957



102Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Kara Duncan Date: 4-23-15 Total Visits: 4

Diagnosis: Shoulder impingement

Precautions:

SUBJECTIVE: Pain Rating: 7-8/10 Functional Changes: I'm trying to go without my sling for a while but I noticed my arm swelling so I put it back on.

OBJECTIVE: Measurements: LR 88° IP ER 30° - P

Treatment Today:

15 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

15 min ☐ Manual Therapy for soft tissue stretching PROM as follows: scapula flex, ER, IR stretching

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

 min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

 min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture ☐ proprioception ☐ movement ☐ per flowsheet

 min ☐ Gait/Stair training: _____

 min ☐ Manual attended estim: _____

 min ☐ Ultrasound to: _____

 min ☐ Set up time for iontophoresis _____ mA/min to _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

 min ☐ Therapeutic Activity: _____

 min ☐ Other timed treatment: _____ ☐ per flowsheet

25 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☒ Unattended estim 1 PE 12.5 CV to Shoulder impingement 15 min

☐ Hot ☒ Cold pack to Shoulder impingement

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

40 min: TOTAL TREATMENT TIME

ASSESSMENT: Pain improving but pt still in a lot of pain. May call more about PE next visit depending on pain.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☒ safety ☒ correct technique

PLAN: Cont per PR - back to work next week. ☒ correct progression

Therapist Signature: _____

License Number: 11957



102Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen Duncan Date: 4-29-15 Total Visits: 1

Diagnosis: (L) shoulder x-ape Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Can't sleep last night 2' pain.

OBJECTIVE: Measurements: Arms Di 145 Shoulder 125, ER central

Treatment Today:

5 min ☒ Therapeutic Exercise for ☒ flexibility ☐ strength ☐ per flowsheet

15 min ☒ Manual Therapy for soft tissue stretching PROM as follows: Super flex, ER, IR stretching
in elbow flexion and pron, supination; (SGL) distraction

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment: log ☐ with manual stim

min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture
☐ proprioception ☐ movement ☐ per flowsheet

min ☐ Gait/Stair training: _____

min ☐ Manual attended estim: _____

min ☐ Ultrasound to: _____

min ☐ Set up time for iontophoresis _____ mA/min to _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

min ☐ Therapeutic Activity: _____

min ☐ Other timed treatment: _____ ☐ per flowsheet

min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. a _____ min

☒ Unattended estim 1FC to (L) shoulder 13 min 15 sec

☐ Hot ☒ Cold pack 2 cubes

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

40 min: TOTAL TREATMENT TIME

ASSESSMENT: Patient is tender & painful. Unable to tolerate AARIM today
although they were attempted. The change is hard today likely
due to painful (on ER MCL) prior to the treatment. Estimate the degree to 4/5

Goals met: _____ pt. requires continued skilled intervention for exercises for ☒ safety ☒ correct technique

PLAN: Resume TENS for pain SGL MV update ☒ correct progression

Therapist Signature: [Signature] License Number: 4951



102 Gregor Mendel Cir Greenwood, SC 29646 864-729-8110

Progress Note / Discharge Note

Name: <u>Karen Duncan</u>	Date: <u>4-29-15</u>
DOB: <u>DOB 6/5</u>	Physician: <u>Timels</u>
Medical Diagnosis: <u>pl. C1 shoulder SAG, PCP</u>	Treatment Diagnosis:

Treatment Received:

- | | | |
|--|---|---|
| ☐ Therapeutic Exercise | ☐ Hot Pack | ☐ PRE's |
| ☐ Ultrasound | ☐ AROM | ☒ Home Exercise Program |
| ☒ PROM | ☒ Cold Pack | ☐ Traction |
| ☒ Electrical Stimulation | ☐ Isometrics | ☐ Kinesiotaping |
| ☒ AAROM | ☐ Manual Techniques | ☐ Other |

Attendance: 5/5 visits 0 cancelled 0 no shows since 4/19/15

Tests/ Measurements:

(C) Deltoid: 0-145° PROM
(C) Shoulder Flex 98° ER neutral (had x in 4/23 but too painful today)

Occupation: _____ Work Status: Not Working Light Modified Full
 Occupational Requirements: _____

Current Physician Limitations (as described by patient): _____

Goals set at Initial Evaluation: Met _____ Not Met _____
 Partially Met _____

Assessment/Comments: ROM progressing but slow due to elevated
pain levels. Progress using ice - also helpful to decrease
pain. Patient also "weather" seems to have an effect on her
pain levels too.

New Goals: _____

Recommendations: Recomm. Home TENS unit to control pain. Cont PT 2 weeks

Steve Traynor, PT Heidi Blake, DPT Tina P. Singer, DPT Forest Newby, PTA Meredith Bernstein, DPT

MD RESPONSE:	
☒ Continue PT	<u>2</u> times per week for <u>6</u> weeks
☐ Change Treatment/s to	_____
☐ Discharge to HEP	_____
☐ Other:	_____

I certify the medical necessity of services furnished under this plan of care.

Physician Signature: [Signature] 4-29-15



102 Gregor Mendel Cir Greenwood, SC 29646 864-729-8110

Daily Progress Note

Patient Name: Karen Duncan Date: 5/6/15 Total Visits: 1

Diagnosis: SLP @ Scope shoulder Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: "I'm rid of that pain from before the surgery but it's still a tender"

OBJECTIVE: Measurements: Pt reports going back to work light duty

Treatment Today:

20 min ☒ Therapeutic Exercise for ☐ flexibility ☐ strength ☒ per flowsheet

10 min ☒ Manual Therapy for soft tissue stretching PROM as follows: 775
flexion, IR, ER semi-reclined

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____
☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture
☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Gait/Stair training: _____

____ min ☐ Manual attended estim: _____

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for iontophoresis _____ mA/min to _____

____ min ☐ Therapeutic Activity: _____

____ min ☐ Other timed treatment: _____ ☐ per flowsheet

30 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☒ Unattended estim 1 PC x 10 min to 6547 semi-reclined 6-12, 0-15.5

☐ Pot ☒ Cold pack 7 estin Pillows over covered over clothing

☐ TENS unit application to _____ ☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

50 min: TOTAL TREATMENT TIME

ASSESSMENT: Unable to do pulleys - guard technique today
Able to add amesalges 2-LESS ppi; on 4/6/15 today
may still need TENS if still pain on 4/6/15

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☒ correct technique

PLAN: Cont POC ☒ correct progression

Therapist Signature: David B. B. PT License Number: 4457



102 Gregor Mendel Cir Greenwood, SC 29646 864-779-8110

Daily Progress Note

Patient Name: Karen Dunbar Date: 5/7/15 Total Visits: 1

Diagnosis: C5/6 Disc Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: pt still unable to lift

OBJECTIVE: Measurements:

Treatment Today:

20 min ☐ Therapeutic Exercise for ☐ flexibility ☒ strength ☐ per flowsheet

15 min ☒ Manual Therapy for soft tissue stretching PIROM as follows: neck to the C6

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

 min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

 min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture
☐ proprioception ☐ movement ☐ per flowsheet

 min ☐ Gait/Stair training:

 min ☐ Manual attended estim:

 min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

 min ☐ Set up time for Iontophoresis _____ mA/min to _____

 min ☐ Therapeutic Activity: ice to the neck ☐ per flowsheet

 min ☐ Other timed treatment: ice

 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☒ Unattended estim x 15 min not at 14.5 V/1.5

☐ Hot ☒ Cold pack

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

 min: TOTAL TREATMENT TIME

ASSESSMENT: pt does not understand

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☐ correct technique

PLAN: continue ☐ correct progression

Therapist Signature: [Signature] License Number: 10156



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen Duncan Date: 5/12/15 Total Visits: 1

Diagnosis: ② Sciatic Nerve Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: 1.1 - 1.2 - 1.3 - 1.4 - 1.5
in 10-15 min

OBJECTIVE: Measurements:

Treatment Today:

10 min ☐ Therapeutic Exercise for ☐ flexibility ☒ strength ☐ per flowsheet

15 min ☒ Manual Therapy for soft tissue stretching PROM as follows: Right to Left (L)
Right to Left

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☒ Manual Therapy for myofascial release and/or trigger point release as follows: Right to Left MFR
to the right of the midline

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture
☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Gait/Stair training:

____ min ☐ Manual attended estim:

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for Iontophoresis _____ m4Min to _____

____ min ☐ Therapeutic Activity:

____ min ☒ Other timed treatment: 5 min to initiate the MFR ☐ per flowsheet

min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☒ Unattended estim 15 min rest at 13.0 L/H

☐ Hot ☐ Cold pack

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min: TOTAL TREATMENT TIME

ASSESSMENT: PT still has a lot of pain in the right leg and
it's not good. It's still not better in MFR.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☐ correct technique

PLAN: 15 min rest ☐ correct progression

Therapist Signature: [Signature] License Number: 2164



102 Gregor Mendel Cir Greenwood, SC 29646 864-279-8110

Daily Progress Note

Patient Name: Karen Dunn Date: 5/14/13 Total Visits: 1

Diagnosis: L5/S1 Spinal Stenosis Precautions:

SUBJECTIVE: Pain Rating: 10 Functional Changes: PT unable to walk 6 min without pain

OBJECTIVE: Measurements:

Treatment Today:

10 min ☐ Therapeutic Exercise for ☐ flexibility ☐ strength ☐ per flowsheet

20 min ☒ Manual Therapy for soft tissue stretching PROM as follows: ROM to ROM (L5/S1)

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☒ Manual Therapy for myofascial release and/or trigger point release as follows: in 20 min

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture ☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Gait/Stair training:

____ min ☐ Manual attended estlm:

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for Iontophoresis _____ mA/min to _____

____ min ☐ Therapeutic Activity: _____ ☐ per flowsheet

____ min ☐ Other timed treatment:

____ min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estlm

☐ Hot ☐ Cold pack

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

35 min: TOTAL TREATMENT TIME

ASSESSMENT: PT unable to walk 6 min without pain

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☐ correct technique

PLAN: Cont 100 ☐ correct progression

Therapist Signature: [Signature] License Number: 3166

2013 05 14 12:00 PM 102 GREGOR MENDEL CIR GREENWOOD, SC 29646



102Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen D... Date: 5/22/15 Total Visits: 1

Diagnosis: (L) Child Stroke SAI) DCE Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Having some difficulty performing tasks.

OBJECTIVE: Measurements: VC 5", ER 95", IR 32" and 1.5"

Treatment Today:

15 min ☒ Therapeutic Exercise for ☒ flexibility ☐ strength ☒ per flowsheet

14 min ☐ Manual Therapy for soft tissue stretching PROM as follows: Pectoralis major, latissimus, trapezius, rhomboids

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☒ Manual Therapy for myofascial release and/or trigger point release as follows: trapezius, rhomboids, latissimus, pectoralis major

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

min ☐ Gait/Stair training:

min ☐ Manual attended estim:

5 min ☒ Ultrasound to trapezius 1 cm² 1 MHz ☐ 100% ☐ 50% ☒ 20%

min ☐ Set up time for iontophoresis _____ min to _____

min ☐ Therapeutic Activity:

1 min ☐ Other timed treatment: Resistance training for trapezius and latissimus ☐ per flowsheet

39 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estim

☐ Hot ☐ Cold pack

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min: TOTAL TREATMENT TIME

ASSESSMENT: Patient is improving with the therapeutic exercises. No significant changes in pain or function. Patient is able to perform tasks with less difficulty.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☒ correct technique

☒ correct progression

PLAN: Continue with exercises

Therapist Signature: [Signature]

License Number: 4757



102 Gregor Mendel Cir Greenwood, SC 29646 864-279 8110

Daily Progress Note

Patient Name: Karen Lamm Date: 5/26/15 Total Visits: 1

Diagnosis: (L5/S1) Sciatic Neuropathy Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: PT reports sitting down on the floor takes over 20 seconds to get up. Also sitting for long

OBJECTIVE: Measurements:

Treatment Today:

10 min ☐ Therapeutic Exercise for ☐ flexibility ☐ strength ☐ per flowsheet

10 min ☒ Manual Therapy for soft tissue stretching PROM as follows: Flexion to the L5
and on motion

☐ Manual Therapy for joint mobilization joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows:

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar:

10 min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

10 min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

10 min ☐ Gait/Stair training:

10 min ☐ Manual attended estim:

10 min ☒ Ultrasound to L5/S1 1.0 w/cm² 1.5 MHz ☒ 100% ☐ 50% ☐ 10%

10 min ☐ Set up time for iontophoresis _____ mA/Min to _____

10 min ☐ Therapeutic Activity:

10 min ☐ Other timed treatment: _____ ☐ per flowsheet

10 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☒ Unattended estim X 5 min on and off 200 Hz/15

☐ Hot ☒ Cold pack on L5/S1

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

10 min: TOTAL TREATMENT TIME

ASSESSMENT: PT did not sit on floor. PT did not sit on floor. PT did not sit on floor.

Goals met: _____ or, requires continued skilled intervention for exercises for ☐ safety ☐ correct technique

PLAN: 10 min ☐ correct progression

Therapist Signature: [Signature] License Number: 2116



102Gregor Mendel Cir Greenwood, SC 29646 864-229-8330

Daily Progress Note

Patient Name: Karen Duncan Date: 5/28/15 Total Visits: 1

Diagnosis: ④ shoulder scope, SAD, DCE Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Better (compared to Tue)
I feel a better shoulder position @ work but I cannot do it yet

OBJECTIVE: Measurements: 120° x P 42° x P 120° x P

Treatment Today:

13 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

16 min ☒ Manual Therapy for soft tissue stretching PROM as follows: upper flex, ER, IR stretching
(④ GH) distal

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

____ min ☐ Gait/Scalr training: ☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Manual attended estim:

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for iontophoresis _____ m/min to _____

____ min ☐ Therapeutic Activity: _____ ☐ per flowsheet

12 min ☒ Other timed treatment: Rock top - to ④ distal 15 to 20 min to ④ distal

40 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estim _____

☐ Hot ☐ Cold pack _____

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

____ min: TOTAL TREATMENT TIME

ASSESSMENT: Pt reports ④ 4th & 5th digit are "numb" when she wakes in the morning
affected to the day. ROM has improved. Pt advised on sleeping position
pillows around ④ on shoulder to the floor

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☒ correct technique ☒ correct progression

PLAN: Cont. see POC

Therapist Signature: [Signature] License Number: 4957



100Grego: Mendel Cir Greenwood, SC 29645 864 229-8330

Daily Progress Note

Patient Name: Karen Duncanson

Date: 6-7-15 Total Visits: 1

Diagnosis: ① Shoulder scope

Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: FA sore today. Still 2 pinches
intermittent GI & ① 4th/5th digits

OBJECTIVE: Measurements:

Treatment Today:

15 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

15 min ☐ Manual Therapy for soft tissue stretching PRIOR to follows ① GIU distention

☒ Manual Therapy for joint mobilization Joint: C7

Direction: distal Grade: II

☒ Manual Therapy for myofascial release and/or trigger point release as follows: scapular muscle, ①

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar:

min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

min ☐ Gait/Stair training: ☐ proprioception ☐ movement ☐ per flowsheet

min ☐ Manual attended assist:

min ☐ Ultrasound to:

min ☐ Set up time for Iontophoresis min min to min w/cm² min ☐ 100% ☐ 50% ☐ 10%

min ☐ Therapeutic Activity:

min ☐ Other timed treatment: ☐ per flowsheet

40 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction sec on lbs and sec off lbs min

☐ Unattended assist:

☐ Hot ☐ Cold pack

☐ TENS unit application to

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min: TOTAL TREATMENT TIME

ASSESSMENT: Continuity of paraspinal PMT to neck. Shoulder soreness still @ RCS

Goals met:

pt requires continued skilled intervention for exercises for ☐ safety ☒ correct technique ☒ correct progression

PLAN: Continue PMT

Therapist Signature: [Signature]

License Number: 4951



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110
234 Birchtree Dr. Greenwood, SC 29649 864-223-0900

Daily Progress Note

Patient Name: Karen Duvall

Date: 6-4-15 Total Visits: 1

Diagnosis: C shoulder

Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: It's done ok. Numbness - fingers
hasn't. Only felt it twice since I got here last

OBJECTIVE: Measurements:

Treatment Today:

10 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

10 min ☒ Manual Therapy for soft tissue stretching PROM as follows: Supine IC, ER IR stretching
Quadriceps

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar _____

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture
☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Gait/Stair training: _____

____ min ☐ Manual attended estim: _____

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for iontophoresis _____ mA/min to _____

____ min ☐ Therapeutic Activity: _____

____ min ☐ Other timed treatment: _____

40 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estim _____

☐ Hot ☐ Cold pack _____

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

____ min: TOTAL TREATMENT TIME

ASSESSMENT: Pr supine ER on table made pt very sore today but
it was ERS. with manual IR stretch, palpable crease "shl" that
released the ER - however pt very sore afterwards

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☒ correct technique
☒ correct progression

PLAN: Cont per PC

Therapist Signature: [Signature]

License Number: 4857



102 Gregor Mendel Cir Greenwood, SC 29646 864-228-8110
234 Birchtree Dr. Greenwood, SC 29649 864-223-0900

Daily Progress Note

Patient Name: Karen Duncan

Date: 10/8/15 Total Visits: 1

Diagnosis: Osteoarthritis

Precautions:

SUBJECTIVE: Pain Rating: 8/10 Functional Changes: When he's on the floor sitting
he has to be in a certain position or he can't sit on the floor.

OBJECTIVE: Measurements:

Treatment Today:

5 min ☒ Therapeutic Exercise for ☒ flexibility ☐ strength ☐ per flowsheet

25 min ☒ Manual Therapy for soft tissue stretching PROM as follows: (L) hip flexion, 100%, 100%

☒ Manual Therapy for joint mobilization Joint: C1-7 Direction: anterior Grade: 3+

☒ Manual Therapy for myofascial release and/or trigger point release as follows: neck, upper back, lower back

post neck tension as MFL

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar

 min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

 min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

 min ☐ Gait/Stair training:

 min ☐ Manual attended estlm:

 min ☐ Ultrasound to: w/cm² MHz ☐ 100% ☐ 50% ☐ 10%

 min ☐ Set up time for iontophoresis mA/min to

 min ☐ Therapeutic Activity:

 min ☐ Other timed treatment:

 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction sec on lbs and sec off lbs. x min:

☐ Unattended estlm

☐ Hot ☒ Cold pack on post neck & arm

☐ TENS unit application to

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

40 min: TOTAL TREATMENT TIME

ASSESSMENT: Pt is a 40 yr old female with a history of osteoarthritis in the knees. She is currently on pain medication and has been unable to sit on the floor for the past several months. She is unable to sit on the floor for the past several months. She is unable to sit on the floor for the past several months.

Goals met: pt. requires continued skilled intervention for exercises for ☐ safety ☒ correct technique ☒ correct progression

PLAN: Continue with manual therapy and exercise. Re-evaluate in 2 weeks. If no improvement, consider referral to physical therapist.

Attention: Spine & Pelvis clinic is open to accept emergency cases. The clinic is open to accept emergency cases. The clinic is open to accept emergency cases.

Therapist Signature: [Signature] License Number: 4457



Gregor Mendel Ctr Greenwood, SC 29646 864-229-8110
234 Birchtree Dr. Greenwood, SC 29649 864-223-0900

Progress Note / Discharge Note

Name: <u>Kay Duncan</u>	Date: <u>6-10-15</u>
DOB: <u>DOB 25</u>	Physician: <u>T. Hays</u>
Medical Diagnosis: <u>Acute low back pain</u>	Treatment Diagnosis:

Treatment Received:

- | | | |
|--|---|---|
| ☒ Therapeutic Exercise | ☐ Hot Pack | ☐ PRE's |
| ☐ Ultrasound | ☒ AROM | ☒ Home Exercise Program |
| ☐ PROM | ☐ Cold Pack | ☐ Traction |
| ☒ Electrical Stimulation | ☐ Isometrics | ☐ Kinesiotaping |
| ☐ AAROM | ☒ Manual Techniques | ☐ Other |

Attendance: 18 / 18 visits 0 cancelled 1 no shows since 4/9/15

Tests/ Measurements:

(1) Standing ROM: L/R: P: ER: 40° P: IR: 71° P:

Occupation: _____ Work Status: Not Working Light Modified Full
Occupational Requirements: _____

Current Physician Limitations (as described by patient): _____

Goals set at Initial Evaluation: Met _____ Not Met _____
Partially Met _____

Assessment/Comments: Pt recently had low back & "aching" on the floor" after
ach last day. A has been possibly swollen in shoulder/neck region since
first treatment on 4/16/15. Right shoulder: On 6/8/15 Pt again worked "on the floor"
in upper extremities. Low back neck pain (numbness in C5/6) - lower legs
same

New Goals: _____

Recommendations: Review fib restrictions Assess neck Cont PT 3x/week x 4-6 wks.

Steve Traynor, PT Heidi Blake, DPT Tina Kaysinger Monaghan, DPT Forest Newby, PTA Brantlee Kidd, PTA

MD RESPONSE:	
☒ Continue PT	<u>3</u> times per week for <u>4-6</u> weeks
☐ Change Treatment/s to _____	
☐ Discharge to HEP	
☐ Other: _____	

I certify the medical necessity of services furnished under this plan of care.

Physician Signature: _____

102 Gregor Mendel Ln. Greenwood, SC 29646 864-229-8110
234 Birchtree Dr. Greenwood, SC 29649 864-223-0900

Daily Progress Note

Patient Name: Kieran Duggan

Date: 6-16-13 Total Visits: /

Diagnosis: Lishoides simplex

Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Back to work 7 days for on floor strain
nothing serious no no

OBJECTIVE: Measurements: (1) ...

Treatment Today:

____min ☐ Therapeutic Exercise for ☐ flexibility ☐ strength ☐ per flowsheet

3 min ☒ Manual Therapy for soft tissue stretching PROM as follows: Spine, Neck, Shoulder
(L5/S1) Extension

☒ Manual Therapy for joint mobilization Joint: C1, C2, C3 Direction: Ant-Post Grade: 3+

☒ Manual Therapy for myofascial release and/or trigger point release as follows: Biceps brachii muscle

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar

min ☐ Functional Dry Needling for ☐ RCM ☐ pain ☐ function per trigger point treatment log ☐ with manual stimulation

min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

___ min ☐ Galt/Stair training:

min ☐ Manual attended estim:

___ min ☐ Ultrasound to:

min ☐ Set up time for iontophoresis _____ w/cn' _____ M1/2 ☐ 100% ☐ 50% ☐ 10%

_____ NAME _____

min ☐ Therapeutic Activity:

____ min ☐ Other timed treatment:

min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction ____ sec on ____ lbs. and ____ sec off ____ lbs x ____ min

☒ Unattended estlm Primer-d to place 7' NW to corner (E) of rock

☐ Hot ☒ Cold pack for pain relief

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min: TOTAL TREATMENT TIME

ASSESSMENT: Patient is unable to perform a full range of motion. Ankle with circum triggered

Recommence: further IT & NI

Goals met: _____ pt. requires continued skilled intervention for exercises for ☒ safety ☒ correct technique

PLAN: $\frac{1}{2} \times 1000 = 500$ correct progression

Therapist Signature:

Licence Number: 4751



102 Gregor Mendel Cir. Greenwood, SC 29646 864-225-8110
234 Birchtree Dr. Greenwood, SC 29649 864-223-0900

Daily Progress Note

Patient Name: Koe De...

Date: 6-26-15 Total Visits: 1

Diagnosis: shoulder

Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Can't catch a ball 11/21/15, 3T
Says when I walked around and sat down I felt some kind of pain in my shoulder. It was like a sharp pain. When I walked up to get my bag in my car I felt like I was going to throw up. I felt like I was going to throw up. I felt like I was going to throw up.
OBJECTIVE: At the back of my shoulder where the joint is. It's a sharp pain.

Treatment Today:

30 min ☒ Therapeutic Exercise for ☒ flexibility ☐ strength ☐ per flow sheet

12 min ☒ Manual Therapy for soft tissue stretching PROM as follows: upper arm flexion, extension, abduction, adduction

GHJ stretching

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture
☐ proprioception ☐ movement ☐ per flow sheet

____ min ☐ Gait/Stair training: _____

____ min ☐ Manual attended estim: _____

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for iontophoresis _____ mA/min to _____

____ min ☐ Therapeutic Activity: _____

____ min ☐ Other timed treatment: _____

____ min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min.

☐ Unattended estim _____

☐ Hot ☐ Cold pack _____

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

____ min: TOTAL TREATMENT TIME

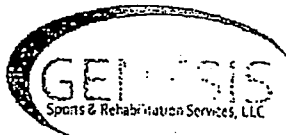
ASSESSMENT: He still has frequent facial grimacing & is not tolerating 2nd
exercise. It's very sore to the touch.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☒ correct technique

☒ correct progression

PLAN: Cont. PT

Therapist Signature: [Signature] License Number: 4857



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110
234 Birchtree Dr. Greenwood, SC 29649 864-223-0900

Daily Progress Note

Patient Name: Hanna D. ... Date: 6-27-15 Total Visits: 87

Diagnosis: (L) xcp, SFA, D/E Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Still have numbness in (left) foot & leg
me - not in my right. I told my medical doctor.

OBJECTIVE: Measurements:

Treatment Today:

28 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

12 min ☒ Manual Therapy for soft tissue stretching PROM as follows: SLASH = 110, 110 IF BLUETRY
(L) GIB distraction

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows:

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar

min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

min ☐ Gait/Stair training:

min ☐ Manual attended estim:

min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

min ☐ Set up time for Iontophoresis _____ mA/min to _____

min ☐ Therapeutic Activity:

min ☐ Other timed treatment:

min TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estim

☐ Hot ☐ Cold pack

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min TOTAL TREATMENT TIME

ASSESSMENT: Disruption to a U. ripation of Cerv. vertebra (in spine)
As reported little to no change in cervical function but suspect 2nd pt's difficulty
relaxing. Did not attempt cervical necks as previous treatment was so poor.

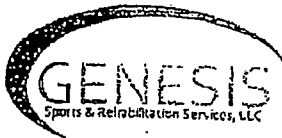
Goals met: _____ pt. requires continued skilled intervention for exercises for ☒ safety ☒ correct technique

☒ correct progression

PLAN: Get in PRX Recommend further MD assessment of neck Anath.
most likely 2nd ripation in c-4, 5, 6, 7, 8, 9, 10, 11, 12.

Therapist Signature: [Signature]

License Number: 4957



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110
234 Birchtree Dr. Greenwood, SC 29649 864-223-0900

Daily Progress Note

Patient Name: Karen Duncan Date: 7/1/15 Total Visits: 1

Diagnosis: Wrist, R Supr. SAJ over Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Not aware of reported pain in R wrist also "no" sign

OBJECTIVE: Measurements:

Treatment Today:

 min ☐ Therapeutic Exercise for ☐ flexibility ☐ strength ☐ per flowsheet

10 min ☒ Manual Therapy for soft tissue stretching PROM as follows: Flexion - R wrist (L)
extension - R wrist (L)

☐ Manual Therapy for joint mobilization Joint: Direction: Grade:

☒ Manual Therapy for myofascial release and/or trigger point release as follows: TRP in sup. & inf. muscles

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

 min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point: treatment log ☐ with manual stim

 min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

 min ☐ proprioception ☐ movement ☐ per flowsheet

 min ☐ Gait/Stair training:

 min ☐ Manual attended estim:

 min ☐ Ultrasound to:

 min ☐ Set up time for iontophoresis mA/min to w/cm² MHz ☐ 100% ☐ 50% ☐ 10%

 min ☐ Therapeutic Activity:

 min ☐ Other timed treatment:

 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction sec on lbs. and sec off lbs. x min

☐ Unattended estim

☐ Hot ☐ Cold pack

☐ TENS unit application to

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

 min: TOTAL TREATMENT TIME

ASSESSMENT: Pt. was in bed at appointment from R wrist shown
into his wrist it could not tolerate much more
mobility

Goal's met: pt. requires continued skilled intervention for exercises for ☐ safety ☐ correct technique

PLAN: ☐ correct progression

Therapist Signature: [Signature] License Number: 7104



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen Dumea Date: 7-6-15 Total Visits: 1

Diagnosis: (L) Shoulder scope, SAD, DCE Precautions:

SUBJECTIVE: Pain Rating: 4-5/10 Functional Changes: Pain better today. It was a Monday (A) work. Feels having traction for (L) need to sit/stand. Aggravated by

OBJECTIVE: Measurements: (L) Shoulder Flex 142° ER 48° IR 90° PROM sup.

Treatment Today:

32 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

10 min ☒ Manual Therapy for soft tissue stretching PROM as follows: Spin Flex, ER, IR, Abduct

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____
☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim
min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

min ☐ Gait/Stair training: ☐ proprioception ☐ movement ☐ per flowsheet

min ☐ Manual attended estim:

min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

min ☐ Set up time for: Iontophoresis _____ mA/min to _____

min ☐ Therapeutic Activity: _____ ☐ per flowsheet

min ☐ Other timed treatment: _____

42 min TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs and _____ sec off _____ lbs. x _____ min

☐ Unattended estim _____

☐ Hot ☐ Cold pack _____

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min TOTAL TREATMENT TIME

ASSESSMENT: Pt in functional positions 4-5-6 is arm on table. She is holding only - not pain. The last given for HEP. Pt scheduled to RMD on 7-13

Goals met: (L) Shoulder ROM improved ☒ requires continued skilled intervention for exercises for ☒ safety ☒ correct technique ☒ correct progression

PLAN: Cap per POC

Therapist Signature: JP MPT License Number: 4957



102 Gregor Mendel Cir Greenwood, SC 29646 864-729-8110

Daily Progress Note

Patient Name: Karen Denson Date: 7/8/15 Total Visits: 1

Diagnosis: Left Hip Surgery, SVD, PPT Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Thigh pain when walking
Time given to HA - will be able to walk without pain

OBJECTIVE: Measurements:

Treatment Today:

5 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☐ per flowsheet

10 min ☒ Manual Therapy for soft tissue stretching PROMs as follows: from 0 to 12
in flexion

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____
☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

min ☐ Gait/Stair training: ☐ proprioception ☐ movement ☐ per flowsheet

min ☐ Manual attended estim:

min ☐ Ultrasound to:

min ☐ Set up time for iontophoresis mA/min to _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

min ☐ Therapeutic Activity:

min ☐ Other timed treatment: ☐ per flowsheet

15 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☒ Unattended estim 15 min set at 1-15 volts

☐ Hot ☒ Cold pack icing & friction

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

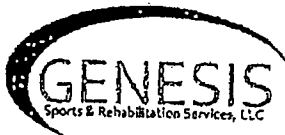
50 min: TOTAL TREATMENT TIME

ASSESSMENT: Pt. had a HA starting into ER it was numb
& tingling into her hand.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☐ correct technique

PLAN: Cont 1 more visit & then 2-3 wks ☐ correct progression

Therapist Signature: [Signature] License Number: 1104



101 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Mr. [Name] Date: 7/1/15 Total Visits: 1

Diagnosis: Left Shoulder Pain Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Difficulty reaching overhead

OBJECTIVE: Measurements: Height: 140 cm, Weight: 70 kg, BMI: 35.7

Treatment Today: 15 min ☐ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

15 min ☐ Manual Therapy for soft tissue stretching PROM as follows: Shoulder flexion/extension

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

min ☐ Gait/Stair training: _____

min ☐ Manual attended estim: _____

min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

min ☐ Set up time for iontophoresis _____ mA/min to _____

min ☐ Therapeutic Activity: _____ ☐ per flowsheet

min ☐ Other timed treatment: _____

min TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☒ Unattended estim 15 min at 140 _____

☐ Hot ☒ Cold pack _____

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min TOTAL TREATMENT TIME

ASSESSMENT: Pain 1/10, ROM improved

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☐ correct technique

PLAN: Continue PT, 15 min, 1x/week ☐ correct progression

Therapist Signature: [Signature] License Number: 1004

END OF REPORT



102 Gregor Mendel Cir Greenwood, SC 29645 854-229-811

Progress Note / Discharge Note

Name: <u>Karen Duncan</u>	Date: <u>7/19/15</u>
DOB: <u>DOB 1/65</u>	Physician: <u>Tina Mays</u>
Medical Diagnosis: <u>L Shoulder Scope</u>	Treatment Diagnosis:

SAD, DCE

Treatment Received:

☐ Therapeutic Exercise	☐ Hot Pack	☐ PRT's
☐ Ultrasound	☐ AROM	☐ Home Exercise Program
☐ PROM	☐ Cold Pack	☐ Traction
☐ Electrical Stimulation	☐ Isometrics	☐ Kinesiotaping
☐ AAROM	☐ Manual Techniques	☐ Other

Attendance: 24/25 visits cancelled no shows since 4/19/15

Tests/Measurements:

AROM Flex = 140° IR = 70° ER = 80°
AROM Flex = 110° IR = sacrum

Occupation: _____ Work Status: Not Working Light Modified Full
Occupational Requirements: _____

Current Physician Limitations (as described by patient): _____

Goals set at Initial Evaluation: Met _____ Not Met _____
Partially Met _____

Assessment/Comments: Pt has been reporting shoulder fatigue from different movements. When some glide on table to her HA. She has been reporting sensitivity to pain up into the neck from the neck position and is very sensitive to touch. It reports pain anywhere from her hand. She does feel full E-stim & the bridge.
New Goals: 110 - 110. She reports numbness & tingling in her hand. She does feel full E-stim & the bridge.
Recommendations: Please return in 4 weeks for

Forest Newby PTA

Steve Traynor, PT Heidi Blake, DPT Tina Paysinger, DPT Forest Newby, PTA Meredith Stevenson, DPT

MD RESPONSE:	
☒ Continue PT	Full speed ahead, no restrictions
☐ Change Treatment/s to	_____
☐ Discharge to HEP	_____
☐ Other:	_____

I certify the medical necessity of services furnished under this plan of care.

Physician Signature: _____

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8/6/2015

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102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen Duncan

Date: 7/15/15 Total Visits: 1

Diagnosis: (L) Shoulder Surge
SAD, DCE

Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Pt. can not feel or
differentiate in her arm to start, she now feels

OBJECTIVE: Measurements:

Treatment Today:

20 min ☒ Therapeutic Exercise for ☐ flexibility ☒ strength ☒ per flowsheet

15 min ☒ Manual Therapy for soft tissue stretching PROM as follows: PROM to the (L)
shoulder in sitting

☒ Manual Therapy for joint mobilization Joint: (L) GHJ Direction: distraction Grade: 2+

☐ Manual Therapy for myofascial release and/or trigger point release as follows:

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

 min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

 min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

 min ☐ Gait/Stair training:

 min ☐ Manual attended estim:

 min ☐ Ultrasound to: w/cm² MHz ☐ 100% ☐ 50% ☐ 10%

 min ☐ Set up time for Iontophoresis mAMin to

 min ☐ Therapeutic Activity: ☐ per flowsheet

 min ☐ Other timed treatment:

 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction sec on lbs. and sec off lbs. x min

☐ Unattended estim

☐ Hot ☐ Cold pack

☐ TENS unit application to

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

35 min: TOTAL TREATMENT TIME

ASSESSMENT: Left shoulder could not be done b/c she
can not tolerate a hand on the back of her arm. She
tolerated other modalities well.

Goals met: pt. requires continued skilled intervention for exercises for ☐ safety ☐ correct technique
☐ correct progression

PLAN: Cont PT.

Therapist Signature: Karen Duncan PTA

License Number: 2164



102 Gregor Mendel Ctr Greenwood, SC 29646 854-229-8210

Daily Progress Note

Patient Name: Karen Duncan Date: 7-21-15 Total Visits: 1

Diagnosis: Distal radius fracture, SAD, DCE Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: I put my - last time is still
not enough on it. I tried to get it but the pain is still there.

OBJECTIVE: Measurements:

Treatment Today:

28 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

8 min ☐ Manual Therapy for soft tissue stretching PROM as follows:

☒ Manual Therapy for joint mobilization Joint: C6 Direction: roto bn Grade: MT

☐ Manual Therapy for myofascial release and/or trigger point release as follows:

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar

 min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

 min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

 min ☐ Gait/Stair training:

 min ☐ Manual attended estlm:

 min ☐ Ultrasound to: w/cm² MHz ☐ 100% ☐ 50% ☐ 10%

 min ☐ Set up time for iontophoresis mA/min to

 min ☐ Therapeutic Activity: ☐ per flowsheet

 min ☐ Other timed treatment:

 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction sec on lbs. and sec off lbs. x min

☐ Unattended estlm

☐ Hot ☒ Cold pack ice to neck

☐ TENS unit application to

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

 min: TOTAL TREATMENT TIME

ASSESSMENT: Added gentle stability/ strengthening to program. Issued
written HEP.

Goals met: pt. requires continued skilled intervention for exercises for ☒ safety ☒ correct technique

☒ correct progression

PLAN: CAT per RxC.

Therapist Signature: J.P. DPT

License Number: 4951



101Grego: Mendel Cir Greenwood, SC 29546 864-729-8110

Daily Progress Note

Patient Name: Karen Duncan

Date: 7-23-15 Total Visits: 1

Diagnosis: (L) glandular neoplasm

Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: 1st knee: thick w/ swelling - a little
when sitting (can't sleep but not bad). 2nd knee: some swelling but not bad

OBJECTIVE: Measurements:

Treatment Today:

34 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

____ min ☐ Manual Therapy for soft tissue stretching PROM as follows:

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows:

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

___ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

___ min ☐ Galt/Stair training:

____ min ☐ Manual attended estim:

min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☒ 10%

_____ min ☐ Set up time for iontophoresis _____ mA Min to _____

min ☐ Therapeutic Activity: _____ ☐ per flow sheet

min ☐ Other timed treatment: _____

min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. & _____ min _____☐ Unattended estim.☐ Hot ☐ Cold pack

☐ TENS unit application to

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min: TOTAL TREATMENT TIME

ASSESSMENT: Ps admitted she had been performing some 5-7B incorrectly & technique correction today. Is able to transfer to use Cism more & independent activities w/o losing any skills. Difficult to v. breath

Goals met: _____ pt. requires continued skilled intervention for exercises for ☒ Safety ☐ correct technique

☒ correct progression

PLAN: Cont on POC

Therapist Signature: [Signature] License Number: 4451

License Number: 445



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Kare Dunbar

Date: 7-24-15 Total Visits: 1

Diagnosis: Cervical Spondylosis

Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Difficulty doing work for this morning. Cannot be caught at work & being caught by the mouth

OBJECTIVE: Measurements: L 135° R 54° IR 70° PROM

Treatment Today:

25 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

5 min ☒ Manual Therapy for soft tissue stretching PROM as follows: Super. Elev. of R. trapezius
to Bill's distraction

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

 min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

 min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

 min ☐ Gait/Stair training: _____

 min ☐ Manual attended estim: _____

 min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

 min ☐ Set up time for iontophoresis _____ mA/min to _____

 min ☐ Therapeutic Activity: _____ ☐ per flowsheet

 min ☐ Other timed treatment: _____

45 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estim

☐ Hot ☐ Cold pack

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min: TOTAL TREATMENT TIME

ASSESSMENT: Technique correction needed for all TA exercises today. Therapist IR. Pt. fatigued but not sick. Added new exercises to program. Patient unable but not painful. ROM as limited as prior. 1/10 w/

Goals met: _____ pt. requires continued skilled intervention for exercises for ☒ Safety ☒ Correct technique

☒ Correct progression

PLAN: Cont. per POC. Continue to monitor for correct technique.

Therapist Signature: [Signature]

License Number: 14957



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen Duncan

Date: 7-27-15 Total Visits: 1

Diagnosis: ② shoulder scope, SAO, DCE

Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Pain in neck & face again, dizziness
again since I was kicked in Sat. Now having interrupted tingling down
right arm. Worse looking up.

OBJECTIVE: Measurements:

Treatment Today:

35 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

15 min ☐ Manual Therapy for soft tissue stretching PROM as follows:

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____
☒ Manual Therapy for myofascial release and/or trigger point release as follows: transverse MFR + post

neck

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Gait/Stair training:

____ min ☐ Manual attended estim:

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for Iontophoresis _____ mA/min to _____

____ min ☐ Therapeutic Activity: _____ ☐ per flowsheet

____ min ☐ Other timed treatment:

____ min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estim

☐ Hot ☒ Cold pack p MT to neck

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

____ min: TOTAL TREATMENT TIME

ASSESSMENT: Very tender to MFR to neck. Symptoms relieved & can traction
Change IR & ER shoulder strength with in 15 min for PT but pt unable to tolerate
much shoulder or neck pain (prior to MT)

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☐ correct technique

☐ correct progression

PLAN: Assist further authorization. Cost skilled PT is 1 strength of shoulder
as tolerated.

Therapist Signature: [Signature]

License Number: 4451



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8111

Progress Note / Discharge Note

Name: <u>Kevin [unclear]</u>	Date: <u>3/1/15</u>
DOB: <u>DOB 1/65</u>	Physician: <u>[unclear]</u>
Medical Diagnosis: <u>[unclear]</u>	Treatment Diagnosis: <u>[unclear]</u>

Treatment Received:

- | | | |
|---|--|--|
| ☐ Therapeutic Exercise | ☐ Hot Pack | ☐ PRE's |
| ☐ Ultrasound | ☐ AROM | ☐ Home Exercise Program |
| ☐ PROM | ☐ Cold Pack | ☐ Traction |
| ☐ Electrical Stimulation | ☐ Isometrics | ☐ Kinesiotaping |
| ☐ AAROM | ☐ Manual Techniques | ☐ Other |

Attendance: 11/1/15 visits cancelled no shows since 1/1/15

Tests/Measurements:

2/2/15 14" 75" 85"
2/2/15 14" 75" 85"

Occupation: [unclear] Work Status: Not Working Light Modified Full
 Occupational Requirements: [unclear]

Current Physician Limitations (as described by patient): [unclear]

Goals set at Initial Evaluation: Met [unclear] Not Met [unclear]

Partially Met [unclear]

Assessment/Comments: PT can now walk without assistance, but still has some pain in the knee. He is able to do some light activities, but still needs to be cautious. He is also having some trouble with his balance.

New Goals: to be able to walk without assistance, to be able to do some light activities, and to be able to maintain his balance.

Recommendations: Continue with PT, and to be cautious when walking.

Steve Traynor, PT Heidi Blake, DPT Tina Paysinger, DPT Forest Newby, PTA Meredith Stevenson, DPT

MD RESPONSE: Full fixed ahead, no restrictions

☒ Continue PT	times per week for <u>12</u> weeks
☐ Change Treatment/s to	<u>[unclear]</u>
☐ Discharge to HEP	<u>[unclear]</u>
☐ Other:	<u>[unclear]</u>

I certify the medical necessity of services furnished under this plan of care.

Physician Signature: [Signature]



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen Duncan

Date: 8-11-15 Total Visits: 1

Diagnosis: ① shoulder scope, SAB, ICE

Precautions:

SUBJECTIVE: Pain Rating: 10 Functional Changes: They rescheduled the appt & the doctor tomorrow. My neck was killing me last week. I did some exercises & it helped but still I sleep with 1 bolt like my neck could hold my head up again. Neck sore today too
OBJECTIVE: Measurements: 158° P, ER 80° P, IR 90° P. I've got vertigo when I look up.

Treatment Today:

35 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

15 min ☒ Manual Therapy for soft tissue stretching PROM as follows: same ① GHJ distraction
PROM ① shoulder ✓, ER, IR.

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows: _____

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture
☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Gait/Stair training: _____

____ min ☐ Manual attended estim: _____

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for Iontophoresis _____ mA/min to _____

____ min ☐ Therapeutic Activity: _____ ☐ per flowsheet

____ min ☐ Other timed treatment: _____

50 min: **TOTAL TIMED CODES**

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estim _____

☐ Hot ☐ Cold pack _____

☐ TENS unit application to _____
☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

____ min: **TOTAL TREATMENT TIME**

ASSESSMENT: All PROM painful @ 60s. & very fatigued to the therapy exercises. Pt advised to see MD regarding vertigo. Likely BPPV as that is similar to a previous experience - vertigo that she had. Suspect ↑ shoulder pain & neck issues.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☒ safety ☒ correct technique
Handout given of new exercises & T to red FB. ☒ correct progression

PLAN: MD update.

Therapist Signature: JK DPT

License Number: 4957



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

2169

Progress Note / Discharge Note

Name: <u>Karen Duncan</u>	Date: <u>8-11-15</u>
DOB: <u>DOB 65</u>	Physician: <u>Tina H</u>
Medical Diagnosis: <u>Ⓛ Shoulder scope</u>	Treatment Diagnosis:

SAD, DCE

Treatment Received:

☒ Therapeutic Exercise	☐ Hot Pack	☒ PRE's
☐ Ultrasound	☐ AROM	☒ Home Exercise Program
☐ PROM	☒ Cold Pack	☒ Traction cerv.
☐ Electrical Stimulation	☐ Isometrics	☐ Kinesiotaping
☐ AAROM	☒ Manual Techniques	☒ Other

Attendance: / visits cancelled no shows since 4/9/15

Tests/ Measurements:

Ⓛ PROM 138° = P, ER 90° = P, IR 90° = P

Occupation: Work Status: Not Working Light Modified Full
Occupational Requirements:

Current Physician Limitations (as described by patient):

Goals set at Initial Evaluation: Met Not Met
Partially Met

Assessment/Comments: Pt had neck flare-up of pain last week - exercises helped but still had pain. Pt is resistant to shoulder pain/movement worsening. Likely related to neck flare-up. PT is trying to progress shoulder strengthening as tolerated. Pt has written handouts of HEP & is compliant. Pt may benefit from further diagnostic eval by MD on Neck.
New Goals:

Recommendations: Cont PT 2x/week & thurs. to v pain & T strength

Steve Traynor, PT Heidi Blake, DPT Tina Paysinger, DPT Forest Newby, PTA Meredith Stevenson, DPT

☒ MD RESPONSE: ☒ Continue PT <u> </u> times per week for <u> </u> weeks ☐ Change Treatment/s to <u> </u> ☐ Discharge to HEP ☐ Other: <u> </u>	
--	--

I certify the medical necessity of services furnished under this plan of care.

Physician Signature:

Daily Progress Note

Patient Name: Mr. D. Date: 8-14-15 Total Visits: 1

Diagnosis: Left shoulder scope, SAD, DCE Precautions:

SUBJECTIVE: Pain Rating: 7/10 Functional Changes: MD ordered an MRI of my neck-but got to wait a wk. Family MD says I have ear infection-put me on Sulfa. My neck is hurting-feels like my head is gonna fall off @ the end of the day. My shoulder
OBJECTIVE: Measurements: feels swollen & tender.

Treatment Today:

10 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

min ☐ Manual Therapy for soft tissue stretching PROM as follows:

☐ Manual Therapy for Joint mobilization Joint: 1 Direction: _____ Grade: _____

☐ Manual Therapy for myofascial release and/or trigger point release as follows:

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Gait/Stair training:

min ☐ Manual attended estim:

min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

min ☐ Set up time for Iontophoresis _____ mA Min to _____min ☐ Therapeutic Activity: _____ ☐ per flowsheet

min ☐ Other timed treatment:

____ min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min _____

☒ Unattended estim. IFC to neck 15 min 11.5CU - 71.3CU

☐ Hot ☒ Cold pack 2 estin

☐ TENS unit application to _____☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min: TOTAL TREATMENT TIME

ASSESSMENT: Pt is notable pain behaviors observed during ROM of shoulder. Pt confirmed the shoulder movements were making her neck symptoms worse. Attempted manual flexion but pt was too guarded to be a therapeutic pull even when muscle tone seemed relaxed.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☒ safety ☐ correct technique ☐ correct progression IFC & ice to use.

Pt confirmed she was icing @ home a year ago also.

PLAN: Get on POC to ↓ pers.

Therapist Signature: [Signature] License Number: 9957



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name:

Karen Duncan

Date:

8-17-15

Total Visits: 1

Diagnosis:

② shoulder scope, SAD, DCE

Precautions:

SUBJECTIVE: Pain Rating: 10

Functional Changes:

Shoulder is ok considering I worked today. Neck is still killing me. No wonder MRI yet.

OBJECTIVE: Measurements:

Treatment Today:

min ☐ Therapeutic Exercise for ☐ flexibility ☐ strength ☐ per flowsheet

30 min ☐ Manual Therapy for soft tissue stretching PROM as follows:

☐ Manual Therapy for joint mobilization Joint: Direction: Grade:

☒ Manual Therapy for myofascial release and/or trigger point release as follows: ② DT, ② levator scap, post neck transverse release

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar

min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

min ☐ Gait/Stair training:

min ☐ Manual attended estim:

min ☐ Ultrasound to: w/cm² MHz ☐ 100% ☐ 50% ☐ 10%

min ☐ Set up time for Iontophoresis mAMin to

min ☐ Therapeutic Activity: per flowsheet

min ☐ Other timed treatment:

min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction sec on lbs. and sec off lbs. x min

☐ Unattended estim

☐ Hot ☐ Cold pack

☐ TENS unit application to

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min: TOTAL TREATMENT TIME

ASSESSMENT: Significant pain to palpation of lower neck prior to tx. Was able to do muscle tone in upper thor area for pt to tolerate cerv. traction. It seems to present a significant cervical spondylosis palpation

Goals met: pt. requires continued skilled intervention for exercises for ☒ safety ☒ correct technique

Pt advised to ice & rest @ home to & overall pain levels correct progression

PLAN:

Cont. PDX

Therapist Signature:

JR DPT

License Number:

4951



102Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen Duncan

Date: 8-19-15 Total Visits: 1

Diagnosis: ① shoulder

Precautions:

SUBJECTIVE: Pain Rating: 10 Functional Changes: Pt called yesterday to therapy clinic to report she reached up @ work & had severe pain on entire @ side (arm & leg). Pt R side by the aprt to come in today. Pt reported no pain meds taken this am 2" going to work & therapy.
OBJECTIVE: Measurements:

Treatment Today:

20 min ☐ Therapeutic Exercise for ☐ flexibility ☐ strength ☐ per flowsheet

20 min ☐ Manual Therapy for soft tissue stretching PROM as follows:

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☒ Manual Therapy for myofascial release and/or trigger point release as follows: ① splenius cap & cerv, @ UT.

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar

min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

min ☐ Gait/Stair training:

min ☐ Manual attended estim:

min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

min ☐ Set up time for Iontophoresis _____ mA/min to _____

min ☐ Therapeutic Activity: _____ ☐ per flowsheet

min ☐ Other timed treatment:

min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☒ Unattended estim Ice to post neck 0.4 CV → 1.3 CV 20 min.

☐ Hot ☒ Cold pack ice estim

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min: TOTAL TREATMENT TIME

ASSESSMENT: Pt i significant pain to palpation @ C6-C7 area. Pain'd i cervical traction but returned when traction released. Estim & ice helped but pt still i tears streaming down face i pain. Pt advised not to attempt to work until she
Goals met: _____ pt. requires continued skilled intervention for exercises for ☒ safety ☒ correct technique ☒ correct progression sees MD.

PLAN: Consult i MD office 2" severity of symptoms. Pt i work in apt @ MD office.

Therapist Signature: JR DPT

License Number: 4957



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Kare Duncan Date: 8-21-15 Total Visits: 35

Diagnosis: (L) shoulder surgery, SAD, DCE Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: Doing better today until I tried to drive over here. My car won't move. I think I slipped almost all yesterday. I put on it now so I could drive. But I was
OBJECTIVE: Measurements: until later but no follow-up & dx is scheduled

Treatment Today:

25 min ☐ Therapeutic Exercise for ☐ flexibility ☐ strength ☐ per flowsheet

25 min ☒ Manual Therapy for soft tissue stretching PROM as follows: supine (L) shoulder v, ER, IR, flexion
(L) GH distraction

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☒ Manual Therapy for myofascial release and/or trigger point release as follows: Spst neck & splenius

cap. c. cen. BUT (L) pect major

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

_____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

_____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

_____ min ☐ Gait/Stair training:

_____ min ☐ Manual attended estim:

_____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

_____ min ☐ Set up time for iontophoresis _____ mA/min to _____

_____ min ☐ Therapeutic Activity: _____ ☐ per flowsheet

_____ min ☐ Other timed treatment:

_____ min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estim

☐ Hot ☐ Cold pack

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

_____ min: TOTAL TREATMENT TIME

ASSESSMENT: Pt declined exam today. Mild palpable spasms during my intervention today but overall muscle tone much better. No headaches during MT today.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☒ safety ☒ correct technique ☒ correct progression

PLAN: Cont. p. POC

Therapist Signature: JP, DPT

License Number: 4957



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen Duncan Date: 8/25/15 Total Visits: 1

Diagnosis: C5hld Scope, SAD, DCE Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: "They did not find anything in the MRI."

OBJECTIVE: Measurements:

Treatment Today:

15 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☐ per flowsheet

25 min ☒ Manual Therapy for soft tissue stretching PROM as follows: PROM to the (L) side in supine. Gentle neck rotation

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☒ Manual Therapy for myofascial release and/or trigger point release as follows: upper trap

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture ☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Gait/Stair training:

____ min ☐ Manual attended estim:

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for Iontophoresis _____ mA/min to _____

____ min ☐ Therapeutic Activity: _____ ☐ per flowsheet

____ min ☐ Other timed treatment:

min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estim

☐ Hot ☐ Cold pack

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

min: TOTAL TREATMENT TIME

ASSESSMENT: Pt did stretch good into (L) rotation but had pain at (L) rotation. (L) upper trap was tender to the touch.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☐ correct technique ☐ correct progression

PLAN: Cont POC

Therapist Signature: Forest Hawley PTH License Number: 2164



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen Duncan

Date: 8/27/15 Total Visits: 1

Diagnosis: (L) Shld scope, SAH, DCE Precautions:

SUBJECTIVE: Pain Rating: 1/10 Functional Changes: No differences in condition
pt reports

OBJECTIVE: Measurements:

Treatment Today:

15 min ☒ Therapeutic Exercise for ☐ flexibility ☐ strength ☐ per flowsheet

23 min ☒ Manual Therapy for soft tissue stretching PROM as follows: pt was taught neck retraction in supine
abd in supine

☐ Manual Therapy for joint mobilization Joint: _____ Direction: _____ Grade: _____

☒ Manual Therapy for myofascial release and/or trigger point release as follows: MFR to (L)

upper trap & neck

☒ Manual Therapy for manual traction ☒ cervical ☐ lumbar gentle

____ min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

____ min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture

☐ proprioception ☐ movement ☐ per flowsheet

____ min ☐ Gait/Stair training:

____ min ☐ Manual attended estim:

____ min ☐ Ultrasound to: _____ w/cm² _____ MHz ☐ 100% ☐ 50% ☐ 10%

____ min ☐ Set up time for Iontophoresis _____ mA/min to _____

____ min ☐ Therapeutic Activity: _____ ☐ per flowsheet

____ min ☐ Other timed treatment:

____ min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction _____ sec on _____ lbs. and _____ sec off _____ lbs. x _____ min

☐ Unattended estim

☐ Hot ☐ Cold pack

☐ TENS unit application to _____

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

38 min: TOTAL TREATMENT TIME

ASSESSMENT: pt was told to work on posture & neck retraction
at home b/c pt appears to be leaning her head more
forward. Pt could not take much add flexion stretching today 2" pass.

Goals met: _____ pt. requires continued skilled intervention for exercises for ☐ safety ☐ correct technique

☐ correct progression

PLAN: Cont POC.

Therapist Signature: Forest Newby PTA

License Number: 2184



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

Daily Progress Note

Patient Name: Karen Duncan

Date: 9-1-15 Total Visits: 1

Diagnosis: ① shoulder scope, SAD, DCE

Precautions:

SUBJECTIVE: Pain Rating: 10 Functional Changes: Neck truly yesterday - he said ulnar paresthesia. Neck still hurts when I look up or turn to the right.
Spoke to [unclear] all weekend.

OBJECTIVE: Measurements:

Treatment Today:

25 min ☒ Therapeutic Exercise for ☒ flexibility ☒ strength ☒ per flowsheet

 min ☐ Manual Therapy for soft tissue stretching PROM as follows:

☐ Manual Therapy for joint mobilization Joint: Direction: Grade:

☐ Manual Therapy for myofascial release and/or trigger point release as follows:

☐ Manual Therapy for manual traction ☐ cervical ☐ lumbar

 min ☐ Functional Dry Needling for ☐ ROM ☐ pain ☐ function per trigger point treatment log ☐ with manual stim

 min ☐ Neuromuscular re-education for ☐ balance ☐ coordination ☐ posture
☐ proprioception ☐ movement ☐ per flowsheet

 min ☐ Gait/Stair training:

 min ☐ Manual attended estim:

 min ☐ Ultrasound to: w/cm² MHz ☐ 100% ☐ 50% ☐ 10%

 min ☐ Set up time for Iontophoresis mA/min to

 min ☐ Therapeutic Activity: ☐ per flowsheet

 min ☐ Other timed treatment:

 min: TOTAL TIMED CODES

☐ Cervical ☐ Lumbar mechanical traction sec on lbs. and sec off lbs. x min

☒ Unattended estim 1 PC to DVT area 7.6-8.6 CV 15 min

☐ Hot ☒ Cold pack 2 estim

☐ TENS unit application to

☐ patient instructed in electrode placement, purpose, setting parameters and safety & returned demonstration

 min: TOTAL TREATMENT TIME

ASSESSMENT: TB ER 2/25 PM 2 lowest vol spacer under elbow.
Pain also painful for PT @ anterior shoulder.

Goals met: pt. requires continued skilled intervention for exercises for ☒ safety ☒ correct technique

☒ correct progression

PLAN: Cont per Ac

Therapist Signature: [Signature]

License Number: 4957



102 Gregor Mendel Cir Greenwood, SC 29646 864-229-8110

2169

Progress Note / Discharge Note

Name: <u>Karen Duncan</u>	Date: <u>9-16-15</u>
DOB: <u>DOB 65</u>	Physician: <u>Timms</u>
Medical Diagnosis: <u>Osteoarthritis, SAD</u> <u>DCE</u>	Treatment Diagnosis:

Treatment Received:

☒ Therapeutic Exercise	☐ Hot Pack	☒ PRE's
☒ Ultrasound	☒ AROM	☒ Home Exercise Program
☐ PROM	☒ Cold Pack	☒ Traction <u>cerivics</u>
☒ Electrical Stimulation	☒ Isometrics	☐ Kinesiotaping
☐ AAROM <u>37</u> <u>39</u>	☒ Manual Techniques	☐ Other

Attendance: 20 / 40 visits ☐ cancelled 2 no shows since 4/7/15

Tests/ Measurements: _____

Occupation: _____ Work Status: Not Working Light Modified Full

Occupational Requirements: _____

Current Physician Limitations (as described by patient): _____

Goals set at Initial Evaluation: Met _____ Not Met _____

Partially Met _____

Assessment/Comments: Pt last seen on 9-1-15. Unable to retest goals
& unexpected discharge. Pt had received a nerve study & reported
she has ulnar neuropathy. Pt continues to have pain when she looks
up or turns right. Shoulder ROM limited 2° pain. Pt had
plateaued in therapy progress 2° pain levels (frequent flare-ups
Now Goals: p working).

Recommendations: D/C to HEP

Steve Traynor, PT Heidi Blake, DPT Tina Paysinger, DPT Forest Newby, PTA Meredith Stevenson, DPT

MD RESPONSE:

- ☐ Continue PT _____ times per week for _____ weeks
- ☐ Change Treatment/s to _____
- ☒ Discharge to HEP
- ☐ Other: _____

I certify the medical necessity of services furnished under this plan of care.

Physician Signature: _____

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Physicians dedicated to the health of America



Guides

to the Evaluation
of Permanent
Impairment

Fifth Edition

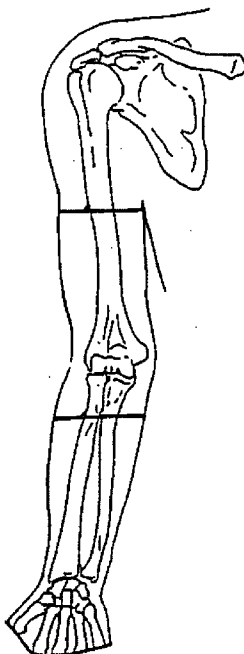
Linda Cocchiarella, MD, MSc, AMA Medical Editor

Gunnar B. J. Andersson, MD, PhD, Senior Medical Editor



Figure 16-1b Upper Extremity Impairment Evaluation Record-Part 2 (Wrist, elbow, and shoulder) Side ☐ R ☐ L

Name Karen Duncan Age 49 Sex ☐ M ☒ F Dominant hand ☒ R ☐ L Date _____
 Occupation _____ Diagnosis _____

Abnormal Motion					Other Disorders	Regional Impairment %	Amputation
Record motion or ankylosis angles and impairment %					List type & impairment %	• Combine (1) + (2)	Mark level & impairment %
Wrist	Flexion	Extension	Ankylosis	Imp %			
	Angle°						
	Imp %						
	RD	UD	Ankylosis	Imp %			
	Angle°						
	Imp %						
Add Imp % Flex/Ext + RD/UD =				(1)	Imp % = (2)		
Elbow	Flexion	Extension	Ankylosis	Imp %			
	Angle°						
	Imp %						
	Pronation	Supination	Ankylosis	Imp %			
	Angle°						
	Imp %						
Add Imp % Flex/Ext + Pro/Sup =				(1)	Imp % = (2)		
Shoulder	Flexion	Extension	Ankylosis	Imp %			
	Angle°	105°	35°				
	Imp %	5%	1%				
	Adduction	Abduction	Ankylosis	Imp %			
	Angle°	45°	115°				
	Imp %	0%	3%				
	Int Rot	Ext Rot	Ankylosis	Imp %			
	Angle°	60°	30°				
	Imp %	0%	1%				
	Add Imp % Flex/Ext + Add/Abd + Int Rot/Ext Rot =						(1)
						Imp % =	

I. Amputation impairment (other than digits)	=	%
II. Regional impairment of upper extremity	TABLES 16-40, 16-43 + 16-46 • (Combine hand % + wrist % + elbow % + shoulder %) FLEXION 5% + EXTENSION 1% + ADD 3% + ADD 0% + EXT ROT 1% + INT ROT 0% = 10%	
III. Peripheral nerve system impairment	=	%
IV. Peripheral vascular system impairment	=	%
V. Other disorders (not included in regional impairment)	TABLES 16-18 + 16-27 25% MAX X 10% = 2.5%	
Total upper extremity impairment (•Combine I, II, III, IV, and V)	=	13%
Impairment of the whole person (Use Table 16-3)	=	%

• Combined Values Chart (p. 604).

If both limbs are involved, calculate the whole person impairment for each on a separate chart and combine the percents (Combined Values Chart).

Guides to the Evaluation of
Permanent Impairment,
Fifth Edition

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First Edition—1971

Second Edition—1984

Third Edition—First Printing December 1988

Second Printing February 1989

Third Edition (Revised)—December 1990

Fourth Edition—June 1993

Fifth Edition—November 2000

Printed in the United States of America

Internet address: www.ama-assn.org

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ISBN 1-57947-085-8

BQ63:0024-00:11/00

The Upper Extremities



- 16.1 Principles of Assessment
- 16.2 Amputations
- 16.3 Sensory Impairment Due to Digital Nerve Lesions
- 16.4 Evaluating Abnormal Motion
- 16.5 Impairment of the Upper Extremities Due to Peripheral Nerve Disorders
- 16.6 Impairment of the Upper Extremities Due to Vascular Disorders
- 16.7 Impairment of the Upper Extremities Due to Other Disorders
- 16.8 Strength Evaluation
- 16.9 Summary of Steps for Evaluating Impairments of the Upper Extremity
- 16.10 Clinical Examples

Introduction

This chapter provides criteria for evaluating permanent impairments due to anatomic impairments of the hand and the upper extremity. The methods discussed in this chapter for evaluation of upper extremity impairment due to amputation, sensory loss, and abnormal motion or ankylosis were based on A. B. Swanson's work and adapted from the fourth edition and updated with input from many of the specialty societies listed in the preface.

The following revisions have been made for the fifth edition: (1) basic principles of assessment have been clarified, (2) updates of the latest scientific information in assessment of upper extremity impairments have been provided, (3) measurement of range of motion of the fingers has been clarified to also detect limited motion due to limited excursion of tendons, (4) impairment determination for nerve entrapment syndromes has been clarified, (5) the criteria for diagnosis of complex regional pain syndrome are discussed and consistent throughout the book, (6) criteria for diagnosis and rating of carpal instability have been clarified, and (7) criteria for diagnosis and rating of weakness not due to other ratable conditions have been clarified.

16.1 Principles of Assessment

16.1a Principles of Impairment Evaluation

Before using the information in this chapter, the *Guides* user should become familiar with Chapters 1 and 2 and the Glossary. Chapters 1 and 2 discuss the *Guides'* purpose, applications, and methods for performing and reporting impairment evaluations. The Glossary provides definitions of common terms used by many specialties in impairment evaluation.

Methods for evaluating impairments of the upper extremities may be described as having anatomic, cosmetic, or functional bases. The physical evaluation determines the *anatomic impairment* and is based on the history and a detailed examination of the individual and the upper extremity(ies). The *cosmetic evaluation* concerns both the individual's and society's reaction to the individual's condition. The *functional evaluation* measures the individual's motor performance of activities of daily living or of a specific task within a set time frame. Functional studies are increasingly sophisticated and can complement the evaluation process. However, the necessary level of standardization in precision and reproducibility to assess function has not yet been developed to derive a numeric impairment rating. Therefore, evaluation of anatomic impairment forms the basis for upper extremity assessment. The impairment ratings originally developed and retained in this chapter were developed to reflect the degree of impairment and its impact on the ability of the individual to perform activities of daily living.

The most practical and useful approach to evaluating impairment of a digit is to compare the current loss of function with the loss resulting from amputation. Total loss of motion and sensibility of a digit, or ankylosis with severe malposition that renders the digit essentially useless, is considered to be about the same as amputation of the part. Ankylosis of a digit or joint in the optimal functional position is given the least motion impairment of the part. Impairment due to total transverse sensory loss of a digit corresponds to 50% of the amputation impairment at the same length or level of involvement (Figures 16-6 and 16-7). Impairment values derived from amputation, loss of motion or ankylosis, and sensibility loss are *combined* using the Combined Values Chart (p. 604).

16.1b Impairment Evaluation: Documentation and Recording

The medical evaluation is the basis for determination of permanent anatomic impairment of the upper extremities. It must be accurate, objective, and well documented. Evaluation of the upper extremities requires a sound knowledge of the normal functional anatomy and would be incomplete without assessment of the general condition of the whole person. It must be thorough and should include several elements: status of activities of daily living; careful observations; both local and general physical examinations; appropriate imaging evaluation; laboratory tests; and, preferably, a photographic record.

An impairment evaluation is based on the examiner's actual findings. A prior injury or illness is considered during assessment of causation and apportionment, as discussed in Chapters 1 and 2. Impairment ratings in this chapter have not been adjusted for hand dominance, as is done in Chapter 13, The Central and Peripheral Nervous System. Hand dominance is difficult to objectively measure and is not accounted for in these impairment ratings. Hand dominance may be right or left and may be marked or slight, or the individual may be completely ambidextrous. Hand dominance should be considered in the determination of disability. If the examiner believes that hand dominance has a significant impact on the ability to perform activities of daily living, this can be discussed in the impairment evaluation report along with the resulting impairment rating. Hand dominance may, of course, be significant when assessing disability.

A complete and detailed examination of the upper extremities is necessary for accurate impairment evaluation. One method for recording results from a systematic examination is the use of the Upper Extremity Impairment Evaluation Record (Figures 16-1a and 16-1b). Part 1 of the evaluation record addresses the hand region and lists impairments due to abnormal motion or ankylosis, amputation, and sensory loss resulting from digital nerve lesions and to other disorders. Part 2 is designed to assist impairment evaluation of the wrist, elbow, and shoulder due to abnormal motion or ankylosis, amputation, and "other" disorders, as well as those related to the peripheral nerve system, peripheral vascular system, and other disorders not included in regional impairments (eg, grip strength). Table 16-1 gives conversions from digit to hand impairment, and Table 16-2 gives those from hand to upper extremity impairment. Regional impairments resulting from the hand, wrist, elbow, and shoulder regions are *combined* to provide the upper extremity impairment (see Section 1.4, Philosophy and Use of the Combined Values Chart, and the Combined Values Chart, p. 604). The upper extremity impairment is then converted to a whole person impairment by means of Table 16-3. When to *add* as opposed to *combine* impairments is discussed in Sections 16.1c and 16.1d and noted in Figure 16-1.

The impairment evaluation record form is designed for use with unilateral upper extremity impairments. Cases of *bilateral involvement* require completion of a separate record form for each upper extremity. The whole person impairment values derived for each upper extremity are then *combined* using the Combined Values Chart (p. 604) to derive the total whole person impairment. If the total *combined* whole person impairment does not seem to adequately reflect the actual extent of alteration in the individual's ability to perform activities of daily living, this should be noted.

Table 16-1 Conversion of Impairment of the Digits to Impairment of the Hand*

% Impairment of		% Impairment of		% Impairment of	
Thumb	Hand	Index or Middle Finger	Hand	Ring or Little Finger	Hand
0 - 1 = 0		0 - 2 = 0		0 - 4 = 0	
2 - 3 = 1		3 - 7 = 1		5 - 14 = 1	
4 - 6 = 2		8 - 12 = 2		15 - 24 = 2	
7 - 8 = 3		13 - 17 = 3		25 - 34 = 3	
9 - 11 = 4		18 - 22 = 4		35 - 44 = 4	
12 - 13 = 5		23 - 27 = 5		45 - 54 = 5	
14 - 16 = 6		28 - 32 = 6		55 - 64 = 6	
17 - 18 = 7		33 - 37 = 7		65 - 74 = 7	
19 - 21 = 8		38 - 42 = 8		75 - 84 = 8	
22 - 23 = 9		43 - 47 = 9		85 - 94 = 9	
24 - 26 = 10		48 - 52 = 10		95 - 100 = 10	
27 - 28 = 11		53 - 57 = 11			
29 - 31 = 12		58 - 62 = 12			
32 - 33 = 13		63 - 67 = 13			
34 - 36 = 14		68 - 72 = 14			
37 - 38 = 15		73 - 77 = 15			
39 - 41 = 16		78 - 82 = 16			
42 - 43 = 17		83 - 87 = 17			
44 - 46 = 18		88 - 92 = 18			
47 - 48 = 19		93 - 97 = 19			
49 - 51 = 20		98 - 100 = 20			
52 - 53 = 21					
54 - 56 = 22					
57 - 58 = 23					
59 - 61 = 24					
62 - 63 = 25					
64 - 66 = 26					
67 - 68 = 27					
69 - 71 = 28					
72 - 73 = 29					
74 - 76 = 30					
77 - 78 = 31					
79 - 81 = 32					
82 - 83 = 33					
84 - 86 = 34					
87 - 88 = 35					
89 - 91 = 36					
92 - 93 = 37					
94 - 96 = 38					
97 - 98 = 39					
99 - 100 = 40					

* See Table 16-2 for converting hand impairment to upper extremity impairment.

16.1c Combining Impairment Ratings

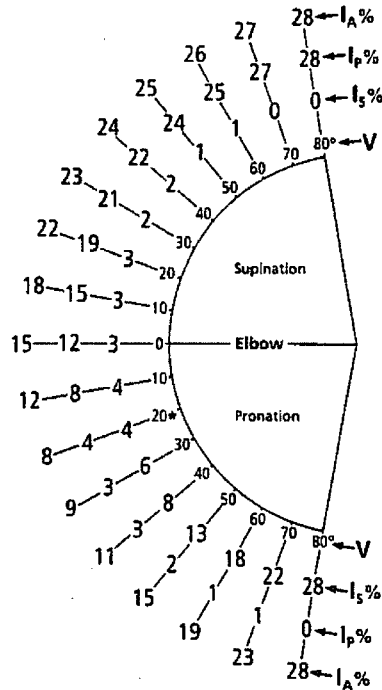
The method for combining various impairments is based on the principle that a second and each succeeding impairment do not apply to the whole unit (eg, whole finger) but only to the part or value that remains (eg, proximal phalanx) after the preceding impairment (eg, amputation through the proximal interphalangeal joint) has been applied.

When a given unit has more than one type of impairment (eg, abnormal motion, sensory loss, and partial amputation of a finger), the various impairments are *combined* to determine the total impairment of the unit (eg, finger) before conversion to the next larger unit (eg, hand). Similarly, multiple regional impairments, such as those of the hand, wrist, elbow, and shoulder, are first expressed individually as upper extremity impairments and then *combined* to determine the total upper extremity impairment. The latter is finally converted to whole person impairment (Table 16-3). The combined value determination is based on the following formula: $A\% + B\% (100\% - A\%) = \text{the combined value of } A\% \text{ and } B\%$.

The Combined Values Chart (p. 604) is used to determine the combined value of two impairment percentages. *All percentages being combined must be expressed on a common denominator or same unit relative value.* If three or more values are to be combined, the two lowest values are first selected and their combined value is found. The combined value and the third value are then combined to give the total value. This procedure can be repeated indefinitely, with the value obtained in each case being a combination of all the previous values.

Figure 16-37 Pie Chart of Upper Extremity Motion Impairments Due to Lack of Pronation and Supination

Relative value of this functional unit to upper extremity impairment is 28%.



$I_A\%$ = Impairment due to ankylosis
 $I_P\%$ = Impairment due to loss of pronation
 $I_S\%$ = Impairment due to loss of supination
 V = Measured angles of motion
 $*$ = Position of function

Redrawn with permission from Swanson AB, Hagert CG, de Groot Swanson G. Evaluation of impairment of hand function. In: Hunter JM, Schneider LH, Mackin E, Calahan A, eds. *Rehabilitation in the Hand*. St Louis, Mo: CV Mosby Co; 1978:31-69.

Example 16-48

Exam: Elbow ankylosis in 80° flexion and 30° supination.

Analysis: Flexion $I_A\% = 21\%$; supination $I_A\% = 23\%$. Add $21\% + 23\% = 44\%$ impairment of the upper extremity.

Impairment Rating: 26% impairment of the whole person (Table 16-3).

16.4i Shoulder Motion Impairment

The shoulder functional unit represents 60% of the upper extremity function. The shoulder has three functional units of motion, each contributing a relative value to its function. The unit-of-motion impairments are converted to upper extremity impairments by multiplying their respective values by 60% as follows:

1. Flexion: 40% of shoulder function.
 Extension: 10% of shoulder function.
 Flexion and extension unit: 50% of shoulder function, or $50\% \times 60\% = 30\%$ of upper extremity function.
2. Abduction: 20% of shoulder function.
 Adduction: 10% of shoulder function.
 Abduction and adduction unit: 30% of shoulder function, or $30\% \times 60\% = 18\%$ of upper extremity function.
3. Internal rotation: 10% of shoulder function.
 External rotation: 10% of shoulder function.
 Internal and external rotation unit: 20% of shoulder function, or $20\% \times 60\% = 12\%$ of upper extremity function.

For each shoulder functional unit of motion, impairment curves were derived according to the basic formula, $A = E + F$, and expressed on a 100% motion unit scale (Figures 16-39, 16-42, and 16-45). These impairment curves were converted to pie charts of upper extremity impairments by applying the upper extremity functional value of each motion unit as a conversion factor (Figures 16-40, 16-43, and 16-46).

The upper extremity impairment resulting from abnormal shoulder motion is calculated from the pie charts by *adding* directly the upper extremity impairment values contributed by each motion unit.

The actual range-of-motion measurements are recorded and applied to the various impairment pie charts. *Impairment values for motion measurements falling between those shown in the pie chart may be adjusted or interpolated proportionally in the corresponding interval.*

Flexion and Extension

The normal range of motion is considered to be from 180° flexion to 50° extension. The positions of function range from 40° flexion to 20° extension. The relative value of this motion unit is 30% of the upper extremity function.

1. Measure the maximum active shoulder flexion and extension, and record the goniometer readings (Figure 16-38).
2. In Figure 16-40, match the measured flexion and extension angles (row headed V) to their corresponding impairments of flexion (row headed $I_F\%$) and extension (row headed $I_E\%$). Impairment values for measured angles falling between those listed in Figure 16-40 may be adjusted or interpolated proportionally in the corresponding interval.
3. Add $I_F\% + I_E\%$ to obtain the percent of upper extremity impairment contributed by decreased shoulder flexion and extension.
4. If the shoulder is ankylosed, match the measured angle (row headed V) to its corresponding ankylosis impairment (row headed $I_A\%$) in Figure 16-40. Interpolate impairment values for intervening angles.

Ankyloses in functional positions (40° flexion to 20° extension) are given the lowest $I_A\%$, or 50% of this motion unit value (Figure 16-39). This corresponds to 15% impairment of the upper extremity (Figure 16-40). Ankylosis in 50° extension or 180° flexion represents 100% loss of this shoulder motion unit (Figure 16-39). This is equivalent to 50% impairment of shoulder function, or 30% impairment ($50\% \times 60\%$) of the upper extremity resulting from loss of this shoulder unit of motion (Figure 16-40).

Figure 16-38 Shoulder Flexion and Extension

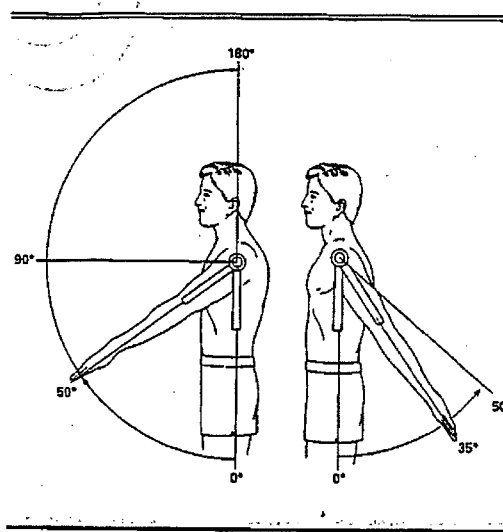
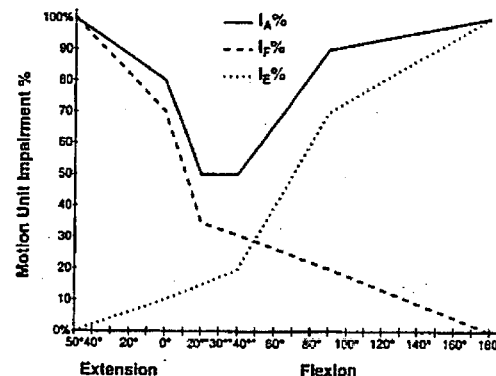


Figure 16-39 Motion Unit Impairment Curves for Ankylosis ($I_A\%$), Loss of Flexion ($I_F\%$), and Loss of Extension ($I_E\%$) of Shoulder

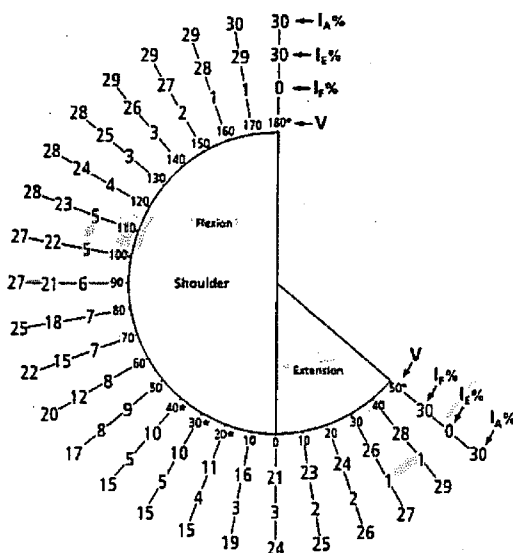
Ankyloses in functional positions (40° to 20° flexion) are given the lowest $I_A\%$ value (50%).



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Figure 16-40 Pie Chart of Upper Extremity Motion Impairments Due to Lack of Flexion and Extension of Shoulder

Relative value of this functional unit to upper extremity impairment is 30%.



$I_A\%$ = Impairment due to ankylosis
 $I_E\%$ = Impairment due to loss of extension
 $I_F\%$ = Impairment due to loss of flexion
 V = Measured angles of motion
 $*$ = Positions of function

Redrawn with permission from: Swanson AB, Hagert CG, de Groot Swanson G. Evaluation of impairment of hand function. In: Hunter JM, Schneider LH, Mackin E, Calahan A, eds. *Rehabilitation in the Hand*. St Louis, Mo: CV Mosby Co; 1978:31-69.

Example 16-49

Exam: Shoulder flexion of 90° and extension of 0° (Figure 16-39).

Analysis: $I_F\%$ = 6% impairment of the upper extremity. $I_E\%$ = 3% impairment of the upper extremity.

Impairment Rating: Add 6% + 3% = 9% impairment of the upper extremity due to decreased shoulder flexion and extension.

Example 16-50

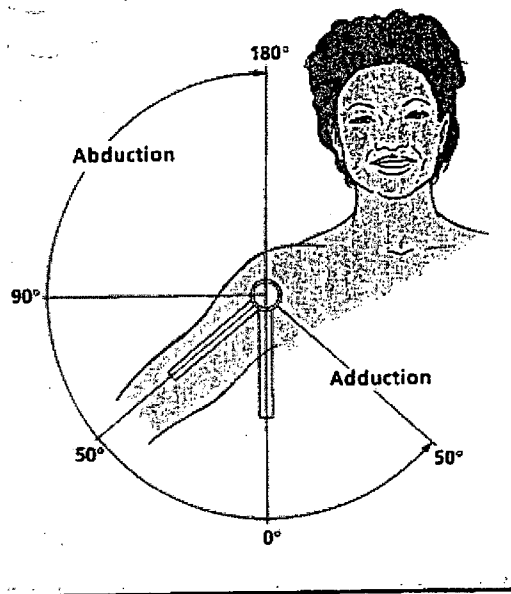
Exam: Shoulder ankylosis in 30° flexion.

Impairment Rating: $I_A\%$ = 15% impairment of the upper extremity due to loss of this shoulder unit of motion.

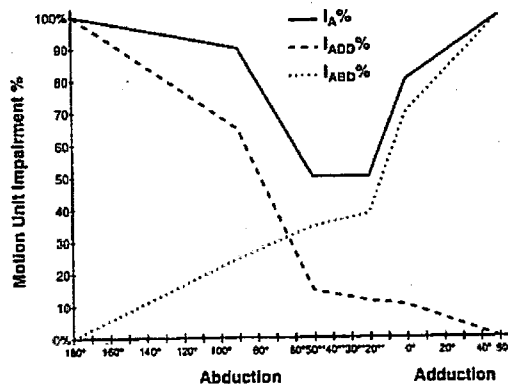
Abduction and Adduction

The normal range of motion is considered to be from 180° abduction to 50° adduction. The positions of function range from 50° abduction to 20° adduction. The relative value of this motion unit is 18% of the upper extremity function.

1. Measure the maximum active shoulder abduction and adduction, and record the *actual* goniometer readings (Figure 16-41).
2. In Figure 16-43, match the measured abduction and adduction angles (row headed V) to their corresponding impairments of abduction (row headed $I_{ABD}\%$) and adduction (row headed $I_{ADD}\%$). Impairment values for motion measurements falling between those listed in Figure 16-43 may be adjusted or interpolated proportionally in the corresponding interval.
3. Add $I_{ABD}\%$ + $I_{ADD}\%$ to obtain the upper extremity impairment contributed by decreased shoulder abduction and adduction.
4. If the shoulder is ankylosed, match the measured angle (row headed V) to its corresponding ankylosis impairment (row headed $I_A\%$) in Figure 16-43. Interpolate impairment values for intervening angles.
5. Ankylosis in functional positions (50° abduction to 20° adduction) are given the lowest impairment percent, or 50% of this motion unit value (Figure 16-42). This corresponds to 9% impairment of the upper extremity (Figure 16-43). Ankylosis in either 50° adduction or 180° abduction represents 100% loss of this shoulder unit of motion (Figure 16-42). This is equivalent to 30% impairment of shoulder function, or 18% impairment (30% × 60%) of the upper extremity resulting from loss of this shoulder motion unit (Figure 16-43).

Figure 16-41 Shoulder Abduction and Adduction**Figure 16-42** Motion Unit Impairment Curves for Ankylosis ($I_A\%$), Loss of Abduction ($I_{ABD}\%$), and Loss of Adduction ($I_{ADD}\%$) of Shoulder

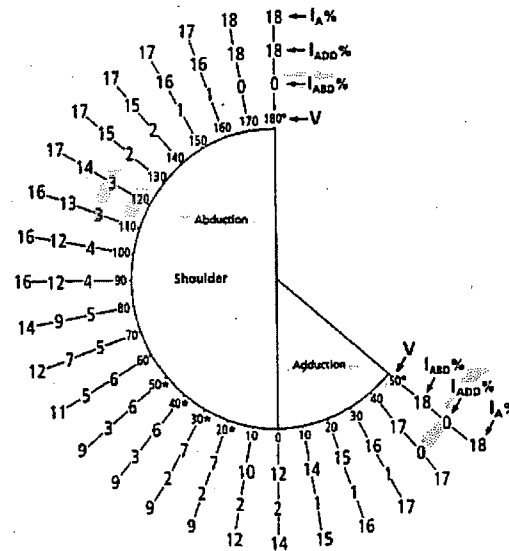
Ankyloses in functional positions (50° to 20° abduction) are given the lowest $I_A\%$ (50%).



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Figure 16-43 Pie Chart of Upper Extremity Motion Impairments Due to Lack of Abduction and Adduction of Shoulder

Relative value of this functional unit to upper extremity impairment is 18%.



$I_A\%$ = Impairment due to ankylosis
 $I_{ABD}\%$ = Impairment due to loss of abduction
 $I_{ADD}\%$ = Impairment due to loss of adduction
 V = Measured angles of motion
 * = Positions of function

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Example 16-51

Exam: Shoulder abduction to 100° and adduction to 0° (Figure 16-43).

Analysis: $I_{ABD}\%$ = 4% impairment of the upper extremity. $I_{ADD}\%$ = 2% impairment of the upper extremity.

Impairment Rating: Add 4% + 2% = 6% impairment of the upper extremity resulting from decreased shoulder abduction and adduction.

Example 16-52

Exam: Shoulder ankylosis in 40° abduction.

Impairment Rating: 9% impairment of the upper extremity due to loss of this shoulder motion unit.

Internal and External Rotation

The normal range of motion is from 90° internal rotation to 90° external rotation. The positions of function range from 30° internal rotation to 50° external rotation. The relative functional value of this motion unit is 12% of the upper extremity function.

1. Measure the maximum active shoulder internal and external rotation, and record the *actual* goniometer readings (Figure 16-44).
2. From Figure 16-46, match the measured internal and external rotation angles (row headed V) to their corresponding impairments of internal rotation (row headed $I_{IR}\%$) and external rotation (row headed $I_{ER}\%$). Impairment values for angles falling between those listed in Figure 16-46 may be adjusted or interpolated proportionally in the corresponding interval.
3. Add $I_{IR}\% + I_{ER}\%$ to obtain the value for upper extremity impairment contributed by decreased shoulder rotation.
4. If the shoulder is ankylosed, match the measured angle (row headed V) to its corresponding ankylosis impairment (row headed $I_A\%$) in Figure 16-46. Interpolate impairment values for intervening angles.

Ankyloses in functional positions (30° to 50° internal rotation) are given the lowest $I_A\%$, or 50% of this motion unit value (Figure 16-45). This corresponds to 6% impairment of the upper extremity (Figure 16-46). Ankylosis in either 90° internal or external rotation represents 100% loss of shoulder rotation function (Figure 16-45). This is equivalent to 20% impairment of shoulder function, or 12% impairment (20% × 60%) of the upper extremity resulting from loss of shoulder rotation (Figure 16-46).

Figure 16-44 Shoulder External Rotation and Internal Rotation

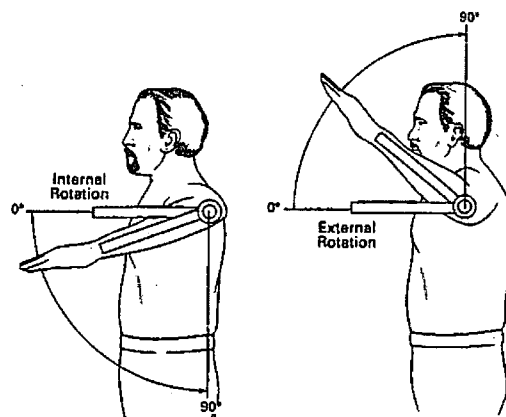
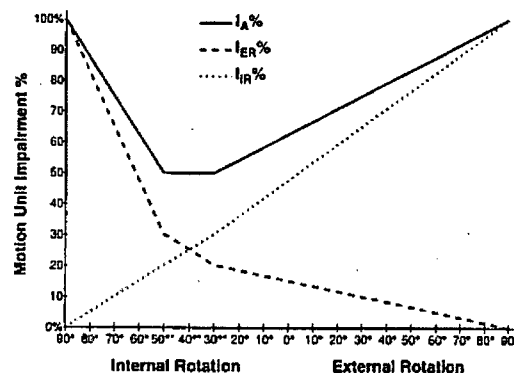


Figure 16-45 Motion Unit Impairment Curves for Ankylosis ($I_A\%$), Loss of Internal Rotation ($I_{IR}\%$), and Loss of External Rotation ($I_{ER}\%$) of Shoulder

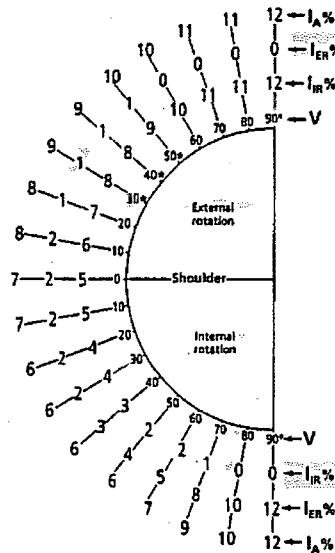
Ankyloses in functional positions (30° internal rotation to 50° internal rotation) are given the lowest $I_A\%$ (50%).



Redrawn with permission from Swanson AB, Hagen CG, de Groot Swanson G. Evaluation of impairment of hand function. In: Hunter JM, Schneider LH, Mackin E, Calahan A, eds. *Rehabilitation in the Hand*. St Louis, Mo: CV Mosby Co; 1978:31-69.

Figure 16-46 Pie Chart of Upper Extremity Impairments Due to Lack of Internal and External Rotation of Shoulder

Relative value of this functional unit to upper extremity impairment is 12%.



$I_A\%$ = Impairment due to ankylosis
 $I_{IR}\%$ = Impairment due to loss of internal rotation
 $I_{ER}\%$ = Impairment due to loss of external rotation
 V = Measured angles of motion
 * = Positions of function

Redrawn with permission from Swanson AB, Hegert CG, de Groot Swanson G. Evaluation of impairment of hand function. In: Hunter JM, Schneider LH, Mackin E, Calahan A, eds. *Rehabilitation in the Hand*. St Louis, Mo: CV Mosby Co; 1978:31-69.

Example 16-53

Exam: Shoulder internal rotation of 40° and external rotation of 50° (Figure 16-46).

Analysis: $I_{IR}\%$ = 3% impairment of upper extremity.
 $I_{ER}\%$ = 1% impairment of upper extremity.

Impairment Rating: Add 3% + 1% = 4% impairment of upper extremity resulting from decreased shoulder rotation.

Example 16-54

Exam: Shoulder ankylosis in 10° external rotation.

Impairment Rating: $I_A\%$ = 8% impairment of the upper extremity resulting from loss of shoulder rotation.

Determining Impairment Due to Abnormal Shoulder Motion

- Using Figures 16-40, 16-43, and 16-46, determine the impairment of the upper extremity contributed by each shoulder unit of motion (flexion and extension, abduction and adduction, internal and external rotation) by adding $I_F\%$ + $I_E\%$, $I_{ABD}\%$ + $I_{ADD}\%$ and $I_{IR}\%$ + $I_{ER}\%$, as described in preceding sections.
- Because the relative upper extremity value of each shoulder functional unit has been taken into consideration in the impairment pie charts, the impairment values contributed by each unit of motion are *added* to determine the impairment of the upper extremity due to abnormal shoulder motion, or it equals $(I_F\% + I_E\%) + (I_{ABD}\% + I_{ADD}\%) + (I_{IR}\% + I_{ER}\%)$.
- If the shoulder is ankylosed, *add* the ankylosis impairments contributed by each unit of motion to determine the upper extremity impairment resulting from loss of shoulder motion.
- Use Table 16-3 to relate the impairment of the upper extremity to impairment of the whole person.

Example 16-55

Exam: Shoulder flexion and extension impairment of 9%, abduction and adduction impairment of 5%, and internal and external rotation impairment of 2% (Figures 16-40, 16-43, and 16-46).

Analysis: Add 9% + 5% + 2% = 16% impairment of the upper extremity.

Impairment Rating: 10% impairment of the whole person (Table 16-3).

Example 16-56

Exam: Shoulder ankylosis in 0° extension, 0° adduction, and 0° rotation.

Analysis: Extension $I_A\%$ = 24%; adduction $I_A\%$ = 14%; rotation, $I_A\%$ = 7%. Add 24% + 14% + 7% = 45% impairment of the upper extremity.

Impairment Rating: 27% impairment of the whole person (Table 16-3).

Table 16-17 Impairment of the Upper Extremity Due to Peripheral Vascular Disease

Symptoms	Upper Extremity Impairment %				
	Class 1 (0%-9%)	Class 2 (10%-39%)	Class 3 (40%-69%)	Class 4 (70%-89%)	Class 5 (90%-100%)
Claudication	None	Intermittent with severe use	Intermittent with moderate use	Intermittent with mild use	Persistent
Pain at rest	None	None	None	Intermittent	Severe and constant
Edema	Transient	Persistent and moderate	Marked	Marked	Marked
Signs of vascular damage	Loss of pulses; minimal loss of subcutaneous tissue of fingertips; arterial calcifications on x-ray; asymptomatic dilation of veins or arteries not requiring surgery; no decreased activity	Healed painless amputation stump of one digit with persistent vascular disease or healed ulcer	Healed amputation stump of two or more digits with persistent vascular disease or superficial ulceration	Amputation of two or more digits of each extremity, or amputation at or above wrist of one extremity with persistent widespread or deep ulceration of one extremity	Amputation of all digits or amputation at or above the wrist of each extremity, with persistent vascular disease or widespread or deep ulcerations of both extremities
Raynaud's phenomenon	Raynaud's symptoms with or without obstructive physiology (as documented by finger brachial indices of < 0.8 or low digital temperatures with decreased laser Doppler signals that do not normalize with warming of affected digits) that completely responds to lifestyle changes and/or medical therapy	Raynaud's phenomena with obstructive physiology (as documented by finger/brachial indices of < 0.8 or low digital temperatures with decreased laser Doppler signals that do not normalize with warming of affected digits) that incompletely responds to lifestyle changes and/or medical therapy			
Medication control	Good	Good	Partial	Partial	Poor

Analysis:

Left upper extremity: 55% impairment of the upper extremity (middle range of class 3) due to peripheral vascular disease; 5% of the upper extremity due to finger amputations (see Section 16.2 and Figure 16-5). Combining these values yields 57% impairment of the left upper extremity, or 34% whole person impairment.

Right upper extremity: 25% of the upper extremity (middle range of class 2), or 15% whole person impairment.

Impairment Rating: Combining 34% with 15% gives 44% whole person impairment.

16.7 Impairment of the Upper Extremities Due to Other Disorders

Conditions not previously described that can contribute to impairments of the hand and upper extremity include bone and joint disorders (Section 16.7a), presence of resection or implant arthroplasty (Section 16.7b), musculotendinous disorders (Section 16.7c), and tendinitis (Section 16.7d), and loss of strength (Section 16.8). The severity of impairment due to these disorders is rated separately according to Tables 16-19 through 16-30 and then multiplied by the relative maximum value of the unit involved as specified in Table 16-18. Appropriate impairment percents are combined with other impairment percents by means of the Combined Values Chart (p. 604).

Table 16-18 Maximum Impairment Values for the Digits, Hand, Wrist, Elbow, and Shoulder Due to Disorders of Specific Joints or Units*

Units and Joints	% Impairment of			
	Unit	Hand	Upper Extremity	Whole Person
Shoulder				
Glenohumeral	—	—	60	36
Acromioclavicular	—	—	25	15
Sternoclavicular	—	—	5	3
Elbow				
Entire elbow	—	—	70	42
Ulnohumeral	—	—	50	30
Proximal radioulnar	—	—	20	12
Wrist				
Entire wrist	—	—	60	36
Radiocarpal	—	—	40	24
Distal radioulnar	—	—	20	12
Proximal carpal row	—	—	30	18
Entire hand	—	100	90	54
Thumb				
Entire thumb	100	40	36	22
CMC	60	24	22	13
MP	15	6	5	3
IP	25	10	9	5
Index and middle				
Entire finger	100	20	18	11
MP	50	10	9	5
PIP	30	6	5	3
DIP	20	4	4	2
Ring or little				
Entire finger	100	10	9	5
MP	50	5	5	3
PIP	30	3	3	2
DIP	20	2	2	1

* Each value is related to the next larger units and the whole person

Skin disorders, including disfigurement, scars, and skin grafts, are evaluated using criteria in Chapter 8, The Skin.

Impairments from the disorders considered in this section under the category of "other disorders" are usually estimated by using other impairment evaluation criteria. *The criteria described in this section should be used only when the other criteria have not adequately encompassed the extent of the impairments.* Some of the conditions described in this section can be concurrent with each other and with decreased motion because they share overlapping pathomechanics. The evaluator must have good understanding of pathomechanics of deformities and apply proper judgment to avoid duplication of impairment ratings.

Table 16-18 shows the maximum values for the digits, hand, wrist, elbow, and shoulder resulting from the conditions described in this section and relates the percents to larger units and the whole person.

Note that the relative upper extremity impairment values for the shoulder, elbow, and wrist are the same for decreased motion (Section 16.4) and "other disorders" (Table 16-18) but differ from those for amputation at similar levels (Table 16-4). The values for individual joints of both the thumb and fingers listed in Table 16-18 have been assigned on a 100% digit unit scale and differ from those listed for amputation (Table 16-4) and range of motion (Section 16.4). The hand impairment value of each digit is the same throughout this entire chapter. *If more than one joint of a specific digit is affected by impairments due to "other disorders" listed in this section, the applicable joint impairment ratings are added only when the joints involved have a full range of motion. Otherwise, the joint impairment values are combined using the Combined Values Chart.*

16.7a Bone and Joint Deformities

If the same unit presents several findings, the following rules must be followed to avoid duplication of impairments. In the digits, wrist, and elbow, manifestations of joint translocation can include lateral deviation, rotational deformity (digit), and/or subluxation or dislocation in any combination. The impairment values due to these findings cannot be combined, and only the finding with the highest impairment value is rated. Limited motion impairment is rated according to Section 16.4 and can be appropriately combined with impairments due to "other disorders" listed in this section, except with those due to joint swelling from synovial hypertrophy, persistent joint subluxation or dislocation, and musculotendinous disorders (Section 16.7c). Joint instability impairment values can be combined with other appropriate impairment values, including decreased motion, but not with arthroplasty. Joint swelling due to synovial hypertrophy is rated only when no other findings are present. Joint crepitation is not rated separately because other findings, such as those listed above, are more reliable indicators of the severity of the same arthritic process.

Table 16-26 Upper Extremity Impairment Due to Symptomatic Shoulder Instability Patterns

Parameters	% Upper Extremity Impairment Due to Symptomatic Shoulder Instability Patterns		
	Occult (6%)	With Subluxating Humeral Head (12%)	With Dislocating Humeral Head (24%)
Confirmed history of acute trauma	No	Yes	Yes
Consistent relationship of symptoms with specific activities/motion ranges	Yes	Yes	Yes
Clinical symptoms reproducible on shoulder stability testing	Yes/No	Yes	Yes
Glenohumeral translation class	I + II	II	III
Demonstrable etiological anatomic lesion	No	Yes	Yes

Compiled by EG McFarland, MD, Baltimore, Maryland.

Example 16-68

History: A 30-year-old athletic male sustained a third episode of anterior shoulder subluxation while delivering an overhead serve during a tennis match. He reported that he had sustained two previous episodes of shoulder subluxation while playing tennis at ages 18 and 25.

Current Symptoms: One year later he reports decreased ability to abduct and externally rotate his shoulder due to pain and a feeling that it is going to "pop" out.

Exam: The shoulder active range of motion is 50° adduction, 130° abduction, 80° internal rotation, and 80° external rotation with normal flexion and extension. The tests for anterior instability, anterior apprehension, and anterior relocation (Jobe's) all are positive. The axial load test showed that the humeral head could be subluxated anteriorly over the glenoid rim, but reduced spontaneously in place when the force-load was withdrawn (class II glenohumeral translation). This maneuver reproduced the clinical symptoms. The shoulder radiogram was normal, but an MRI confirmed an anterior glenoid labrum tear. The man refuses surgery for personal reasons.

Analysis: According to Table 16-26, a class II humeral translation (subluxating head) with a history of previous trauma, consistent relationship of symptoms with specific motions, reproducible symptoms on clinical testing, and positive radiographic findings corresponds to 12% upper extremity impairment.

The upper extremity impairment due to decreased shoulder motion is found in Section 16.4: $I_{ADD}\% = 0\%$ and $I_{ABD}\% = 2\%$ (Figure 16-43); $I_{IR}\% = 0\%$ and $I_{ER}\% = 0\%$ (Figure 16-46). The upper extremity motion impairment is 2%.

Impairment Rating: The upper extremity impairments due to shoulder instability (12%) and decreased motion (2%) are *combined* (Combined Values Chart, p. 604) and equal 14% of the upper extremity, or 8% of the whole person (Table 16-3).

16.7b Arthroplasty

Resection arthroplasty of a joint may be carried out with or without implant replacement. Impairment ratings for the upper extremity following arthroplasty of specific joints are listed in Table 16-27 and reflect upgraded information.

In the presence of decreased motion, motion impairments are derived separately (Section 16.4) and combined with the arthroplasty impairment (Combined Values Chart, p. 604). If the same joint presents other findings, the rules outlined on page 499 must be followed to avoid duplication of impairments. However, impairment due to arthroplasty *cannot be combined* with impairments due to instability, subluxation, or dislocation.

After *arthrodesis* procedures, the impairment is based on the *ankylosis impairment* ($I_A\%$) for the corresponding angle of fusion (V) according to the guidelines in Section 16.4.

A severe symptomatic failure of an implant arthroplasty procedure (eg, symptomatic breakage or subluxation of the device) is given 100% of the joint value as listed in Table 16-18.

Impairments involving the resection of malignant tumors with reconstructive surgery including arthroplasty should receive individual consideration.

Table 16-27 Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints

Level of Arthroplasty	% Impairment of Upper Extremity	
	Implant Arthroplasty	Resection Arthroplasty
Total shoulder	24	30
Distal clavicle (isolated)	—	10
Proximal clavicle (isolated)	—	3
Total elbow	28	35
Radial head (isolated)	8	10
Total wrist	24	—
Radiocarpal	16	—
Ulnar head (isolated)	8	10
Proximal row carpectomy	—	12
Carpal bone (isolated)	8	10
Radial styloid (isolated)	—	5
Thumb		
CMC	9	11
MP	2	3
IP	4	5
Index or middle finger		
MP	4	5
PIP	2	3
DIP	1	2
Ring or little finger		
MP	2	2
PIP	1	1
DIP	1	1

CMC: thumb carpometacarpal; IP: thumb interphalangeal; MP: metacarpophalangeal; PIP: proximal interphalangeal; DIP: distal interphalangeal.

Modified from Swanson AB, de Groot Swanson G. Principles and methods of impairment evaluation in the hand and upper extremity. In: Engelberg AE, ed. *Guides to the Evaluation of Permanent Impairment*. Third ed. Chicago, Ill: American Medical Association; 1989:47; prepared with the assistance of DM Lichtman, Fort Worth, Texas, and EG McFarland, Baltimore, Maryland.

Example 16-69

Exam: An individual with a total wrist (radiocarpal and distal radioulnar joints) replacement has 30° flexion and 20° extension, 0° radial deviation, and 30° ulnar deviation.

Analysis: Wrist implant arthroplasty = 24% impairment of the upper extremity (Table 16-27). The impairments of the upper extremity due to restricted motion are found in Figures 16-28 and 16-31:

$$I_F\% = 5\%; I_E\% = 7\%$$

$$I_{RD}\% = 4\%; I_{UD}\% = 0\%$$

$$5\% + 7\% + 4\% = 16\%$$

Impairment Rating: 24% combined with 16% = 36% upper extremity impairment (Combined Values Chart, p. 604).

Table 16-28 Digit Impairment Due to Intrinsic Tightness

Intrinsic Tightness Severity (Passive Flexion of PIP Joint With MP Joint Hyperextended)	% Digit Impairment*
Mild: PIP flexion 80°-60°	20
Moderate: PIP flexion 59°-20°	40
Severe: PIP flexion ≤ 20°	60

* Multiply by the relative hand value of the digit (Table 16-18) to determine the hand impairment.

Modified from Swanson AB, Mays JD, Yamauchi Y. A rheumatoid arthritis evaluation record for the upper extremity. *Surg Clin North Am*. 1968;48:1003-1013.

16.7c Musculotendinous Impairments

Intrinsic Tightness

Intrinsic tightness in the hand may be demonstrated by a test described by Bunnell. Hyperextension of the metacarpophalangeal (MP) joint in a normal hand still allows passive flexion of the proximal interphalangeal (PIP) joint. If the intrinsic muscles are tight or contracted, the available stretch of these muscles is taken up by the hyperextended position of the MP joint, and passive flexion of the PIP joint will be difficult. The digit impairment due to intrinsic tightness is rated according to Table 16-28 and multiplied by the relative hand value of the digit (Table 16-18) to derive the hand impairment value.

The impairment due to intrinsic tightness can be combined with other impairments of the same digit, providing they do not share the same pathomechanics, eg, in extensor tendon subluxation over the MP joint (Table 16-30). Intrinsic tightness impairment cannot be combined with that due to decreased motion at the MP or PIP joints.

Constrictive Tenosynovitis

The impairment percent due to constrictive tenosynovitis (Table 16-29) is multiplied by the relative hand value of the digit (Table 16-18) to derive its hand impairment. This impairment may be combined with other impairments of the digit (Combined Values Chart, p. 604) but not with decreased motion.

Table 16-29 Digit Impairment Due to Constrictive Tenosynovitis

Constrictive Tenosynovitis Severity	% Digit Impairment*
Mild: inconstant triggering during active range of motion	20
Moderate: constant triggering during active range of motion	40
Severe: constant triggering during passive range of motion	60

* Multiply by the relative hand value of the digit (Table 16-18) to determine the hand impairment.

Modified from Swanson AB, Mays JD, Yamauchi Y. A rheumatoid arthritis evaluation record for the upper extremity. *Surg Clin North Am.* 1968;48:1003-1013.

Table 16-30 Digit Impairment Due to Extensor Tendon Subluxation Over the MP Joint

Severity of Extensor Tendon Subluxation in Intermetacarpal Groove	% Digit Impairment*
Mild: tendon subluxation on MP joint flexion only	10
Moderate: reducible tendon subluxation	20
Severe: nonreducible tendon subluxation	30

* Multiply by the relative hand value of the digit (Table 16-18) to determine the hand impairment.

Modified from Swanson AB, Mays JD, Yamauchi Y. A rheumatoid arthritis evaluation record for the upper extremity. *Surg Clin North Am.* 1968;48:1003-1013.

Extensor Tendon Subluxation at the MP Joint of the Fingers

The digit impairment due to extensor tendon subluxation at the metacarpophalangeal (MP) joint (Table 16-30) is multiplied by the relative hand value of the digit (Table 16-18) to obtain its hand impairment value. It *cannot be combined* with impairment due to restricted motion at the MP joint or to other related manifestations of the same pathomechanical disturbance.

16.7d Tendinitis

Several syndromes involving the upper extremity are variously attributed to tendinitis, fasciitis, or epicondylitis. The most common of these are the stubborn conditions of the origins of the flexor and extensor muscles of the forearm where they attach to the medial and lateral epicondyles of the humerus. Although these conditions may be persistent for some time, they are not given a permanent impairment rating unless there is some other factor that must be considered.

If an individual has had tendon rupture or has undergone surgical release of the flexor or extensor origins or medial or lateral epicondylitis, or has had excision of the epicondyle, there may be some permanent weakness of grip as a result of the tendon rupture or the surgery. In this case, impairment can be given on the basis of weakness of grip strength according to Section 16.8b. Although there is no good data on the time required to regain maximum strength after surgery, the data on strength loss after carpal tunnel release suggests that impairment rating according to Section 16.8b should not be determined less than 1 year after surgery.

16.8 Strength Evaluation

Because strength measurements are functional tests influenced by subjective factors that are difficult to control and the *Guides* for the most part is based on anatomic impairment, the *Guides* does not assign a large role to such measurements. Those who have contributed to the *Guides* believe that further research is needed before loss of grip and pinch strength is given a larger role in impairment evaluation.

Strength measures the power with which musculo-tendinous units act across a bone-joint lever-arm system to actively generate motion, or passively resist movement against gravity and variable resistance. The effectiveness and magnitude of muscle contraction depends on the integrity of the dynamic and passive elements of a complex lever system, including its muscles and tendons, normal passive motion in the joints across which the muscles act, and the quality of innervation of the muscles. Many subjective or nonmeasurable factors, including fatigue, handedness, time of day, age, nutritional state, pain, and the individual's cooperation, further influence strength measurements. Voluntary muscle strength testing remains somewhat subjective until a precise way of measuring muscle contraction is generally available. It should also be noted that the correlation of strength with performance of activities of daily living is poor and that increased strength does not necessarily equate with increased function.

16.8a Principles

In a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the *Guides*, the loss of strength may be rated separately. An example of this situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. If the examiner judges that loss of strength should be rated separately in an extremity that presents other impairments, the impairment due to loss of strength *could be combined with the other impairments, only if based on unrelated etiologic or pathomechanical causes. Otherwise, the impairment ratings based on objective anatomic findings take precedence.* Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (eg, thumb amputation) that prevent effective application of maximal force in the region being evaluated.

Motor weakness associated with disorders of the peripheral nerve system and various degenerative neuromuscular conditions are evaluated according to guidelines described in Section 16.5 and the Chapter 13, The Central and Peripheral Nervous System. It should be understood that weakness or loss of strength can occur without muscle atrophy.

When evaluating strength, the examiner must have good reason to believe the individual has reached maximal medical improvement and that the condition is a "permanent" one as defined in Chapter 1 and the Glossary. Maximum strength is usually not regained for at least a year after an injury or surgical procedure. Because impairment is evaluated when the individual has reached MMI, strength can only be applied as a measure when a year or more has passed since the time of injury or surgery. This determination is best made with measurements taken over a period of time. Two methods are used to determine loss of strength in the upper extremity. Measurements of grip and pinch strength are used to evaluate power weaknesses relating to the structures in the hand, wrist, or forearm. Manual muscle testing of major groups is used for testing strength about the elbow and shoulder.

16.8b Grip and Pinch Strength

Tests repeated at intervals during an examination are considered to be reliable if there is less than 20% variation in the readings. If there is more than 20% variation in the readings, one may assume the individual is not exerting full effort. The test is usually repeated three times with each hand at different times during the examination, and the values are recorded and later compared.

Grip strength measurements must be performed in a standard manner because altering wrist, forearm, and/or elbow position will change the results. The generally accepted position for measurements is for the individual to be seated with back against the chair and feet flat on the floor. The arm should be relaxed beside the lateral torso, the elbow flexed at 90°, and the forearm and wrist in neutral position. *Grip strength* measurements may be taken with a Jamar dynamometer. The second (4 cm) or third (6 cm) position, according to the size of the hand, usually allows the individual to apply maximal force comfortably.

Two techniques have been reported to help detect individuals who exert less than maximal effort on grip strength testing. Stokes pointed out that the plotting of grip strength measurements from each of the five handle settings of the Jamar dynamometer would produce a bell-shaped curve. Those individuals not exerting maximal effort will produce results yielding a straight line or a flat curve.

An alternate method is the rapid exchange grip technique. The grip strength first is determined by standard techniques. The individual then is instructed to grip the dynamometer with maximal effort, first with one hand, then quickly with the other hand, for at least five exchanges. Individuals who did not exert maximal effort with the standard technique will record significantly higher strength readings. If they become aware of this, the strength of both hands will drop dramatically.

Pinch strength measurements are done with a pinch gauge and may include chuck or three-digit pinch, key or lateral pinch, and tip pinch with separate digits. Key pinch measurements usually are sufficient. Measurements are repeated three times. The three readings each for grip and pinch strength are averaged and compared to those of the opposite extremity, which usually is normal. If both extremities are involved, the strength measurements are compared to the average normal strengths listed in Tables 16-31 through 16-33.

Table 16-31 Average Strength of Unsupported Grip by Occupation in 100 Subjects

Occupation	Grip Strength (kg)			
	Males		Females	
	Major Hand	Minor Hand	Major Hand	Minor Hand
Skilled	47.0	45.4	26.8	24.4
Sedentary	47.2	44.1	23.1	21.1
Manual	48.5	44.6	24.2	22.0
Average	47.6	45.0	24.6	22.4

Adapted with permission from Swanson AB, Matev IB, de Groot Swanson. The strength of the hand. *Bull Prosthet Res.* Fall 1970:145-153.

Table 16-33 Average Strength of Lateral Pinch by Occupation in 100 Subjects

Occupation	Lateral Pinch (kg)			
	Males		Females	
	Major Hand	Minor Hand	Major Hand	Minor Hand
Skilled	6.6	6.4	4.4	4.3
Sedentary	6.3	6.1	4.1	3.9
Manual	8.5	7.7	6.0	5.5
Average	7.5	7.1	4.9	4.7

Adapted with permission from Swanson AB, Matev IB, de Groot Swanson. The strength of the hand. *Bull Prosthet Res.* Fall 1970:145-153.

Table 16-32 Average Strength of Grip by Age in 100 Subjects

Age Group (yrs)	Grip Strength (kg)			
	Males		Females	
	Major Hand	Minor Hand	Major Hand	Minor Hand
< 20	45.2	42.6	23.8	22.8
20-29	48.5	46.2	24.6	22.7
30-39	49.2	44.5	30.8	28.0
40-49	49.0	47.3	23.4	21.5
50-59	45.9	43.5	22.3	18.2

Adapted with permission from Swanson AB, Matev IB, de Groot Swanson. The strength of the hand. *Bull Prosthet Res.* Fall 1970:145-153.

If there is evidence that the individual is exerting less than maximal effort, the grip strength measurements are invalid for estimating impairment. It is acknowledged that wide variations exist in strength, even among persons doing the same kind of work. Little evidence exists of a significant difference in grip strength between the dominant and nondominant hand. If the evaluator believes that a significant difference in grip strength was lost in the dominant hand and that it impacts the ability to perform activities of daily living, this should be addressed in the evaluation report (see Section 16.1b).

Table 16-34 Upper Extremity Joint Impairment Due to Loss of Grip or Pinch Strength

% Strength Loss Index	% Upper Extremity Impairment
10- 30	10
31- 60	20
61-100	30

An index of loss of strength uses the following formula:

$$\frac{\text{Normal strength} - \text{Limited strength}}{\text{Normal strength}} = \frac{\text{Strength loss}}{\text{index \%}}$$

Impairments of the upper extremity due to loss of pinch and grip strength are based on the values of the strength loss index shown in Table 16-34.

Rate the function that measures the greatest loss of strength. Both measurements are not applied.

16.8c Manual Muscle Testing

Manual muscle testing assesses an individual's ability to move a joint through a full range of motion against gravity, or move it against additional resistance applied by the examiner, and/or hold the joint position against resistance. Manual muscle testing is subject to the individual's conscious or unconscious control. Individuals whose performance is inhibited by pain or fear of pain may not be good candidates for this testing. Results of strength testing should be reproducible on different occasions or by two or more trained observers.

Table 16-35 Impairment of the Upper Extremity Due to Strength Deficit From Musculoskeletal Disorders Based on Manual Muscle Testing of Individual Units of Motion of the Shoulder and Elbow

% Upper Extremity Impairment			
Joint Relative Value	Unit of Motion Relative Value	Strength Deficit*	
		5%-25%†	30%-50%‡
Shoulder (60%)			
Flexion	24	1-6	7-12
Extension	6	0-2	2- 3
Abduction	12	1-3	4- 6
Adduction	6	0-2	2- 3
Internal rotation	6	0-2	2- 3
External rotation	6	0-2	2- 3
Elbow (70%)			
Flexion	21	1-5	6-11
Extension	21	1-5	6-11
Pronation	14	1-4	4- 7
Supination	14	1-4	4- 7

* Use clinical judgment to select the appropriate percentage from the range of values shown for each severity grade.

† Complete range of motion against gravity only without resistance.

‡ Complete range of motion against gravity with some resistance.

Derived from Section 16.4 and Table 16-11 by G. de Groot Swanson, Grand Rapids, Michigan.

Upper extremity impairment ratings for strength deficits about the elbow and shoulder (Table 16-35) were derived by multiplying the maximum relative value of each unit of motion by the percentage of severity of strength deficit found on manual muscle testing. The relative functional value of each unit of motion is the same as in Section 16.4, Evaluating Abnormal Motion. The severity of strength deficits is classified and rated on the same principles used for evaluation of the peripheral nerves (Table 16-11). The numeric grades are sometimes also named 5, normal; 4, good; 3, fair; 2, poor; 1, trace; and 0, no muscle contraction. In the absence of peripheral nerve involvement, most weaknesses usually fall in the grade 4 category: "complete active range of motion against gravity with some resistance." Few injuries result in a more profound weakness, such as a grade 3 category: "complete active range of motion against gravity only, without resistance." Muscle strength graded 3 or lower is usually accompanied by other clinical findings such as atrophy. *Because the functional units of motion of each joint were assigned on a 100% scale, the upper extremity impairment values derived for weakness of each unit of motion are added directly together.*

Example 16-70

History: Healed Bennett's fracture.

Physical Exam: Individual complained of pain and weakness when he applied and removed strong alligator clamps. Full active range of motion of the thumb ray. Positive "grind" test at the carpometacarpal (CMC) joint. Lateral (key) pinch was 6 kg on the injured side and 10 kg on the normal side.

Clinical Studies: Radiographs: irregularities of the CMC joint surfaces with arthritic changes.

Analysis: $\frac{10\% - 6\%}{10\%} = 40\%$ strength loss index %

This corresponds to a 20% joint impairment (Table 16-34). The maximum impairment value of the CMC joint is 22% of the upper extremity (Table 16-18).

Impairment Rating: $20\% \times 22\% = 4\%$ impairment of the upper extremity due to symptomatic post-traumatic arthritis at the CMC joint.

Example 16-71

History: A worker sustained an open injury to the lateral side of the elbow with proximal damage to the extensor carpi radialis longus and brevis, and pronator teres, and loss of a portion of the lateral epicondyle of the humerus.

Physical Exam: Normal neurologic examination.

Full active range of elbow extension and supination against gravity with full resistance. Full active range of flexion and pronation against gravity with some resistance: grade 4 (Table 16-35).

Analysis: Flexion weakness: 5% impairment of the upper extremity. Pronation weakness: 4% impairment of the upper extremity.

Impairment Rating: $5\% + 4\% = 9\%$ impairment of the upper extremity due to strength deficit about the elbow.

Example 16-72

History: An individual "pulled" his shoulder while sorting some lumber. A full-thickness tear of the rotator cuff was diagnosed on MRI. He failed to respond to conservative management and underwent open surgical repair.

Current Symptoms: Currently works with restrictions due to shoulder weakness, easy fatiguability, and some pain with overhead movement.

Clinical Studies: After optimal healing time and therapy, the MRI showed a healed rotator cuff with some scarring.

Physical Exam: Full active range of shoulder rotation, extension, and adduction. Full active range of shoulder flexion and abduction against gravity with some resistance: grade 4 (Table 16-35).

Analysis: Flexion weakness: 6% upper extremity impairment. Abduction weakness: 3% upper extremity impairment.

Impairment Rating: $6\% + 3\% = 9\%$ impairment of the upper extremity due to weakness about the shoulder.

16.9 Summary of Steps for Evaluating Impairments of the Upper Extremity

I. Determine the upper extremity impairment derived for the hand region.

Determine and record each of the following on the Upper Extremity Evaluation Record, Part 1 (Figure 16-1).

Hand Region

1. Individual digit impairment due to *amputation* (Sections 16.2c and 16.2d).

Note: Thumb amputations proximal to the MP joint are rated in terms of upper extremity impairment (Table 16-4 and page 440) and *added* to the upper extremity impairment value obtained from step 8 below.

2. Individual digit impairment due to *sensory* loss from digital nerve lesions (Section 16.3; Figures 16-6 and 16-7; and Tables 16-6 and 16-7).

Note: Impairment related to neuromas of digital nerves is discussed in Section 16.3c.

3. Individual joint impairment due to *abnormal motion* (Section 16.4: thumb IP, p. 454; MP, p. 456; CMC, p. 458; finger DIP, p. 462; PIP, p. 462; MP, p. 464).

Note: The motion impairments at the DIP, PIP, and MP joints of the fingers are *combined* (p. 465 and Combined Values Chart, p. 604) to determine the digit impairment. The thumb motion impairments at the IP, MP, and CMC joints are *added* (p. 460).

4. Individual digit impairments due to *other disorders* (Section 16.7).

5. **Total individual digit impairment:** *combine* impairments due to amputation (step 1), sensory loss (step 2), abnormal motion (step 3), and other disorders (step 4) (Combined Values Chart, p. 604).

6. *Convert individual digit impairments to hand impairments* (Table 16-1).

7. **Total hand impairment:** *add* the hand impairment values contributed by each digit.

8. *Convert the total hand impairment to impairment of the upper extremity* (Table 16-2).

9. If applicable, *add* the upper extremity impairment due to *thumb amputation proximal to the MP joint* (Table 16-4) to the upper extremity impairment derived from the hand region (step 8).

10. If applicable, determine the upper extremity impairment due to *loss of strength* and *combine* with the upper extremity impairment derived from the hand region (step 8).

11. If no other upper extremity impairment exists, **convert the upper extremity impairment related to the hand region to an impairment of the whole person** (Table 16-3).

12. If other impairments of the upper extremity are present, enter the upper extremity impairment value due to the Hand Region on Line II of Part 2 of the Evaluation Record.

II. Determine the upper extremity impairment derived from the Wrist, Elbow, and Shoulder Regions and enter on the appropriate space or line of Upper Extremity Evaluation Record, Part 2 (Figure 16-1).

1. Wrist Region

Determine upper extremity impairments due to *loss of motion* (Section 16.4g) and *other disorders* (Section 16.7), and *combine* the values to determine the upper extremity impairment related to the wrist region. Enter on line II.

2. Elbow Region

Determine upper extremity impairments due to *loss of motion* (Section 16.4h) and *other disorders* (Section 16.7), and *combine* the values to determine the upper extremity impairment related to the elbow region. Enter on line II.

3. Shoulder Region

Determine upper extremity impairments due to *loss of motion* (Section 16.4i) and *other disorders* (Section 16.7), and *combine* the values to determine the upper extremity impairment involving the shoulder region. Enter on line II.

III. Determine the upper extremity impairment due to *amputation through the arm or forearm* (Section 16.2b) and enter on line I of the Evaluation Record, Part 2.

IV. Determine the upper extremity impairment due to *peripheral nerve disorders* (Section 16.5) and enter on line III of the Evaluation Record, Part 2.

V. Determine the upper extremity impairment due to *peripheral vascular disorders* (Section 16.6) and enter on line IV of the Evaluation Record, Part 2.

VI. Determine the upper extremity impairments due to *other disorders not included in regional impairment* (Section 16.7) and enter on line V of the Evaluation Record, Part 2.

VII. Determine the total upper extremity impairment and enter on the bottom of Part 2 of the Record.

Combine the upper extremity impairments due to *amputation* (other than hand) (Line I of Part 2), *regional disorders* (hand, wrist, elbow, shoulder) (Line II of Part 2), *peripheral vascular disorders* (Line III of Part 2), *peripheral nerve disorders* (Line IV of Part 2), and *other disorders not included in regional impairment* (Line V of Part 2) (Combined Values Chart, p. 604).

VIII. Convert the upper extremity impairment to a whole person impairment (Table 16-3).

IX. When *both upper extremities* are involved, derive the whole person impairment percent for each and then *combine* both values using the Combined Values Chart (p. 604).

16.10 Clinical Examples

Example 16-73

History: Table saw injury. Maximum medical rehabilitation reached.

Findings: Index finger: Amputation at DIP joint with painful neuroma on radial side that prevents use of the digit for most activities. Thumb: Amputation through CMC joint.

Analysis:

Index finger:

DIP joint amputation = 45% digit impairment (Table 16-5), or 9% hand impairment (Table 16-1) and 8% upper extremity impairment (Table 16-2).

Radial nerve neuroma: Grade 1 pain or sensory deficit = 95% deficit (Table 16-10a); maximum impairment of the upper extremity for deficit of radial palmar digital nerve of index finger = 5% (Table 16-15). $95\% \times 5\% = 5\%$ (rounded) impairment of the upper extremity.

8% (amputation) *combined* with 5% (neuroma) equals 13% impairment of the upper extremity due to the index finger (See Section 16.4f and Combined Values Chart, p. 604).

Thumb:

Amputation at the CMC joint = 38% impairment of the upper extremity (Table 16-4).

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47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80																
48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81																
49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82																
50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83																
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50

The values are derived from the formula $A + B(1-A)$ = combined value of A and B, where A and B are the decimal equivalents of the impairment ratings. In the chart all values are expressed as percents. To combine any two impairment values, locate the larger of the values on the side of the chart and read along that row until you come to the column indicated by the smaller value at the bottom of the chart. At the intersection of the row and the column is the combined value.

For example, to combine 35% and 20%, read down the side of the chart until you come to the larger value, 35%. Then read across the 35% row until you come to the column indicated by 20% at the bottom of the chart. At the intersection of the row and column is the number 48. Therefore, 35% combined with 20% is 48%. Because of the construction of this chart, the larger impairment value must be identified at the side of the chart.

If three or more impairment values are to be combined, select any two and find their combined value as above. Then use that value and the third value to locate the combined value of all. This process can be repeated indefinitely, the final value in each instance being the combination of all the previous values. In each step of this process the larger impairment value must be identified at the side of the chart.

Note: If impairments from two or more organ systems are to be combined to express a whole person impairment, each must first be expressed as a whole person impairment percent.

South Carolina Workers' Compensation Commission
1612 Marion Street • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov



Physician's Statement

Claimant's Name: Karen Duncan
Physician's Name: Anthony Timmons
Practice/Clinic: Lakeland's Ortho.
Preparer's Name: _____
Phone: 803 229 2663

Employer's Name: _____
Insurance Carrier: _____
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: 10/29/14 Date of last visit: 10/14/15

Diagnosis or nature of injury or illness: OA left shoulder

Body part(s) injured: left shoulder Body part(s) affected: LLE

Date of Maximum Medical Improvement: _____

Based on the AMA Guidelines, the claimant has sustained a three (3) % medical impairment to ONE injured body part(s) and a 0 % medical impairment to whole body other affected body part(s).

☒ The claimant is able to return to work without restriction.

☐ The claimant is able to return to work with the following restrictions:

☐ The claimant is unable to return to work at his or her current employment.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

☒ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☐ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Treating Physician: [Signature]

Date: 11-2-15

9/07

14B

Physician's Statement

South Carolina Workers' Compensation Commission

7333 Main Street, Suite 500
P.O. Box 1715
Columbia, SC 29202-1715
(803) 737-5700 www.wcc.sc.gov



WCC File # 1421162
Carrier File # 201410038507
Carrier Code # 00093
Employer FEIN # 340196300

Claimant's Name: Karen M. Duncan SSN: **SSN #** Employer's Name: Eaton Corporation
Address: **ADDRESS** Greenwood, SC 29646 Address: 2210 Highway 72/221 East, Greenwood, SC 29649
Home Phone # (864) **PHONE** Work Phone # Insurance Carrier: Old Republic Insurance Company c/o Sedgwick Claims Management Services, Inc.
Preparer's Name: J. Russell Goudelock, II Law Firm: McAngus Goudelock & Courie Phone Number: (803) 227-2222

The date of injury reported on Form 12A is: 9/26/2014.

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

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

Claimant reached maximum medical improvement on (m/d/yyyy) (copy of medical report must be attached).

Compensation payments are current as of (m/d/yyyy) and shall continue until otherwise ordered or until Form 17 is signed by the claimant.

A Form 17 was offered and refused on (m/d/yyyy).

- II. ☐ **Address suspension, termination, or reduction of temporary disability payments for any cause.**

☐ a. At any time pursuant to § 42-9-260(E).

☐ b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.

The basis for the termination/ suspension is ____

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

Claimant reached MMI on October 14, 2015 and was released with a 3% impairment rating to her left upper extremity by Dr. Anthony Timms.

Claimant reached maximum medical improvement on 10/14/2015 (m/d/yyyy) (copy of medical report must be attached).

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

- V. ☐ **Determine amount of compensation for claims involving a fatality.**

☐ a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.

☐ b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

- VI. ☐ **Mediation**

☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.

☐ b. Mediation is required pursuant to Reg. 67-1802.

☐ c. Mediation is requested by consent for the Parties pursuant to Reg. 67-1803.

☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Failure to respond pursuant to Reg. 67-208 B in writing or by submission of a Form 22 may result in ordered mediation pursuant to Reg. 67-1801 B.

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

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Darren S. Haley, Esquire
address Post Office Box 26062, Greenville, South Carolina 29616 on the 17th day of February 20 16.
by ☒ first class postage ☐ certified mail ☐ personal service.
A \$25.00 filing fee and updated Form 18 is required.

Preparer's Signature

Attorney for Employer/Carrier
Title

rgoudelock@mqclaw.com
Email

February 17, 2016
Date

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

WCC FORM # 21
Revised 7/13

21

Employer's Request for Hearing

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1421162

KAREN M. DUNCAN,

Employee,

Claimant,

vs.

EATON CORPORATION,

Employer,

AND

OLD REPUBLIC INSURANCE COMPANY
C/O SEDGWICK CLAIMS MANAGEMENT
SERVICES, INC.,

Carrier,

Defendants.

VERIFICATION

Pursuant to S.C. Code Ann. Section 42-1-705(C) and other applicable law, I verify the contents of the Form 21 are accurate and true to the best of my knowledge on this date.



J. Russell Goudelock, II
Post Office Box 12519, Capitol Station
Meridian, 1320 Main Street, 10th Floor (29201)
Columbia, South Carolina 29211-2519
(803) 779-2300

ATTORNEYS FOR DEFENDANTS

Date: February 17, 2016

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5739 www.wcc.sc.gov



PRE-HEARING BRIEF
WCC File No: 1421162

Claimant's Name: Karen M. Duncan SSN: SSN #
Address: ADDRESS, Greenwood, SC 29646
Home Phone: (864)PHONE Work Phone: _____
Preparer's Name: J. Russell Goudelock, II

Employer's Name: Eaton Corporation
Address: 2210 Highway 72/221 East, Greenwood, SC 29649
Carrier: Old Republic Insurance Company
Preparer's Phone #: (803) 227-2222

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Comp. Rate: \$366.00 2. AWW: \$548.97 Date of Injury: 09/26/14
3. Type of injury and body part(s): Left shoulder.
4. Facts in controversy: Has Claimant reached maximum medical improvement? Is the Claimant entitled to permanent partial specific scheduled loss of use to her left shoulder? Is the Claimant entitled to additional medical treatment?
5. Legal issues involved: S.C. Code Ann. Sections 42-9-30 and 42-15-60; other applicable statutes, regulations and case law.
6. Unusual aspects: Defendants reserve the right, and may move, to postpone or adjourn the scheduled hearing to exercise due process rights afforded by the S.C. Administrative Procedures Act, and other applicable law, to cross-examine, respond to and/or otherwise oppose evidence presented by Claimant.
7. Witnesses (designate if expert):* Gary Shojaie, Lori Esco, Tony Waters, Marlene Coates and/or other representative(s) from Employer; see no. 6 above.
8. Exhibits: Relevant employment, personnel, attendance and payroll records from Employer; transcript of Claimant's deposition testimony (May 11, 2016); see no. 6 above.
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance): See Defendants' Notice (May 9, 2016); see no. 6 above.
Name, address, and specialty, if any, of the treating physician: Anthony Timms, M.D., Lakeland Orthopaedics, Greenwood, SC.
11. Impairment rating(s); body part(s); physician and date of opinion: 3% impairment to the left upper extremity, October 14, 2015; "Claimant is able to return to work without restrictions and will not require future medical care", Anthony Timms, M.D.
12. I am amending my Form 50/51 in the following manner: None.

☐ **Mediation**

- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
☐ b. Mediation is required pursuant to Reg. 67-1802.
☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-4803.
☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

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

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

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Darren S. Haley, Esquire
address Post Office Box 26062, Greenville, South Carolina 29616 on the 9th day of May 20 16.
by ☒ first class postage ☐ certified mail ☐ personal service.

Signature: [Signature]
Date of Hearing: May 24, 2016

Email: rgoudelock@mgclaw.com
Time needed for hearing: 45 minutes

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

WCC FORM # 58
ed 7/13

58

PRE-HEARING BRIEF



AMENDED PRE-HEARING BRIEF
WCC File No:1421162

Claimant's Name: Karen Duncan Employer's Name: Eaton Corporation
Address: ADDRESS Address: 2210 Highway 72/221 East
City: Greenwood State: SC Zip: 29646 City: Greenwood State: SC Zip: 29649
Home Phone: (864) PHONE Work Phone: (864) 229-3006 Carrier: Old Republic Insurance Company
Preparer's Name: Darren S. Haley, Esq. Preparer's Phone #: (864) 235-6638

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$366.00 2. AWW: \$548.97 Date of Injury: September 26, 2014
3. Type of injury and body part(s): Left Shoulder/Torn Rotator Cuff
4. Facts in controversy: Is the Claimant entitled to permanent partial specific scheduled loss of use to her left shoulder? Is the Claimant entitled to additional medical treatment?
5. Legal issues involved: S.C. Code Ann. Sections 42-9-30; other applicable statutes, regulations and case law.
6. Unusual aspects: N/A
7. Witnesses (designate if expert):* Claimant; Dr. William DeVault (Expert); Jason Embler, PT, SCS (Expert)
8. Exhibits: Functional Capacity Evaluation (March 9, 2016); Impairment Rating from Dr. William DeVault (May 14, 2016); Transcript of Claimant's Deposition Testimony; Relevant Medical Records
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
Functional Capacity Evaluation (March 9, 2016); Impairment Rating from Dr. William DeVault (May 14, 2016); Transcript of Claimant's Deposition Testimony; Relevant Medical Records; See enclosed Notice of Witnesses and Written Medical Reports to be Introduced as Direct Evidence on Behalf of Claimant
10. Name, address, and specialty, if any, of the treating physician: Anthony Timms, M.D.,
Lakelands Orthopaedic & Sports Medicine Clinic, PA; 102 Gregor Mendel Circle, Greenwood, SC 9646
11. Impairment rating(s); body part(s); physician and date of opinion: On or about November 2, 2015, Dr. Anthony Timms assigned to Claimant a 3% impairment to the upper extremity. Upon information and belief, said impairment rating was the result of a partial functional capacity evaluation (PCE). Claimant still requires assistance to perform work activities. On May 14, 2016, Claimant was seen by Dr. William DeVault of The Orthopedic Center to obtain an impairment rating. Dr. DeVault assigned to Claimant a 53% left shoulder permanent and partial impairment.
12. I am amending my Form 50/51 in the following manner:

☐ Mediation

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

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

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to J. Russell Goudelock, II, Esq.

Address P.O. Box 12519, Columbia, SC 29211 on the 12th day of August 2016, by:

☒ first class postage ☒ certified mail ☐ personal service ☐ electronic service

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

Signature: [Signature]

Date of hearing: August 30, 2016

Email: darren@darrenhaley.com

Time needed for hearing: 1 Hour

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

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO.: 1421162

KAREN M. DUNCAN,
Employee,

Claimant,

vs.

EATON CORPORATION,
Employer,

AND

OLD REPUBLIC INSURANCE
COMPANY C/O SEDGWICK
CLAIMS MANAGEMENT
SERVICES, INC.
Carrier,

Defendants.

**AMENDED NOTICE OF WITNESSES AND
WRITTEN MEDICAL REPORTS TO BE
INTRODUCED AS DIRECT EVIDENCE ON
BEHALF OF CLAIMANT**

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND J.
RUSSELL GOUDELOCK, II, ESQ.:

YOU ARE NOTIFIED that the Claimant, pursuant to the provisions of the South
Carolina Workers' Compensation Act and Section 1-23-330 of the South Carolina Code of Laws,
submit the following medical records and other documents as evidence:

	DOCTOR/EXAMINER	PRACTICE	DATE(S)
1.	William DeVault, MD	The Orthopedic Center	5/14/2016
2.	Jason Embler, PT, SCS	Advanced Physical Therapy, LLC	3/9/2016
3.	Anthony R. Timms, MD	Lakelands Orthopaedic & Sports Medicine Clinic, PA	10/29/2014- 7/13/2015
4.	Anthony R. Timms, MD	Self Regional Healthcare	3/17/2015
5.	Dennis Murphy, MD	Tower Pointe Family Medicine	10/7/2014

YOU ARE FURTHER NOTIFIED that you have the right to cross-examine or otherwise oppose this evidence and, should you desire to exercise this right, you are to promptly schedule the deposition of any provider whose records who are submitted, for the purposes of cross examination, or otherwise promptly submit opposing medical records into evidence.

YOU ARE FURTHER NOTIFIED that these records, or photocopies of the same, will be provided to the South Carolina Workers' Compensation Commission for insertion in their file and for consideration as evidence on behalf of the Claimant.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Claimant: Karen Duncan, Jason Embler, Dr. William DeVault and/or other examiners of the Claimant.



Darren S. Haley (S.C. Bar No.: 14564)
Willie J. Peters (S.C. Bar No.: 100974)
The Haley Law Firm, LLC
1007 Pendleton Street
Greenville, SC 29601
(864) 235- 6638 (Ph) (864) 370-1201 (Fax)
darren@darrenhaley.com
Attorneys for Claimant

Greenville, South Carolina
August 12, 2016

South Carolina Workers' Compensation Commission
1533 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675



WCC File #: 1421162
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: Karen Duncan SSN: SSN # Employer's Name: Eaton Corporation
Address: ADDRESS Address: 2210 Highway 72/241 East
City: Greenwood State: SC Zip: 29646 City: Greenwood State: SC Zip: 29649
Home Phone: 864-PHONE Work Phone: 864-229-3000 Insurance Carrier: Old Republic Insurance Co.
Preparer's Name: Darren S. Haley Law Firm: The Haley Law Firm Preparer's Phone #: 864-235-6628

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☒ claimant ☐ employer (check one) Date of injury: September 26, 2014

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

Please see additional pages attached.

(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

I certify that I have served this document pursuant to R.67-211 by delivering a copy to J. Russell Gaudelock, II, Esq.
Name

P.O. Box 12519, Columbia, SC 29211
Address

on the 13th day of December 2016 by ☐ first class mail ☐ personal service ☒ certified mail.

Preparer's Signature: [Signature] Title: Attorney/Preparer Date: SCWCC/16
DEC 15 2016
JUDICIAL

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

If the claimant appeals and is representing himself or herself, the Judicial Department will prepare the additional copies of this form and serve this form on the opposing party. R.67-701B. Otherwise, file the original and four copies of this form with the Judicial Department. The appeal must be postmarked no later than 14 days from the date of service of the Hearing Commissioner's decision. R.67-701 and R.67-205. Attach the filing fee to this form. Attach a Form 32 if you are unable to pay the filing fee. Refer to R.67-701 through R.67-711 for additional information.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO.: 1421162

KAREN M. DUNCAN,	)	
Employee,	)	
	)	
Appellant,	)	
	)	
vs.	)	
	)	
EATON CORPORATION,	)	
Employer,	)	
	)	
AND	)	
	)	
OLD REPUBLIC INSURANCE	)	
COMPANY C/O SEDGWICK	)	
CLAIMS MANAGEMENT	)	
SERVICES, INC.	)	
Carrier,	)	
	)	
Respondents.	)	
	)	

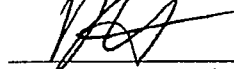
**ADDITIONAL PAGES FOR
FORM 30**

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds:

1. Did the Commissioner assign the correct permanent impairment rating for Appellant's left shoulder?
 - a. The Commissioner disregarded the information provided in the medical records and reports filed by the Appellant at the hearing on August 30, 2016, and incorrectly assigned a 10% permanent impairment rating to Appellant's left shoulder in the above-referenced case. The exhibits that Appellant submitted at the aforementioned hearing were: Exhibit 1 (Impairment Rating from William DeVault, MD); Exhibit 2 (Functional Capacity Exam

performed by Jason Embler, PT, SCS); Exhibit 3 (Medical Records from Lakelands Orthopaedic & Sports Medicine Clinic, PA); Exhibit 4 (Medical Records from Self Regional Healthcare); and Exhibit 5 (Medical Records from Tower Pointe Family Medicine).

Respectfully Submitted,



Darren S. Haley (S.C. Bar No.: 14564)
Willie J. Peters (S.C. Bar No.: 100974)
The Haley Law Firm, LLC
1007 Pendleton Street
Greenville, SC 29601
(864) 235-6638 (Ph) (864) 370-1201 (Fax)
darren@darrenhaley.com
Attorneys for Appellant

Greenville, South Carolina
December 13, 2016

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO.: 1421162

KAREN M. DUNCAN,	)
Employee,	)
	)
Appellant,	)
	)
vs.	)
	)
EATON CORPORATION,	)
Employer,	)
	)
AND	)
	)
OLD REPUBLIC INSURANCE	)
COMPANY C/O SEDGWICK	)
CLAIMS MANAGEMENT	)
SERVICES, INC.	)
Carrier,	)
	)
Respondents.	)

BRIEF OF APPELLANT

SCWCC

JAN 3 2017

JUDICIAL

Karen Duncan (hereinafter, "Appellant, " or "Ms. Duncan"), through counsel, respectfully submits to the South Carolina Worker's Compensation Commission the herein Brief of Appellant.

STATEMENT OF THE CASE

Appellant has been employed with Eaton Corporation since 2008. Ms. Duncan's current job title is a Final Inspector, and she has been employed in this position since 2012. Ms. Duncan's job requires frequent pulling on heavy doors and drawers. On or about September 26, 2014, Ms. Duncan, while working in her capacity as a final inspector, was attempting to open a door to a unit to do an inspection when she heard a "pop" in her left shoulder. As a result of her injury, she began experiencing severe, continuous pain in her left shoulder. Ms. Duncan reported her injury to her supervisor, Amanda Nix, on Monday, September 29, 2014. Eaton Corporation

referred Ms. Duncan to Dennis Murphy, M.D. (hereinafter, "Dr. Murphy") at Piedmont Health Group, LLC (hereinafter, "Piedmont Health").

Ms. Duncan began receiving treatment from Piedmont Health on or about September 30, 2014. After an extensive work-up, Dr. Murphy submitted the following assessment: (1) Tendonitis of shoulder; (2) Joint pain in the shoulder/clavicle region; and (3) Overuse syndrome. Subsequently, Ms. Duncan was referred to Lakelands Orthopaedic & Sports Medicine Clinic, PA (hereinafter, "Lakelands Orthopaedic") for physical therapy.

Ms. Duncan began undergoing physical therapy at Lakelands Orthopaedic on or about October 29, 2014. On or about December 11, 2014, Ms. Duncan was referred to Palmetto Imaging to obtain an MRI. Zachary Kilpatrick, M.D. was the attending physician. The conclusions of the MRI are as follows: "(1) Inflamed A-C joint; (2) Variation of a Rim-Rent tear propagating from the bursal side noted at the distal anterior insertion of the supraspinatus. A miniscule delaminating intrasubstance component is also present; (3) Superior labral fraying; and (4) Non-displaced split tear of the horizontal segment of biceps long head tendon." See Appellant's APA pp. 22-23.

Despite medication, rigorous physical therapy, and other treatment, Ms. Duncan was still experiencing severe pain in her left shoulder. Anthony R. Timms, MD (hereinafter, "Dr. Timms") recommended to Ms. Duncan that she undergo surgery on her left shoulder. After being advised of the alternatives, risks and benefits of surgery, Ms. Duncan informed Dr. Timms that she wished to proceed to surgery.

On March 17, 2015, Ms. Duncan underwent arthroscopic surgery on her left shoulder at Self Regional Healthcare. See Appellant's APA pp. 26-28. Dr. Timms was the attending surgeon. His pre-operative diagnoses were "left shoulder impingement; biceps tendon tear

proximally; labral tear; partial versus full-thickness cuff tear," and his post-operative diagnosis was "left shoulder impingement; biceps tendon tear proximally; labral tear; partial versus full-thickness cuff tear; acromioclavicular (AC) joint arthritic changes were significant." *Id.* After the operation, Ms. Duncan was out of work from approximately March 17, 2017 until approximately April 29, 2015.

On or about April 9, 2015, Ms. Duncan began physical therapy at Genesis Sports and Rehabilitation. When Ms. Duncan returned to work on or about April 30, 2015, she was still in great pain and was placed on light duty. While on light duty, Ms. Duncan's job responsibilities were limited to computer work and updating folders.

On or about November 2, 2015, Ms. Duncan had an appointment with Dr. Timms, wherein Dr. Timms assigned a 3% impairment to Ms. Duncan's upper extremity, and a 0% whole body impairment. Despite the fact that Ms. Duncan's condition had regressed to the point that the pain in her shoulder was worse than it was prior to her surgery, Dr. Timms released Ms. Duncan to full work duty on or about November 2, 2015. Although Ms. Duncan has been placed on full duty, she still requires assistance from her co-workers with various tasks that required lifting, pushing, pulling, crawling, and other physical actions. Ms. Duncan's supervisors are aware of this.

Believing Dr. Timms' impairment rating to be inaccurate, on or about March 9, 2016, Ms. Duncan underwent a functional capacity examination (hereinafter, "FCE") at Align Networks, where Ms. Duncan was treated by Jason Embler, PT, SCS (hereinafter, "Mr. Embler"). See Appellant's APA pp. 5-11. On or about May 14, 2016, Ms. Duncan had an appointment with William DeVault, M.D. (hereinafter, Dr. DeVault") for the purposes of obtaining an independent

medical examination and impairment rating. After an extensive work up, Dr. Devault assigned a 53% impairment rating to Appellant's left shoulder. See Appellant's APA pp. 1-4.

On August 30, 2016, a hearing for this matter was held in Laurens County, South Carolina before Commissioner Avery B. Wilkerson, Jr. (hereinafter, the "Commissioner "). On December 1, 2016, the Commissioner filed a Decision and Order, assigning a 10% permanent impairment rating to Appellant's left shoulder. On December 13, 2016, Appellant, through counsel, filed a timely appeal of the Commissioner's Decision and Order, alleging that the Commissioner disregarded the medical records and reports submitted by Appellant, and incorrectly assigned a 10% permanent impairment rating to Appellant's left shoulder.

QUESTIONS PRESENTED

1. Did the Commissioner err in assigning a 10% permanent impairment rating to the Appellant's left shoulder?

ARGUMENT

In light of the testimony and APA's submitted by Appellant at the hearing, the Commissioner erred by assigning a 10% impairment rating to the Appellant's left shoulder. Specifically, the reports provided by Mr. Embler, and Dr. DeVault show that a higher permanent impairment rating should have been assigned. Mr. Embler found that Ms. Duncan performed with "determined consistent effort and demonstrated appropriate pain behaviors." See Appellant's APA p. 5. Furthermore, Mr. Embler's report indicates that Ms. Duncan is able to perform light work with occasional lifting below waist height of 10 pounds, 0 pounds at shoulder height and 0 pounds overhead. She could push 15 pounds and pull 21 pounds. *Id.* Ms. Duncan could occasionally reach at waist height, with no overhead reaching. *Id.* The findings submitted in Mr. Embler's report are consistent with those by Dr. DeVault.

As mentioned above, Dr. DeVault found that, "based on the American Medical Association Guides to the Evaluation of Permanent Impairment, Fifth Edition, Ms. Duncan has 53% left shoulder permanent and partial impairment..." See Appellant's APA p. 4. Dr. DeVault also found that "in order to maintain her current level of function, Ms. Duncan will need four physician visits per year and sixteen physical therapy visits per year for treatment of acute exacerbations of her left shoulder conditions." Id.

Appellant is of the belief that Dr. Timms did not perform a complete functional capacity evaluation when he assigned the 3% permanent impairment rating to the upper extremity. Dr. Timm's examination of the Appellant was very brief, lasting approximately five minutes.

It is undisputed that, although Ms. Duncan has been released to full work duty, she requires assistance from co-workers to perform tasks involving heavy objects. Furthermore, Ms. Duncan is unable to lift her left arm above her head. Currently, Ms. Duncan still experiences a great amount of pain. In addition to the pain in her left shoulder area, Ms. Duncan also suffers from severe pain and weakness in the left side of her neck and left elbow, as well as numbness in her left ring finger and pinky. Ms. Duncan takes two Aleve capsules every day to help cope with the pain. On occasion, Ms. Duncan needs to take vacation days from work when the pain and swelling simply won't allow her body to perform her job duties. Ms. Duncan's supervisors are aware of this. Due to Ms. Duncan's injuries she has to overcompensate with the right side of her body to accomplish physical tasks. Furthermore, Ms. Duncan requires assistance for several day-to-day tasks, such as laundry, cleaning, and yard work.

The Commissioner did not provide a sufficient basis for his finding that Dr. DeVault's impairment rating was erroneous. Regarding Dr. DeVault's findings, the Commissioner stated in his Decision and Order as follows: "[i]t is based upon an erroneous combination of multiple

medical conditions and erroneous calculations. An appropriate calculation, based upon findings reflected in Dr. DeVault's medical report, would reflect an impairment rating of 13% to the left shoulder. I base this finding upon the Claimant's APA pp. 1-4 and Defendants' Exhibit No. 1." Claimant's APA pp. 1-4 is the report from Dr. DeVault, which includes his findings and impairment rating. Defendant's Exhibit No. 1 is excerpted portions of the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th Edition 2001). The Commissioner did not specifically state why Dr. DeVault's findings were erroneous. In the Commissioner's Decision, he provided that the correct calculation, according to Dr. DeVault's findings, would reflect a 13% impairment rating to Appellant's left shoulder. However, the Commissioner did not provide his methods for reaching said impairment rating. Furthermore, the Commissioner still awarded the Appellant a 10% impairment rating. Lastly, Appellant's previously submitted APA's, along with her undisputed testimony from the hearing simply do not support a finding of a 10% permanent impairment rating to Ms. Duncan's left shoulder.

CONCLUSION

For the aforementioned reasons, Appellant alleges that the Commissioner erred in assigning at 10% permanent impairment rating to the Appellant's left shoulder, and requests that a new permanent impairment rating be assigned which reflects the Appellant's impairment.

Respectfully submitted,



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Greenville, South Carolina
January 27, 2017

Attorneys for Appellant

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1421162

KAREN M. DUNCAN,

Employee,

Claimant/Appellant,

vs.

EATON CORPORATION,

Employer,

AND

OLD REPUBLIC INSURANCE CO.,

Carrier,

Defendants/Respondents.

RESPONDENTS' BRIEF TO THE FULL
COMMISSION

STATEMENT OF THE CASE

Claimant sustained an admitted injury to her left shoulder on September 26, 2014 when she felt something pull in her left shoulder while trying to open a jammed door. Defendants furnished medical benefits and temporary total disability benefits. Claimant was out of work for a six-week period of time from March 17, 2015 through April 29, 2015, and thereafter returned to restricted duty work until September 2, 2015. Claimant returned to work regular duty at that time and continues to work for the Employer.

Claimant was released at maximum medical improvement by Dr. Anthony Timms, her treating physician, on November 2, 2015 and assigned a 3% impairment rating to Claimant's left upper extremity. Further, Dr. Timms notes that the Claimant can return to work without restrictions and will not require future medical care.

Defendants filed a Form 21 Request for a Hearing seeking an award for permanent partial disability compensation benefits to the Claimant. A hearing was held on August 30, 2016 in Laurens,

South Carolina before Commissioner Avery B. Wilkerson, Jr. Commissioner Wilkerson issued a Decision and Order on December 1, 2006 finding that the Claimant sustained 10% permanent partial disability to her left shoulder.

The Claimant filed a Form 30 seeking review by the Full Commission and taking exception to Commissioner Wilkerson's permanent disability rating.

MEDICAL EVIDENCE

Claimant was initially treated by Dr. Dennis Murphy at Piedmont Health Group for a period of time before being referred to an orthopedist. (Def. APA pp. 35-42). Thereafter, Claimant was evaluated by Dr. Anthony Timms. On March 17, 2015, Dr. Timms performed arthroscopic surgery to include a subacromial decompression, biceps tenotomy, rotator cuff debridement, labral debridement and distal clavicle excision. (Def. APA pp. 30-32). The surgery did not require any open procedure or emplacement of any bolts, screws or anchors. (Tr. Of Testimony, p.35, ll. 2-7). Claimant underwent physical therapy. (Def. APA p. 44). Claimant noted at physical therapy on May 6, 2015 that she is rid of the pain from before the surgery, but she is still tender. (Def. APA p. 51). On August 17, 2015, Claimant notes that her shoulder is okay considering she worked today. (Def. APA p. 80). Claimant was discharged from physical therapy as of September 1, 2015 (Def. APA p. 86).

On October 14, 2015, Claimant returned to see Dr. Timms at which time he notes she is complaining of the left little finger numbness, some left shoulder soreness, and a lot of neck pain. His report reflects that the Claimant states her shoulder is probably the least of the problems she is having now. Dr. Timms indicates that the shoulder itself has pretty good range of motion. There is glenohumeral abduction to about 100 degrees with external rotation to about 30 degrees. Forward flexion and internal rotation look good. There is negative supraspinatus, negative impingement, negative O'Brien's sign, just some general tenderness, but again it is mostly referred back to the elbow and neck. Dr. Timms also states that he does not believe her neck symptoms are related to the injury to her left shoulder. As far as her left shoulder is concerned, Claimant was deemed to be at maximum medical

improvement. Dr. Timms released Claimant to full activities without restriction and assigned a 3% impairment of the left upper extremity due to slight restriction of abduction and external rotation. (Def. APA p. 27).

Claimant's attorney referred Claimant for a Functional Capacity Examination on dated March 9, 2016 which stated Claimant is able to perform light duty work. (Cl. APA p. 5-11). Claimant's attorney also referred Claimant for evaluation by Dr. William DeVault which took place on May 14, 2016. Dr. DeVault opined that the Claimant has reached maximum medical improvement for her left shoulder injury and assigned her with a 53% impairment rating to her left shoulder. (Cl. APA p. 1-4). Defendants submitted excerpted portions of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (5th Edition) which reflected that the appropriate calculations of Dr. DeVault's finding would support a permanent impairment rating of 13% to the shoulder. (Def. Ex. D-1). These calculations assumed that Dr. DeVault's findings were accurate, which Defendants submit is in contradiction to physical examination findings in other medical records from Claimant's treating physician, Dr. Timms. It is also noteworthy that, at the time of the FCE and Dr. DeVault's evaluation that were performed on referral by Claimant's attorney, Claimant was experiencing an unrelated left elbow condition that actually required surgery in June 2016. (Tr. of Testimony, p. 38, l. 8 – p. 40, l. 5).

During the intervening eight months between Dr. Timms' discharge of Claimant and Dr. DeVault's evaluation, Claimant did not seek or require any other form of treatment or evaluation for her left shoulder condition until the referral to Dr. DeVault by her attorney. (Tr. of Testimony, p. 37, ll. 1-25). Claimant is right-handed. (Tr. of Testimony, p. 40, ll. 6-7).

QUESTIONS PRESENTED FOR REVIEW

Is Commissioner Wilkerson's permanent disability award of 10% to Claimant's left shoulder supported by the credible medical evidence?

ARGUMENTS

Defendants contend that Commissioner Wilkerson's award to Claimant of 10% permanent partial disability to her left shoulder is supported by the substantial and credible evidence in the record. We respectfully request the Full Commission affirm the Order of the Single Commissioner.

1. **The authorized treating physician assigned Claimant a 3% impairment rating to the left upper extremity which the parties stipulate should convert to a 5% impairment rating to the left shoulder.**

Defendants provided Claimant with appropriate medical treatment by the treating physician, Dr. Anthony Timms. Dr. Timms specifically indicates in his last evaluation, dated October 14, 2015, that the shoulder has pretty good range of motion. Dr. Timms finds she is at maximum medical improvement, can return to work full duty, and has a 3% impairment rating to the left upper extremity due to slight restriction of abduction and external rotation. Commissioner Wilkerson gave proper weight to the facts that Dr. Timms is the authorized treating physician, that he evaluated Claimant's condition throughout his treatment and followed Claimant's progress on multiple occasions for almost one year. Commissioner Wilkerson was correct in his findings and giving greater weight to the medical opinion of Dr. Timms. The Administrative Procedures Act mandates that the Commissioner take the evidence, judge the credibility and weight of that evidence, and from that judgment determine the facts of the case. Rogers v. Kunja Knitting Mills, Inc., 312 S.C. 377, 381, 440 S.E.2d 401, 403 (Ct. App. 1994). Commissioner Wilkerson's Findings of Fact and Conclusions of Law are based on the evidence presented at the hearing and he provided compelling rationale for his decisions. His Findings of Fact and Conclusions of Law should be affirmed.

2. **Dr. William DeVault evaluated the Claimant on referral by Claimant's attorney. He saw Claimant on only one occasion and assigned the Claimant a permanent impairment rating of 53% to the left shoulder, which is not credible based upon the evidence in the record.**

Commissioner Wilkerson correctly found that Dr. DeVault's impairment rating does not appropriately follow the AMA Guides. The impairment rating is based upon an erroneous combination of

multiple stacked medical conditions and erroneous calculations. Dr. DeVault reflects various measurements for Claimant's range of motion for flexion, extension, abduction, adduction, internal rotation and external rotation. An appropriate calculation, based upon the assumption that the findings reflected in Dr. DeVault's medical report are correct and credible, would reflect an impairment rating of 13% to the left shoulder. (Def. Ex. D-1).

3. **Claimant contends that the impairment rating is not reflective of her restrictions and limitations based upon her testimony that she needs to get assistance at work to perform tasks, has inability to lift her left arm above her head, has severe pain and weakness in the left side of her neck and left elbow, as well as numbness in her left ring finger and pinky.**

Commissioner Wilkerson specifically found as fact that the Claimant did not sustain any other or additional injury, including but not limited to an injury to her neck, left arm, left hand or left fingers. At the time of the hearing, Claimant had been working at full duty since October 2015. (Tr. of Testimony, p. 42, ll. 2-9). At the time of the hearing, she had not required nor sought any treatment for her left shoulder condition for almost eleven months. (Tr. of Testimony, p. 41, ll. 10-14). Her only medication for her shoulder at the time of the hearing was over-the-counter Aleve. (Tr. of Testimony, p. 41, ll. 15-17).

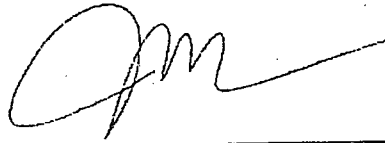
Commissioner Wilkerson accepted the entirety of the evidence submitted and issued a finding that the Claimant sustained a 10% permanent partial disability to the left shoulder based on the medical evidence as a whole. Commissioner Wilkerson also considered the Claimant's testimony, and after reviewing all of the evidence, fairly and properly determined the Claimant sustained a 10% permanent partial disability to her left shoulder.

CONCLUSION

Commissioner Wilkerson weighed the substantial evidence in the record to make his Findings of Fact, Conclusions of Law and Order. In a workers' compensation action, the existence of any conflicting opinions between the doctors is a matter left to the Workers' Compensation Commission. Harbin v. Owens-Corning Fiberglass, (S.C. 1985) 286 S.C. 67, 332 S.E.2d 211. Commissioner Wilkerson's determination that greater weight be assigned to the authorized treating physician who treated the

Claimant for almost one year, instead of to the physician who saw the Claimant for one appointment on referral by her attorney, was appropriate and reasonable in light of the substantial disparity in the impairment ratings and other evidence in the record as a whole. Commissioner Wilkerson's award of 10% permanent partial impairment to Claimant's shoulder should be affirmed.

Respectfully submitted,



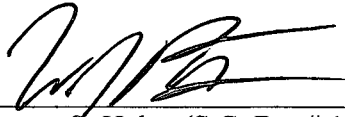
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Certificate of Counsel

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

January 22, 2018



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