

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM THE S.C. WORKERS'
COMPENSATION COMMISSION

RECEIVED

MAR 02 2018

Opinion No. 2017-UP-443 (S.C. Ct. App. filed Nov. 29, 2017) S.C. SUPREME COURT

Lettie Spencer, Respondent,

v.

NHC Parklane, Employer/Petitioner,

and

Premier Group Insurance Co., Inc. Carrier/Petitioner.

APPENDIX - PART II

Clarke W. McCants, III
Nance, McCants & Massey
PO Box 2881
Aiken, SC 29802
(803) 649-6200 Ext. 21
Attorney for Petitioners

Other Counsel of Record:

Andrew Wade Creech
Garrett Brendan Johnson
Elrod Pope Law Firm
Post Office Box 11091
Rock Hill, South Carolina 29731

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FEB 23 2018

S.C. SUPREME COURT



6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

Patient Name: LETTIE B SPENCER
Date of Birth:
Account: 179171-LS
Date: 10/25/2012

To Whom It May Concern:

LETTIE B SPENCER was treated in our office on 10/25/2012. She was discharged at 11:39:44 AM. Please excuse LETTIE for this appointment.

Work Restrictions / Additional Instructions

Sit Down Work Only

If unable to accommodate restrictions patient should be out of work until next scheduled appointment.

If you have further questions regarding the patient's work status you must talk with the patient and have them contact our office. Due to HIPAA regulations we are unable to verbally confirm the appointment, work note or the work status of the patient without their signed consent unless they are covered under workers compensation.

William Lehman MD

SCANNED

SPENCER, LETTIE

Page 1 / 1



6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

Procedure Order

Ordering Site

INDIAN LAND OFFICE

6237 Suite 313 Carolina Commons Drive

Indian Land, SC 29707

(803) 329-3130 X 216 Delores

Fax: (803) 329-2611 985-4380

Report Date: 10/29/2012

Patient Information

LETTIE B SPENCER

Gender: Female

Date of Bir.

SSN (last 4 digits):

Patient Insurance Information

PREMIER GROUP INS (866) 414-7442

Group #NONE

Plan #WC18202011021728



Path Chambers
866-440-6782

Procedures Ordered

REFERRAL / CONSULT (ADD COMMENTS)

Note: refer to Dr. Nandurkar for est 7 SNRB LEFT L-5 and pain management

Diagnosis: Radiculitis (729.2)

Ordered by: William Lehman, MD

End of Procedures Ordered

William Lehman MD

Electronically signed by William Lehman MD

LETTIE B SPENCER

Patient #: 179171-LS

DOB: 11/28/1947 (64 years)

Monday, October 29, 2012

Page 1 / 1

1 >> Rvel Corporation p 1/4

Page 000102

2012-10-30 15:47
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MEDICAL QUESTIONNAIRE

RE: LETTIE SPENCER

1. In your opinion "most probably and to a reasonable degree of medical certainty" has Ms. Spencer developed depression and psychological overlay-as a result of her ongoing chronic pain and inability which is the direct result from her work related back injury?

X
YES

NO

2. If the above answer is yes, do you recommend Ms. Spencer seek treatment for her depression and psychological overlay with a psychiatric professional?

X
YES

NO

William Lehman, M.D.

11/19/2012
Date

NOV 21 2012

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Page 000103

ROA 241

LETTIE B SPENCER

11/26/2012

Patient #: 179171-LS

DOB:

History of Present Illness

The patient is a year old female who is in today for TEST RESULTS. Note for "TEST RESULTS": ct lumbar myelogram

Subjective Transcription

She presents for further follow up regarding work related injury to her lower back which occurred on 6/12/11 while functioning as an LPN, National Health Care, just previously being treated by Randall Drye, M.D., Columbia Neurosurgical Associates, then Tony Owens, M.D., Pain Management at South Carolina Pain Associates, Columbia, SC. She has undergone left S1 joint injection as well as RF ablation on the left at L5-S1 and S2. She has been out of work since November 2011.

She has remained quite depressed and continues to lose weight to some extent, responding to some extent to Neurontin and Nucynta. A CT myelogram has been performed as of 9/11/11, which again, was a very poor study, showing some mild central stenosis L4-5 with 9 mm diameter centrally. She has responded a little bit to Neurontin, which was increased to 600 mg tid. She continues to require Nucynta. She still has mainly back pain but occasionally does have symptoms that extend into the left calf. I had recommended a left L5 selective nerve root block versus a spinal cord stimulator, but the referral has not been authorized as yet.

Previous Health History Form is reviewed and updated from 10/25/12.

Objective Transcription

Ms. Spencer is alert and conversant, oriented X 3. Vital signs are unchanged. She still has the appearance of someone who is very depressed and chronically ill. She apparently is only taking Trazodone which is mainly used for sleep. Her weight is 109 pounds. She does have radicular symptoms extending into the left calf. There is seemingly improved straight leg raise, but with continued decreased touch and pinprick sensation on the left lateral thigh and upper portion of the left calf as compared to the opposite side. Gait remains slow, deliberate, reciprocal heel to toe.

SPENCER, LETTIE

Page 1 / 2

Page 000104

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ROA 242



6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2511

LETTIE B SPENCER

02/12/2013

Patient #: 179171-LS

DOB:

History of Present Illness

The patient is a year old female who presents for a recheck of Back pain.

Subjective Transcription

She presents for follow up regarding selective nerve root block on the left at L5 which, amazingly, helped dramatically, though the radiofrequency facet joint ablation and left SI joint injection really offered very little response to her pain syndrome. She actually had no low back pain whatsoever for about three days. She still has difficulty driving. Her weight has stabilized to 106 pounds. She has been taking Neurontin 600 mg t.i.d. with minimal side effect. She still requires pain medication.

Previous Health History Form is reviewed and updated from 1/14/13.

Objective Transcription

Ms. Spencer is alert and conversant, oriented X 3. Vital signs are unchanged. She does appear to be much more positive. She does have a tentative appointment with a psychologist in Charlotte in the near future. She has some back pain and limited mobility and still has some radicular symptoms in the left leg without evidence of neurologic deficit.

Assessment & Plan

Radiculitis (729.2)

Current Plans:

- SELECT NERVE ROOT BLOCK L5 - LEFT (64483); Routine (#2 Dr. Nandurkar)
- Neurontin 800MG, 1 Tablet three times daily, #90, 02/12/2013, No Refill. Active.
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 02/12/2013, No Refill. Active.
- Restrictions are in place until follow up appointment
- Follow up in 1 month or as needed

Assessments Transcription

WORK INJURY 6/12/11 WITH BACK PAIN/LEFT LEG RADICULAR SYMPTOMS, SIGNIFICANT
THOUGH TEMPORARY RESPONSE TO LEFT L5 SELECTIVE NERVE ROOT BLOCK;
REACTIVE DEPRESSION WITH SEVERE WEIGHT LOSS, SOMEWHAT IMPROVED.

SPENCER, LETTIE

Page 1 / 2

Page 000106

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ROA 244

Assessment & Plan

Low back pain (724.2)

Current Plans:

- Neurontin 600MG, 1 Tablet three times daily, #60, 11/26/2012, No Refill. Active.
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 11/26/2012, No Refill. Active.
- Sit Down Work Only
- Follow up in 6 weeks or as needed

Chronic back pain (724.5)

Current Plans:

Stenosis of lumbosacral spine (724.02)

Current Plans:

Assessments Transcription

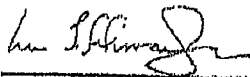
WORK INJURY 6/12/11 WITH ONGOING BACK AND LEFT LEG RADICULAR SYMPTOMS, MILD STENOSIS L4-5 CONSISTENT WITH SYMPTOMS, SEVERE DEPRESSIVE SYMPTOMATOLOGY.

Plan Transcription

She continues to require referral to Dr. Nandurkar requiring possible L5 selective nerve root block versus bone growth stimulator. I think she needs the decompression controlled before considering any more aggressive treatment. I continued Neurontin at 600 mg tid, and if she needs something more, such as Celexa, or otherwise. I refilled Nucynta 75 mg. I will see her back in three to four weeks for further follow up hoping that something will have happened at that point to treat her ongoing difficulties. It is obvious that she can pursue only sedentary work activity and this will likely per a work capacity for an extended period of time.
William L. Lehman, Jr., M.D. / as 801_2580

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)

Patty Chambers, RN, CCM, nurse case manager, Corvel Corporation - fax: 866-440-6782
Premier Group Insurance, Claim #WC18202011021728, P.O. Box 1122, Murfreesboro, TN 37133



Electronically signed by William L. Lehman MD

SPENCER, LETTIE

Page 2 / 2

Plan Transcription

I increased Neurontin to 800 mg t.i.d. and refilled Nucynta 75 mg. Another selective nerve root block left L5 seems to be appropriate. Due to her continued difficulty with driving to Columbia and back, I think that she needs to remain out of work for an additional period of time, though I feel that she does have a reasonably good prognosis for improvement. Whether this will be sufficient for her to return back to her previous work activity is unclear, and she may require Vocational Rehabilitation.

Addendum: The case manager, Ms. Patty Chambers, RN, CCM, was available after the examination to coordinate medical care as appropriate.
William L. Lehman, Jr., M.D. / as 801_4145

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)

Patty Chambers, RN, CCM, nurse case manager, CorVel Corporation - fax: 866-440-6782
Premier Group Insurance, Claim #WC18202011021728, P.O. Box 1122, Murfreesboro, TN 37133
(MAIL)



Electronically signed by William Lehman

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SPENCER, LETITE

Page 2 / 2



6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

LETTIE B SPENCER

04/02/2013

Patient #: 170171-LS

DOB:

History of Present Illness

The patient is a year old female who presents for a recheck of Back pain.

Subjective Transcription

She presents for follow up regarding her work injury of 6/12/2011 with back and left leg radicular symptoms, stating that the selective nerve root block at L5 has continued to be helpful. She had her second injection recently and basically has no further leg pain, though she still has considerable back pain. She tried increasing Neurontin, but it caused weakness, nausea and a tired feeling. She has seen a psychologist in Charlotte who has confirmed that she has a major depression. No medications were recommended specifically. She still weighs about 103 pounds and has not been able to gain. She has recently seen a family physician, Dr. Bradley, because of her progressive weakness and was found to have a low blood pressure. Her blood pressure medications were diminished. An echo was negative. The stress test has been ordered because of EKG changes, and this is going to be done in the near future by Dr. Delphila.

Health History Form is on the chart and reviewed with her, including medications and allergies.

Objective Transcription

Ms. Spencer is alert and conversant, but is obviously thin and does appear to be quite debilitated. She continues to have significant back pain with limited mobility. There are no left leg radicular symptoms currently with a negative straight leg raise and no definite neurologic deficit.

Assessment & Plan

Low back pain (724.2)

Current Plans:

- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 04/02/2013, No Refill. Active.
- Restrictions - Patient has been released w/ permanent restrictions: less than sedentary work.
- Follow up as needed

Assessments Transcription

WORK INJURY 6/12/11 WITH CHRONIC BACK PAIN, RESOLVED LEFT LEG RADICULAR SYMPTOMS STATUS POST SNRB L5 ON THE LEFT X 2, NO RESPONSE TO FACET ABLATION OR LEFT SI JOINT INJECTION; CHRONIC DEPRESSION WITH SEVERE WEIGHT LOSS.

SPENCER, LETTIE

Page 1 / 2

Plan Transcription

It appears that the back condition will persist over an extended period of time, though fortunately, she no longer has any leg symptoms or evidence of radiculopathy. It is obvious that Ms. Spencer is functioning at less than a sedentary level, not only to her back difficulties requiring independent recumbency, but also a chronic pain syndrome as well as major depression. She can wean herself off of Neurontin as her leg symptoms have gone away. She does require chronic pain management as well as psychiatric medications. Dr. Nandurkar would be a good resource for the chronic pain management, but she probably needs to see a psychiatrist to get her appropriate medications for her depression, though Dr. Bradley could perhaps pursue this quite adequately.

I gave her Nucynta at her request, but would prefer that the pain patch she is asking for be provided through pain management, along with the Nucynta chronically. She does have permanent restrictions in terms of function, which have been previously described and will be permanent in nature. I don't think an FCE is going to be helpful as resulting to aggravate her back pain and she is chronically functioning at a lessened sedentary level. She appears to have reached maximum medical improvement from an orthopaedic standpoint.

Referring to the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition, Ms. Spencer qualifies for a Class 1 level of impairment based on stenosis present at L4-5 with resolved radiculopathy. The default level of impairment would be 7% whole person. This is equivalent to a regional lumbar spine impairment of 9%.

William L. Lehman, Jr., M.D. / as 801_5122

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)

Patty Chambers, RN, CCM, nurse case manager, CorVel Corporation - fax: 866-440-6782

Premier Group Insurance, Claim #WC18202011021728, P.O. Box 1122, Murfreesboro, TN 37133 (MAIL)



Electronically signed by William L. Lehman

SPENCER, LETTIE

Page 2 / 2



6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2511

Patient Name: LETTIE B SPENCER
Date of Birth:
Account: 179171-LS
Date: 04/02/2013

To Whom It May Concern:

LETTIE B SPENCER was treated in our office on 04/02/2013. She was discharged at 03:22:24 PM. Please excuse LETTIE for this appointment.

Work Restrictions / Additional Instructions

Restrictions - Patient has been released w/ permanent restrictions; less than sedentary work.

If unable to accommodate restrictions patient should be out of work until next scheduled appointment.

If you have further questions regarding the patient's work status you must talk with the patient and have them contact our office. Due to HIPAA regulations we are unable to verbally confirm the appointment, work note or the work status of the patient without their signed consent unless they are covered under workers compensation.

William Lehman

SPENCER, LETTIE

Page 1 / 1

8.

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ORIGINAL RECORD ON
APPEAL

Page 000111

ROA 249

Springs Memorial Hospital
Lancaster, SC 29720
RADIOLOGY REPORT

NAME SPENCER, LETTIE F		SEX F	ACCOUNT NUMBER D006334539
ORDERING PHYSICIAN Lehman, William L. MD		PT. STATUS REG SDC	LOCATION OPB
ATTENDING PHYSICIAN Lehman, William L. MD		DATE OF EXAM 09/11/2012	MEDICAL RECORD NO. M000594470
		RADIOLOGY NO.	

EXAM# TYPE/EXAM RESULT
000748584 CT/LUMBAR SPINE WITHOUT CONTRAS

CLINICAL HISTORY: Back pain.

EXAMINATION: CT of the lumbar spine, post myelogram.

REPORT:

In this patient in which access to the CSF space was obtained fluoroscopically at the L4-L5 level, the injection in part was extradural in that there is some contrast about the paraspinal soft tissues at the L4-L5, L3-L4 and L2-L3 levels. The injection also had to breach the venous system at some time given the fact that there is some minimal contrast seen within the intrarenal collecting systems.

The field-of-view visualized from the upper endplate of T11 through the lower sacrum. Preserved vertebral body heights and alignment.

Distal cord and conus are of normal size and signal, conus ends L1.

The T11-T12 level is unremarkable.

The T12-L1 level is unremarkable.

The L1-L2 level is unremarkable.

The L2-L3 level is unremarkable.

The L3-L4 level is unremarkable.

The L4-L5 level demonstrates mild central canal stenosis related to annular disc bulging and facet arthropathy, the thecal sac triangularly shaped with the AP diameter of the spinal canal in the region of maximum pathology at about 9 mm.

The L5-S1 level is unremarkable

OCT 18 2012

IMPRESSION:

Mild acquired central canal stenosis at the L4-L5 level as described.

PAGE 1

Signed Report

(CONTINUED)

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10/11/2012 03:29 pm

LETTIE F SPENCER 10/28/1947

Page 000112

SCANNED

1/2

Springs Memorial Hospital

Lancaster, SC 29720
RADIOLOGY REPORT

NAME SPENCER, LETTIE F		SEX F	ACCOUNT NUMBER D006334539
ORDERING PHYSICIAN Lehman, William L. MD	PT. STATUS REG SDC	LOCATION OPS	MEDICAL RECORD NO. M000594470
ATTENDING PHYSICIAN Lehman, William L. MD	DATE OF BIRTH	AGE	DATE OF EXAM 09/11/2012
			RADIOLOGY NO.

EXAM#	TYPE/EXAM	RESULT
000748584	CT/LUMBAR SPINE WITHOUT CONTRAS	
<Continued>		

Remaining lumbar disc space levels without significant findings.

** REPORT SIGNED IN OTHER VENDOR SYSTEM 09/11/2012 **
Reported By: TOMMY L. WEAVER, MD

CC: William L. Lehman MD

Technologist: JULIE H. COX, RT(R)
Transcribed Date/Time: 09/11/2012 (1257)
Transcriptionist: RAD.HAYVI
Printed Date/Time: 09/11/2012 (1320) Batch No: 1663

PAGE 2 Signed Report

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10/11/2012 03:29 pm

LETTIE F SPENCER 09/11/28/1947
Page 000113

SCANNED

2/2

Springs Memorial Hospital
800 West Meeting Street, Lancaster, SC 29720
803-288-1478

Patient: SPENCER, LETTIE F DOB:

Patient #: D008388302 MRN: M000594470 Date In: 06/04/2013
Discharge Instructions

You have been diagnosed and treated by a specialist in Emergency Medical Care. These discharge instructions have been prepared for you in order that you better understand your condition, and how this condition may affect you now that you have been discharged from our emergency room. Please read these instructions carefully, and do not hesitate to call us if you have any questions.

Your emergency care provider today was: ANSARI, AMIR

Referred to:

SHEALY, K. D. MD, INTERNAL MED
Phone: (803) 285-7414
1025 W. MEETING ST LANCASTER, SC 29720
LANCASTER SC 29720

Follow up in 2 days

The exam and treatment you received today has been provided on an emergency basis only. This is not a substitute for complete medical care. You, not Springs Memorial Hospital, are responsible for arranging and obtaining follow-up care with a doctor or other healthcare provider, which includes making arrangements for payment. If your problem worsens or new symptoms appear and you are unable to arrange prompt follow-up care, call or return to this emergency room.

If you had EKG's or X-rays done in the Emergency Department, they will be reviewed by a specialist. If their interpretation is different from the Emergency care provider, you or your physician will be notified.

If you had cultures done, results are usually available within 48-72 hours. If the results indicate a need for re-evaluation or change in treatment, you will be notified.

General education is provided to all patients at discharge. It is important for everyone to understand that a stroke is an EMERGENCY. Every minute counts. ACT FAST. When you get home you may refer to the the copy of the Patient Discharge Instructions that were provided to you. Signs and Symptoms of a Stroke include sudden numbness or weakness, sudden trouble seeing, sudden confusion, sudden loss of balance or coordination or sudden severe headache. Risk factors include high blood pressure,

5

Springs Memorial Hospital
800 West Meeting Street, Lancaster, SC 29720
803-286-1479

Patient: SPENCER, LETTIE F DOB:

Patient #: D006388302 MRN: M000584470 Date In: 06/04/2013
Discharge Instructions

overweight, poor diet, physical inactivity, smoking, diabetes, excessive alcohol intake, heart disease and heredity. Call 911 immediately for sudden numbness or if weakness of a extremity is noticed. Check the time so you will know when the first symptoms appeared. Medication compliance is very important. If you are prescribed a blood thinner (such as Coumadin), take it exactly as perscribed by your doctor. Do not skip or double up the dosage without talking to your doctor. When discharged on Coumadin, it is important to follow-up with your doctor within 2 weeks for lab monitoring.

Discharge Instructions (Pro-MED Clinical Systems, L.L.C.)

Printed on: 06/04/2013 19:05

Page 000115



ROA 253

ANXIETY

ANXIETY

WHAT IS ANXIETY?

Anxiety is a vague uncomfortable feeling of fear or dread.

This can cause many different physical symptoms. These include;

- Irritability - Sleeplessness (insomnia)
- Dizziness - Headache
- Chest discomfort - Trouble breathing
- Passing out - Pounding heart beat
- Stomach pain - Nausea, vomiting or diarrhea

WHAT SHOULD I KNOW AND DO FOR ANXIETY REACTION?

- Try to identify what causes you anxiety. Common causes are:
 - Daily activities--appointments, traffic, deadlines.
 - Life changes--changes in job or children.
 - Overload--a feeling of too many responsibilities or demands on your time.
 - Helplessness--problems seem to be beyond your control.
- If possible, try to eliminate the cause of your stress.
- Reduce your stress level by:
 - Getting regular exercise. Just a 15-30 minute walk each day may help.
 - Eat a balanced diet and eat regularly. Don't be rushed when eating.
 - Get enough sleep. Rest during the day when possible.
A 15-30 minute rest will make a difference.
 - Use relaxation techniques such as breathing exercises.
- Find something you enjoy and set aside 30 minutes each day for that activity.
- Try to identify how you react to stress.
- Books or tapes on anxiety and anxiety relief may be helpful.
- Consider counseling to help you understand the reasons for your anxiety.

WHEN AND WHY SHOULD I FOLLOW UP WITH THE DOCTOR?

- If your symptoms are getting worse instead of better.
- If you develop chest pain or have trouble breathing.
- If you have a severe headache not relieved by rest and/or over the counter pain medicine.
- If you have repeated fainting spells.
- If you have continued vomiting. 9905>

Springs Memorial Hospital
800 West Meeting Street, Lancaster, SC 29720
803-288-1479

Patient: SPENCER, LETTIE F DOB:

Patient #: D006388302 MRN: M000594470 Date In: 08/04/2013
Discharge Instructions

DEPRESSION

DEPRESSION

WHAT IS DEPRESSION?

Depression is a feeling of continued sadness, hopelessness or loss of interest in personal matters. There are many causes for depression: loss of a loved one, loss of a job, major illness/injury, hormonal changes (after the birth of a baby). Depression can occur at any age from childhood to the late adulthood. Frequently, once the cause for depression is identified and dealt with, symptoms improve. Professional counseling can assist in dealing with depression and learning how to cope with the causes.

WHAT SHOULD I KNOW AND DO FOR DEPRESSION

- Seek assistance (physician, therapist, support groups, family, church).
- Use medications only as prescribed by your doctor.
- Maintain normal daily activities even if you don't feel up to it.

WHEN AND WHY SHOULD I FOLLOW UP WITH A DOCTOR?

- If you feel overwhelmed or consider ending your life, call for help immediately.
- If you feel the symptoms of depression returning.

Your condition may benefit from home health services.

Please ask for home health assistance or information.

0103>

5

SYNCOPE (FAINTING)

SYNCOPE (FAINTING)

WHAT IS SYNCOPE (FAINTING)?

It is a loss of consciousness that occurs when the blood pressure is too low to provide enough blood flow to the brain. Some of the causes are strokes, heart problems, heat exhaustion, dehydration, severe pain, internal bleeding and emotional upsets.

WHAT SHOULD I DO FOR SYNCOPE?

- Know the warning signs of fainting:
 - dizziness
 - vision disturbance
 - nausea
 - turning pale
- If you have the warning signs, lie down right away and do not get up until the symptoms pass.
- The symptoms usually go away quickly once you lie down.
- You may feel tired for several hours after a fainting spell.

WHEN AND WHY SHOULD I FOLLOW UP WITH THE DOCTOR?

- If you have another fainting spell.
- If you have an irregular or very fast heartbeat at the time of the fainting spell.
- If you have a fainting spell when you are already sitting or lying down.

SEEK IMMEDIATE MEDICAL ATTENTION IF:

- If you develop a severe headache, chest pain, abdominal or back pain with a fainting spell.

Your condition may benefit from home health services.

Please ask for home health assistance or information.

0103>



Height: 5ft. 2in.	Weight: 48.36 kg	Source:	Medical Records
Allergies: penicillin-	☐ Pregnant ☐ Breastfeeding		

Note: If the ellipsis (...) is seen at the end of the list, please refer to the patient record for additional items

ADMISSION Source ☐ Patient ☐ Nursing Home ☐ Previous Admission ☐ H&P ☐ Copied from Patient's Labeled Meds ☐ Patient's Pharmacy: ☐ Other: _____ (name) ☐ Patient Provided & Verified Medication List Personal Meds: ☐ Sent to Pharmacy ☐ Sent home with _____ (name)		DISCHARGE If Personal Meds Stored in Pharmacy, Obtained and Sent Home With ☐ Patient or ☐ Other: _____ (name)
--	--	---

Medication Name Dosage / Frequency / Route	Indication For Use	Date/Time Last Taken U=Unknown T=Today Or Record Date	Continue In Hospital	Continue At Discharge	Next Dose Due At:
Patient Is Knowledgeable About Home Meds: ☐ Yes ☐ No					
Aldactone 25 milligram(s) once a day oral			☐ Yes ☐ No (time) First Dose: @	☒ Yes ☐ No	
Klonopin 0.5 milligram(s) HS oral			☐ Yes ☐ No (time) First Dose: @	☒ Yes ☐ No	
Norvasc 6 milligram(s) once a day oral			☐ Yes ☐ No (time) First Dose: @	☒ Yes ☐ No	
Nucynta 75 milligram(s) every 6 hours oral			☐ Yes ☐ No (time) First Dose: @	☒ Yes ☐ No	
Potassium Chloride 20 milliequivalent(once a day oral			☐ Yes ☐ No (time) First Dose: @	☒ Yes ☐ No	
Tapazole 5 milligram(s) HS oral			☐ Yes ☐ No (time) First Dose: @	☒ Yes ☐ No	
trazODONE 50 milligram(s) once a day (at bedoral			☐ Yes ☐ No (time) First Dose: @	☒ Yes ☐ No	
			☐ Yes ☐ No (time) First Dose: @	☐ Yes ☐ No	
			☐ Yes ☐ No (time) First Dose: @	☐ Yes ☐ No	
			☐ Yes ☐ No (time) First Dose: @	☐ Yes ☐ No	

Discontinue Medications Not Taken _____ _____ _____	
--	--

Hospital Pharmacy Order: Compare Pre-Admission Medications with Formulary Medications. Formulary medications that are identical in form and content may be dispensed for the pre-admission medications continued in the hospital, EXCEPT, do NOT dispense substitutions for the following medications:

Vaccination Decision (Risk Assessment completed on admission)			
☐ Pneumococcal vaccine	☐ Indicated	☐ Not Indicated	☐ Administer vaccine per protocol
☐ Influenza vaccine	☐ Indicated	☐ Not Indicated	☐ Administer vaccine per protocol

ADMISSION RECONCILIATION Date/Time ☐ READ BACK of a: ☐ Telephone ☐ Verbal Order		DISCHARGE RECONCILIATION Date/Time ☐ READ BACK of a: ☐ Telephone ☐ Verbal Order	
Physician Name/Nurse Signature & Title		Physician Name/Nurse Signature & Title	
Date/Time/Ordering Physician Signature:		Date/Time/Ordering Physician Signature:	
Transcribed: Date/Time/Signature/Title:		Transcribed: Date/Time/Signature/Title:	
Noted: Date/Time/Admission Nurse/Title/Initials:		Noted: Date/Time/Admission Nurse/Title/Initials:	

Medication Reconciliation
Springs Memorial Hospital

NAME: SPENCER, LETTIE F DOB: AGE:
 MR#: M000694470 PT#: D006388302 DATE IN: 6/4/2013
 EDP: ANSARI, AMIR PCP: SHEALY, K. D. MD
 Referral Physician SHEALY, K. D. MD

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ORIGINAL RECORD ON
APPEAL

WC FAST TRACK PROCEDURE VISIT

Place of Service: Lancaster Office.

Date of Service: 01/28/2013

Referring Physician: William Lohman, MD

Ref: Ms. Lettie Spencer; Chart #: SPELE000; DOB:

SUBJECTIVE:

Ms. Lettie Spencer is a 47 year old female who presents to The Piedmont Interventional Spine & Pain Center for fast track lumbar epidural injection for her work related chronic low back and left leg pain symptoms. Her pain is located in the lower back. The pain started about 2 year(s) ago after work related injury in 6/2011, and since it began the pain intensity has worsened over the last 5 month(s). Today her pain is constant with variable intensity and described as 7 out of 10 and sharp. The pain is radiating to left back of the calf. Her pain is associated with tingling in her left leg and on top of foot left. Her pain is worse while sitting and standing for a prolonged period of time. Her pain is better with rest. She denies any saddle numbness, severe weakness, fever, or extreme pain.

She states that the pain started as a result of work related injury at NHC on 06/12/2011 as a LPN. She states she was pushing a medicine cart that caught on the carpet and between slick tile where she fell. She has been out of work since November 2011. She was seen at in Columbia by neurosurgeon and pain doctor. She was treated by Dr. Owens at South Carolina Pain Associates, Columbia, SC in 2011 where she had SI joint left injections and RFA injection procedure which she states did not help. The patient states she has had extensive PT in the past which did not help the patient. She also tried the back brace and TENS unit which did not help it actually made her pain worse. The Patient indicates her pain is worse in the evening and Her pain does awaken her from sleep. She usually gets 6 hr(s) of uninterrupted sleep a night. Lately her pain is getting worse and not able to do the things that she used to do before and she is getting depression. She also lost the appetite and lost some weight. She says WC is working on that she can get mental health help. Recently she was seen by Dr. Lehman for her pain symptoms. He ordered CT myelogram and recommended left L5 SNRB. Her case manager is here with her.

The Patient denies any allergy to latex, local anesthetics, or kenalog. She denies any bleeding disorder and is not taking any blood thinning medications.

Occupational History: She is working as LPN at National Health Care. She has been out of work since November 2011. Dr. Lehman has her under work restrictions: Sit down work only and no driving.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.

Medication History:Active:

Aldactone (active)
Klonopin (active)
Neurontin (active)
Norvasc (active)
Nucynta 75 mg Tab (active)
potassium acetate (active)
Tapazole (active)
Trazodone (active)

Past Medical History: Cardiovascular Hx: (+) hypertension. Endocrine Hx: (+) hyperthyroidism.

Spencer, Lettie 01/28/13 - SPELEB00

Sanjay Nandurkar MD

Past Surgical History: She admits past surgical history of neck surgery, hysterectomy.
Family History: She admits a family history of hypertension associated with mother (deceased), heart disease associated with father (deceased).
Social History: She denies tobacco use, alcohol use, illegal drug use.
LMP: She is s/p hysterectomy.
Review of Systems: Denies any fever, vertigo, dizziness, ear symptoms, chest pain, bilateral leg edema, shortness of breath, abdominal pain, hematuria, face swelling, blood in stool, seizures, bleeding problems, heat/cold intolerance, or suicidal ideation. Admits back pain.

PHYSICAL EXAMINATION:

Vitals: BP Sitting: 115/68 HR: 72 5 ft. 2.000 in. Weight: 105 lbs. BMI: 19
Gen Appearance: Alert, oriented, appropriate, well appearing, not in distress. Psych: Judgement & insight intact. Looks depressed. **Skin:** No rashes/erythema noted. **HEENT:** Conjunctiva is pink, sclera is non icteric. **Lungs:** Breathing non-labored. **Heart:** No clubbing, cyanosis, or edema. **Abdomen:** Abdomen non-distended. **Extremities:** No deformities, edema. Appears warm and well perfused.
Musculoskeletal: Large joint ROM within functional limits w/o deformity. Thoracic Spine: No midline tenderness or deformity.

Lower back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are positive. She is able to stand tiptoe & on heel. Waddell signs are positive 0/5.

Neurological: Neurological examination of the both lower extremities are normal with symmetrical sensation over all lumbosacral dermatomes, normal motor strength 5/5 in all muscle groups and symmetrical reflexes. She exhibits a negative SLR, negative Babinski's sign and there is no ankle clonus. Gait is age appropriate with good tone and no evidence of pathological muscle atrophy. EXCEPT there is some numbness over leg and foot along left L5 distribution.

Trigger Points: Palpation reveals no trigger point(s).

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

PRE PROCEDURE ASSESSMENT:

1. 724.4 = Radicular Syndrome, Lower Limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.

Ms. Lettie Spencer is a year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain and extensive PT including brace and TENS unit but not much help. Intely her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram and he recommended Left L5 SNRB. Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight.

INFORMED CONSENT: I have discussed the benefits, alternatives Rx's and possible risks but not limited to sepsis, hemorrhage, pain, and failure to achieve the stated goals of the procedure were all discussed, on 01/28/2013 at 10:36 AM. The Lettie Spencer expressed understanding and is agreeable to

Spencer, Lottie 01/28/13 - SPELE000

Saujay Nandurkar MD

proceeding as planned. She denies any fever, chills, weakness or bleeding diathesis and use of blood thinners. Lottie denies allergy to IVP dye, heparin, latex, local anesthetics and steroids. An appropriate consent form was signed, indicating, Lottie Spencer understands the procedure and its possible complications, risks, and alternatives.

PROCEDURE:

Name of the patient: Lottie Spencer
Procedure: Lumbar Transforaminal Steroid Injection.
IV Started: NO.
Sedation: NO.

Lottie Spencer was transferred to the block room and placed in a prone position on table with a pillow at appropriate position. After placement of EKG and pulse ox monitors, appropriate area was prepped and draped in sterile fashion and procedure was performed in the usual manner.

Level: Left L5-S1.
Fluoroscopy Guidance Used: YES for guidance and localization of spinal needle.

Technique:

A oblique paraspinous approach was used with C Arm fluoroscopy guidance. The injection site was infiltrated with 10 cc of 1% lidocaine mixed with sodium bicarbonate using a 1.5 inch, 25 gauge needle. A # 25 gauge spinal 3.5 inch needle was introduced under fluoroscopy guidance. The entry into the epidural space was confirmed with epidurogram after injecting 2 cc of water-soluble, nonionic contrast. A total solution containing 3 cc of PF 1% Lidocaine and Kenalog 60 mg was injected. The intravascular/intrathecal flow was not observed on injection.

Lottie tolerated the procedure well. Needle site was dressed with bacitracin ointment and sterile Band-Aid. She was taken to the post-block recovery area for further observation.

I was present during the entire procedure.

POST PROCEDURE ASSESSMENT:

Post procedure Diagnosis: Same as above.

Post procedure pain level: 0 on a scale of 0-10. She denies any pain immediately following injection.

Purposeful response to verbal or tactile stimulation: YES

PLAN:

I have discussed the findings and pathophysiology of above diagnosis including prognosis and various treatment options including pain interventional procedures, medications, physical therapy, Psychotherapy, Spinal Cord stimulator and activity modification. She understands and agrees for the plan as below. Dr Lehman has also discussed these with her. Seems she is not a surgical candidate at present.

- Ms. Lottie Spencer has a scheduled follow up appointment with Dr. Lehman.
- Patient assessed for efficacy of current medication regimen. Continue current medication(s) and no refill prescription given today. Continue klonopin, neurontin and nycynta.
- Advised to remain active within limit of pain.
- She was advised regarding importance of proper spine posturing, daily ROM/Ex, better sleeping habits,

Spencer, Lettie 01/28/13 - SPELE000

Sanjay Nandurkar MD

- stress control and relaxation techniques.
- She will benefit from psychological eval for her reactive depression.
 - If she continues to have significant pain and if she is not a surgical candidate she will be candidate for dorsal column stimulator trial for her chronic back and leg pain.
 - Above plan discussed with her case manager.

FOLLOW UP: She has a follow up appointment with Dr. Lehman.

Lettie was discharged home in stable condition with driver. Post procedure instructions reviewed with patient.

PCP: Robert Bradley, MD

Sanjay Nandurkar, MD

Updated on 01/28/2013 By: _____
Sanjay Nandurkar, MD

Updated on 01/28/2013 By: _____
Sanjay Nandurkar, MD

PROCEDURE NOTE

Place of Service: Lancaster Office.
Date of Service: 03/14/2013
Referring Physician: William Lehman, MD

Ref: Ms. Lettie Spencer; Chart #: SPELE000; DOB: .

SUBJECTIVE:

Lettie Spencer is a year old female who presents to Piedmont Interventional Spine & Pain Center for a transforaminal epidural steroid injection. This is her 2nd injection of this series. Previous TF ESI helped her and pain relief is more than 80 % for 5 weeks. She states she is NPO and has a driver for return home.

Pain is located in left lower back. The pain is radiating to left leg to the calf. The pain is associated with tingling in the left leg and top of the left foot. The pain is throbbing and described as intermittent. The pain intensity ranges from 5 to 10 on scale of 0-10 and current pain intensity is 7. She denies any saddle numbness, severe weakness, or fever. The Patient denies any allergy to latex, dye, local anesthetics, or steroids. She denies any bleeding disorder and is not taking any blood thinning medications. The patient is still currently not working as this pain is a work related accident.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.

Medication History: No change in meds from 01/31/2013

Past Medical History: Cardiovascular Hx: (+) hypertension. Endocrine Hx: (+) hyperthyroidism.

LMP: She is s/p hysterectomy.

Review of Systems: No change in review of systems.

I have reviewed the chart notes and I am aware of the family/social history. Since the last evaluation her medical history has not changed.

PHYSICAL EXAMINATION:

Vitals: BP Sitting: 167/79 HR: 67

Constitutional: Alert, oriented, cooperative and appropriate. CVS: No clubbing, cyanosis or edema. RS: Breathing non labored..

Back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are positive. She is able to stand tiptoe & on heel. Waddell signs are positive 0/5.

Neurological: Neurological examination of the both lower extremities are normal with symmetrical sensation over all lumbosacral dermatomes, normal motor strength 5/5 in all muscle groups and symmetrical reflexes. She exhibits a negative SLR, negative Babinski's sign and there is no ankle clonus. Gait is age appropriate with good tone and no evidence of pathological muscle atrophy. EXCEPT there is some numbness over leg and foot along left L5 distribution.

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

INFORMED CONSENT: I have discussed the risks, benefits, alternatives of the procedure with the patient on 03/14/2013 at 11:42 AM. There are no contraindications to the procedure. Lettie Spencer expressed understanding and is agreeable to procedure and gave a written consent. She denies any fever.

Page: 1

Page 000125

5

Spencer, Lettie 03/14/13 - SPBLE000

Sanjay Nandurkar MD

chills, weakness, bleeding disorder, or use of blood thinners. She also denies allergy to IVP dye, latex, local anesthetics, and local steroids.

PROCEDURE:

Name of the patient: Lettie Spencer

Procedure: Lumbar Transforaminal Steroid Injection.

IV Started: NO.

Sedation: NO.

Lettie Spencer was transferred to the block room and placed in prone position on the table with a pillow at the appropriate position. After placement of EKG and pulse ox monitors, the appropriate area was prepped and draped in sterile fashion and the procedure was performed in the usual manner.

Level: Left L5-S1.

Fluoroscopy Guidance Used: YES for guidance and localization of spinal needle.

Technique:

A oblique paraspinous approach was used with C arm fluoroscopy guidance. The injection site was infiltrated with 5 cc of 1% lidocaine mixed with sodium bicarbonate with a 1.5 inch 25 gauge needle. A # 25 gauge spinal 3.5 inch needle was introduced under fluoroscopy guidance. The entry into the epidural space was confirmed with epidurogram after injecting 2 cc of water-soluble, nonionic contrast. A total solution containing 3 cc of PR 1% Lidocaine and Kenalog 60 mg was injected. The intravascular/intrathecal flow was not observed on injection.

Lettie tolerated the procedure well. Needle site was dressed with bacitracin ointment and sterile Band-Aid. She was taken to the post-block recovery area for further observation.

I was present during the entire procedure.

ASSESSMENT:**Pre Procedure Diagnosis:**

1. 724.4 = Radicular Syndrome, Lower limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.

Post Procedure Diagnosis: Same

Pre Procedure Pain Level: As Above

Post Procedure Pain Level: 1 on a scale of 0-10.

Purposeful response to verbal or tactile stimulation: YES

Ms. Lettie Spencer is a year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight.

She is s/p SNRB with good pain relief for 4-5 weeks.

Page: 2

Page 000126

5

Spencer, Lettie 03/14/13 - SPELE000

Sanjay Nandurkar MD

PLAN:

- Ms. Lettie Spencer will follow up with Dr. Lehman.
- If she continues to have pain and if she is not a surgical candidate one can consider SCS trial for her continued radicular pain.
- Patient assessed for efficacy of current medication regimen. Continue current medication(s) and no refill prescription given today
- Advised to remain active within limit of pain.

FOLLOW UP: She should follow up with Dr. Lehman.

Lettie was discharged home in stable condition with driver. Post procedure instructions reviewed with patient.

PCP: Robert Bradley, MD

Sanjay Nandurkar, MD

FOLLOW UP VISIT

Place of Service: Lancaster Office.

Date of Service: 05/13/2013

Ref: Ms. Lettie Spencer; Chart #: SPELE000; DOB:

SUBJECTIVE:

Ms. Lettie Spencer is a year old female who presents to Piedmont Interventional Spine & Pain Center for follow-up evaluation after procedure for her back pain symptoms. Her WC MCM is here with her today, Patty Chambers. She has seen Dr. Lehman since she was here last and he has released her. Today her pain is located in the lower back. She is s/p TFESI. The procedure helped her pain and/or function and is still helping. Her leg pain is still much better about 30%. Still continues to have lower back pain. Dr Lehman said he can not do anything more and recommended pain management. The pain is radiating to back of leg to below the knee. Numbness is little better. The pain is constant with variable intensity, dull and current intensity is 7 on a scale of 0-10. She denies any severe weakness, fever, or extreme pain. Since the last visit, Lettie states her pain symptoms are better with pain medications. Dr. Lehman was writing her Nucynta 75mg #40. She says she takes about 2-3 a day. She has been out about 1 week now. She is not prescribed medications through the PISPC. Current plan of management is helping her to control pain and improve daily function. She does not have medication bottles for review today.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.

Medication History:

Active:

Aldactone (active)
Klonopin (active)
Norvasc (active)
Nucynta 75 mg Tab (active)
potassium acetate (active)
Tapazole (active)
Trazodone (active)

Past Medical History: Cardiovascular Hx: (+) hypertension. Endocrine Hx: (+) hyperthyroidism.

Opioid Contract: NO.

I have reviewed the chart notes, and I am aware of the family/social history. Since the last evaluation her medical history has not changed.

Review of Systems: Denies any fever, vertigo, dizziness, ear symptoms, chest pain, bilateral leg edema, shortness of breath, abdominal pain, hematuria, face swelling, blood in stool, seizures, bleeding problems, heat/cold intolerance, or suicidal ideation. Admits back pain.

PHYSICAL EXAMINATION:

Vitals: Afebrile and Stable Vital signs.

Constitutional: Patient appears alert, appropriate, cooperative, pleasant, in no apparent distress. Psych:

Patient judgment and insight is good. Skin: No rashes/erythema noted. Extremities: Appears normal without any deformities, edema, or calf tenderness. Musculoskeletal: Musculoskeletal exam of major joints reveals functional range of motion, no abnormal muscle tone and no obvious wasting.

Back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are mildly positive. She is able to stand tiptoes & on heel. Waddell signs are positive 0/5. Neurological: Neurological examination of the both lower extremities are normal with symmetrical sensation over all lumbosacral dermatomes, normal motor strength 5/5 in all muscle groups and symmetrical reflexes. She exhibits a negative SLR, negative Babinski's sign and there is no ankle clonus. Gait is age appropriate with good tone and no evidence of pathological muscle atrophy. Numbness is better than before.

Trigger Point: Palpation reveals no trigger points.

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

ASSESSMENT/PLAN:

1. 724.4 = Radicular Syndrome, Lower limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.

Ms. Lettie Spencer is a 45 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen pshyologist in Charlotte once but no follow up. She is not a surgical candidate.

She is s/p SNRB x 2 with good pain relief.

- Ms. Lettie Spencer will be scheduled in 4 week(s) for office visit.
- Patient assessed for efficacy of current medication regimen, Continue current medication(s) and will refill her Nucynta.
- She is not taking neurontin anymore as her leg pain is better.
- Advised to remain active within limit of pain.
- Will evaluate her for chronic opioid therapy at next visit. SOAPP/ORT and contract..
- Needs folios up with her psychologist for her reactive depression.
- Continue home exercise.
- Diff Rx options discussed including SCS trial. But before she needs follow up with her psychologist.

FOLLOW UP: She should return to the office for follow up OV in 4 week(s) or sooner if the condition worsens, changes, and/or if any concerns.

Prescriptions:

Nucynta Dosage: 75 mg Tab Sig: One by mouth every 8-12 hours Total Daily Dose Qty: 3 Dispense: 60 Refills: 0 Allow Generic: Yes

Spencer, Lettie 05/13/13 - SPELE000

Sanjay Mandurkar MD

Sanjay Mandurkar, MD

Page: 3

Page 000130

ROA 268

Sanjay Nandurkar MD
Interventional Spine Specialist834 W Meeting St, Ste A
Lancaster SC 29720
Ph: (803) 289-PAIN
Fax: (803) 283-1522

Letter of Medical Necessity LumboSacral Orthosis - LSO (631)

Patient: Lettie Spence Chart # SPELE000 Date 6/10/13 DC # _____

DURABLE MEDICAL EQUIPMENT: Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, pendulous abdomen design, prefabricated.

HCPCS CODE: L0621 ✓ WL (small)

BILLING CODE: 1620

DIAGNOSIS: ☒ Low back pain (724.2) ☒ Radicular syndrome (724.4) ☒ Lumbar disc syndrome (722.73)
☒ Muscle spasm (728.85) ☐ Spondylolisthesis, congenital (738.4) ☐ Lumbar IVD degen. (722.52)
☐ Sciatica (724.3) ☐ Lumbar sprain/strain (847.2) ☐ Lumbosacral sprain/strain (846.0)
☐ Other (Include ICD-9 code) _____

ONSET OF DIAGNOSIS: _____

INDICATIONS AND EXPECTED BENEFITS (check those appropriate)

- | | |
|--|--|
| ☐ Relaxation of muscle spasm | ☐ Symptomatic relief and management of chronic pain |
| ☐ Muscle re-education | ☐ Adjunctive treatment of post-traumatic acute pain |
| ☐ Reduce exacerbations of disc injury | ☒ Increase stabilization of spine/SI joint |
| ☒ Improve overall clinical picture | ☐ Increase the stability of the spondylolisthesis |
| ☒ Significantly reduce pain | ☐ Significantly increase mobility without pain |
| ☐ Other: _____ | |

DURATION OF NEED: ☐ More than 3 months ☐ More than 6 months ☐ Up to 12-months ☒ Lifetime

Utilizing accepted standards of medical practice, the above-prescribed durable medical equipment is essential in the continuous treatment of this patient.

Medical Provider: NANDURKARSignature: [Signature]

Page 000131

Date: 6/10/13

SCANNED

FOLLOW UP VISIT

Place of Service: Lancaster Office.
Date of Service: 06/10/2013

Piedmont Interventional
Spine & Pain Center
834 W. Meeting St., Ste. A
Lancaster, SC 29720

Ref: Ms. Lattie Spencer; Chart #: SPELE000; DOB: .

SUBJECTIVE:

Ms. Lattie Spencer is a year old female who presents to Piedmont Interventional Spine & Pain Center for follow-up evaluation and medication refill for her back pain symptoms. Today her pain is located in the lower back. The pain is radiating to back of leg above the knee. The pain is constant with variable intensity, dull and current intensity is 7 on a scale of 0-10. She denies any severe weakness, fever, or extreme pain. She states she saw Dr. W Brian O'Malley in Charlotte who suggested Functional rehab program in Charlotte, she does not want to do this as she doesn't want to be away from her family. She talks to case manager and would consider going to Columbia if necessary. Since the last visit, Lattie states her pain symptoms are little better with pain medications. She is prescribed medications through the PISPC. She is not having any difficulty with her medications and they are effective without any side effects. Current plan of management is helping her to control pain and improve daily function. She does not have medication bottles for review today.

She filled SOAPP/ORT questionnaire on 06/10/2013 and score is 3/1. She is low risk for COT.
Occupational History: She is working as LPN at National Health Care. She has been out of work since November 2011. Dr. Lehman has her under work restrictions: Sit down work only and no driving.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.

Medication History:Active:

Aldactone (active)
Klonopin (active)
Norvasc (active)
Nucynta 75 mg Tab (One by mouth every 8-12 hours) (active)
potassium acetate (active)
Tapazole (active)
Trazodone (active)

Past Medical History: Cardiovascular Hx: (+) hypertension. Endocrine Hx: (+) hyperthyroidism.

I have reviewed the chart notes, and I am aware of the family/social history. Since the last evaluation her medical history has not changed.

Review of Systems: Denies any fever, vertigo, dizziness, ear symptoms, chest pain, bilateral leg edema, shortness of breath, abdominal pain, hematuria, face swelling, blood in stool, seizures, bleeding problems, heat/cold intolerance, or suicidal ideation. Admits back pain.

PHYSICAL EXAMINATION:

Vitals: Afebrile and Stable Vital signs.

Constitutional: Patient appears alert, appropriate, cooperative, pleasant, in no apparent distress. Psych: Patient judgment and insight is good. Skin: No rashes/erythema noted. Extremities: Appears normal without any deformities, edema, or calf tenderness. Musculoskeletal: Musculoskeletal exam of major joints reveals functional range of motion, no abnormal muscle tone and no obvious wasting.

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JUN 20 2013
PISPC

Spencer, Lettie 06/10/13 - SPELB000

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Back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are mildly positive. She is able to stand tiptoe & on heel. Waddell signs are positive 0/5.

Neurological: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes.

Trigger Points: Palpation reveals no trigger points.

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

ASSESSMENT/PLAN:

1. 724.4 = Radicular Syndrome, Lower Limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.

Ms. Lettie Spencer is a year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psychologist in Charlotte once and he recommended for inhouse rehab. She is not a surgical candidate. She is s/p SNRB x 2 with good pain relief for some time. She still has leg and back pain. Injection did not helped much of her lower back pain.

- Ms. Lettie Spencer will be scheduled in 4 week(s) for office visit.
- Patient assessed for efficacy of current medication regimen, Continue current medication(s) and refill prescription given today
- Advised to remain active within limit of pain.
- SCAPP/ORT Score and Opioid Contract signed today.
- She has not decided for functional rehab at Charlotte at present.
- will order back brace (small) for her. She tried back brace that helped her to support back and significant reduction in back pain in office.
- If she continues to have have significant pain after rehab will consider SCS trial for chronic back and leg pain. Provided she has clearance from psychologist.
- will give her SCS video.
- Discussed with patient and case manager.

FOLLOW UP: She should return to the office for follow up OY in 4 week(s) or sooner if the condition worsens, changes, and/or if any concerns.

Prescriptions:

Nucynta Dosage: 75 mg Tab Sig: One by mouth every 8-12 hours Dispense: 60 Refills: xx Allow Generic: Yes

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06/20/2013 08:47

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PISPC

PAGE 06/06

Spencer, Lettie 06/10/13 - SPELE000

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Sanjay Nandurkar, MD

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LETITIA
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MD

06/20/2013 08:47

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PISPC

PAGE 03/06

Piedmont Interim Spine Ctr.
Patient Face Sheet
6/20/2013

Patient Chart #: SPELE000
Patient Name: Little B. Spencer
Street 1:
Street 2:
City: I
Phone: (0

D.O.B.:
Sex: Female
SSN:
Mar Status:
S.O.F.:
Assigned Provider: Sanjay G. Nandurkar

Age:

Employer Name:
Street 1:
City:
Phone:

Case Information

Case Desc: LAN 06/10/2013
Last Visit: 6/10/2013
Referral: William L. Lehman MD
Attendant Name: Little B. Spencer
Street 1:
City: I
Phone:
SSN:

Diagnosis 1: 724.4
Diagnosis 2: 721.3
Diagnosis 3: 722.52
Diagnosis 4:

Ins Co #: FRE00
Insurance 1: Premier Group Insurance
Street 1: PO Box 1122
Street 2:
City: Murfreesboro, TN 37133
Phone:
Ins-Start:
End:

Insured 1 Name: Little B. Spencer
Street 1:
Street 2:
Phone:
D.O.B.:
Policy Number:
Group Number:

Sex: Female

Ins Co #:
Insurance 2:
Street 1:
Street 2:
City:
Phone:
Ins-Start:
End:

Insured 2 Name:
Street 1:
Street 2:
City:
Phone:
D.O.B.:
Policy Number:
Group Number:

Sex:

Ins Co #:
Insurance 3:
Street 1:
Street 2:
City:
Phone:
Ins-Start:
End:

Insured 3 Name:
Street 1:
Street 2:
City:
Phone:
D.O.B.:
Policy Number:
Group Number:

Sex:

RECEIVED
JUN 21 2013
SCA

FOLLOW UP VISIT

Place of Service: Lancaster Office.

Date of Service: 07/11/2013

Ref: Ms. Lottie Spencer; Chart #: SPBLE000; DOB:

SUBJECTIVE:

Ms. Lottie Spencer is a year old female who presents to Piedmont Interventional Spine & Pain Center for follow-up evaluation for her back pain symptoms. She watched SCS video and thinks this could help her and she would like to try this. She has not rec'd her back brace yet. Today her pain is located in the lower back. The pain is radiating to back of left leg. The pain is constant with variable intensity, dull and current intensity is 7 on a scale of 0-10. She denies any severe weakness, fever, or extreme pain. Since the last visit, Lottie states her pain symptoms are the same. She is not prescribed medications through the PISPC. Current plan of management is helping her to control pain and improve daily function. She does have medication bottles for review today.

She filled SOAPP/ORT questionnaire on 06/10/2013 and score is 3/1. She is low risk for COT. Occupational History: She is working as LPN at National Health Care. She has been out of work since November 2011. Dr. Lehman has her under work restrictions: Sit down work only and no driving.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.

Medication History:Active:

Aldactone (active)
Klonopin (active)
Norvasc (active)
Nucynta 75 mg Tab (One by mouth every 8-12 hours) (active)
potassium acetate (active)
Tapazole (active)
Truzodone (active)
vibryd (active)

Past Medical History: Cardiovascular Hx: (+) hypertension. Endocrine Hx: (+) hyperthyroidism.
Opioid Contract: YES.

I have reviewed the chart notes, and I am aware of the family/social history. Since the last evaluation her medical history has not changed.

Review of Systems: Denies any fever, vertigo, dizziness, ear symptoms, chest pain, bilat leg edema, shortness of breath, abdominal pain, hematuria, face swelling, blood in stool, seizures, bleeding problems, heat/cold intolerance, or suicidal ideation. Admits back pain.

PHYSICAL EXAMINATION:

Vitals: Afebrile and Stable Vital signs.

Constitutional: Patient appears alert, appropriate, cooperative, pleasant, in no apparent distress. Psych: Patient judgment and insight is good. Skin: No rashes/erythema noted. Extremities: Appears normal without any deformities, edema, or calf tenderness. Musculoskeletal: Musculoskeletal exam of major joints reveals functional range of motion, no abnormal muscle tone and no obvious wasting..

Page: 1

Page 000136

 SCANNED

ROA 274

Spencer, Lettie 07/11/13 - SPELE000

Sanjay Nandurkar MD

Back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are mildly positive. She is able to stand tiptoe & on heel. Waddell signs are positive 0/5.

Neurological: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes.

Trigger Point: Palpation reveals no trigger points.

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

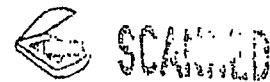
ASSESSMENT/PLAN:

1. 724.4 = Radicular Syndrome, Lower limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.
3. 338.4 = Chronic Pain Syndrome.

Ms. Lettie Spencer is a 70 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psyhologist in Charlotte once and he recommended for inhouse rehab. She is not a surgical candidate. She is s/p SNRB x 2 with good pain relief for some time. She still has leg and back pain.

- Ms. Lettie Spencer will be scheduled in 4 week(s) for office visit.
- Patient assessed for efficacy of current medication regimen, Continue current medication(s) and no refill prescription given today
- Advised to remain active within limit of pain.
- SOAP/ORT Score and Opioid Contract signed today.
- Her back brace is approved per her case manager who is present here. Back Brace given
- Will recommend SCS trial for her pain control. Before that will order psych eval for pre trial psych eval.
- SCS trial discussed in detail.

FOLLOW UP: She should return to the office for follow up OV in 4 week(s) or sooner if the condition worsens, changes, and/or if any concerns.



Spencer, Lettie 07/11/13 - SPELE000

Sanjay Nandurkar MD

Prescriptions:

Nucynta Dosage: 75 mg Tab Sig: One by mouth every 8-12 hours Dispense: 75 Refills: XXX Allow
Generic: Yes

_____, Sanjay Nandurkar, MD

Updated on 07/11/2013 By: _____ Sanjay Nandurkar, MD

Updated on 07/11/2013 By: _____ Sanjay Nandurkar, MD



FOLLOW UP VISIT

Place of Service: Lancaster Office.

Date of Service: 08/08/2013

Ref: Ms. Leticia Spencer; Chart #: SPELB000; DOB: [REDACTED]

SUBJECTIVE:

Ms. Leticia Spencer is a [REDACTED] year old female who presents to Piedmont Interventional Spine & Pain Center for follow-up evaluation for her back pain symptoms. Today her pain is located in the lower back. The pain is radiating to back of leg. The pain is constant with variable intensity, dull and current intensity is 7-8 on a scale of 0-10. She denies any severe weakness, fever, or extreme pain. Since the last visit, Leticia states her pain symptoms are better with pain medications. Her back brace is helping her pain, esp. when riding in a car. She is not prescribed medications through the PISPC. Current plan of management is helping her to control pain and improve daily function. She does have medication bottles for review today. She has been approved for comprehensive rehab in Charlotte.

Occupational History: She is working as LPN at National Health Care. She has been out of work since November 2011. Dr. Lehman has her under work restrictions: Sit down work only and no driving.

She filled SOAPP/ORT questionnaire on 06/10/2013 and score is 3/1. She is low risk for COT.

Occupational History: She is working as LPN at National Health Care. She has been out of work since November 2011. Dr. Lehman has her under work restrictions: Sit down work only and no driving.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.

Medication History:Active:

- Trazodone (active)
- Norvasc (active)
- Tapazole (active)
- Klonopin (active)
- potassium acetate (active)
- Aldactone (active)
- vibryd (active)
- Nucynta 75 mg Tab (One by mouth every 8-12 hours) (active)

Past Medical History: Cardiovascular Hx: (+) hypertension. Endocrine Hx: (+) hyperthyroidism.

Opioid Contract: YES.

I have reviewed the chart notes, and I am aware of the family/social history. Since the last evaluation her medical history has not changed.

Review of Systems: Denies any fever, vertigo, dizziness, ear symptoms, chest pain, bilat leg edema, shortness of breath, abdominal pain, hematuria, face swelling, blood in stool, seizures, bleeding problems, heat/cold intolerance, or suicidal ideation. Admits back pain.

PHYSICAL EXAMINATION:

Vitals: Afebrile and Stable Vital signs.

Constitutional: Patient appears alert, appropriate, cooperative, pleasant, in no apparent distress. Psych: Patient judgment and insight is good. Skin: No rashes/erythema noted. Extremities: Appears normal

Page: 1

Page 000139

ROA 277

Spencer, Leticia 08/08/13 - SPJLE000

Sanjay Nandurkar MD

without any deformities, edema, or calf tenderness. Musculoskeletal: Musculoskeletal exam of major joints reveals functional range of motion, no abnormal muscle tone and no obvious wasting.

Back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are mildly positive. She is able to stand tiptoe & on heel. Waddell signs are positive 0/3.

Neurological: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes.

Trigger Points: Palpation reveals no trigger points.

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

ASSESSMENT/PLAN:

1. 724.4 = Radicular Syndrome, Lower Limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.
3. 338.4 = Chronic Pain Syndrome.

Ms. Leticia Spencer is a year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psychologist in Charlotte once and he recommended for inhouse rehab. She is not a surgical candidate.

She has been approved for comprehensive rehab at charlotte.

- Ms. Leticia Spencer will be scheduled in 8 week(s) for office visit.
- Patient assessed for efficacy of current medication regimen, Continue current medication(s) and refill prescription given today
- Advised to remain active within limit of pain.
- Will see her after rehab program.

FOLLOW UP: She should return to the office for follow up OV in 8 week(s) or sooner if the condition worsens, changes, and/or if any concerns.

Prescriptions:

Nucynta Dosage: 75 mg Tab Sig: One by mouth every 8-12 hours Dispense: 75 Refills: XXX Allow
Generic: Yes

Page: 2

Page 000140

ROA 278

Spencer, Lottie 08/08/13 - SP3LE000

Sanjay Nandurkar MD

Sanjay Nandurkar, MD

Page: 3

Page 000141

ROA 279

Progress Notes

Patient: Spencer, Lettie B
DOB: [redacted] / [redacted] / [redacted] Sex: Female
Phone: [redacted]
Address: [redacted]

Provider: Sanjay G Nandurkar, MD
Date: 10/10/2013

Subjective:

CC:

1. Back pain.

HPI:

Pain Management:

Pain located over lower back. The pain intensity has remained same since last visit. The pain quality is described as dull, aching. The severity of the pain is 3/10 average. Pain is constant. The pain is radiating left calf. The pain is associated with weakness in left leg. The pain is worse at the end of the day. The pain is aggravated by standing. The pain is better with TENS, lying down. Patient does not c/o severe weakness, extreme pain, fever. Current management includes: Nucynta and membrane stabilizers, home exercise program, TENS unit, back brace.

She has finished chronic pain rehab center at Chelabote. And she is doing overall better. She is also using TENS units every day. She is feeling less depressed and able to manage her pain with medications and TENS.

Medication Follow Up:

Patient is prescribed medications through the PISPC. Patient is not having difficulty with medications. The medications are effective without any side effects. Patient states not getting pain medications from other physicians. Daily function is better with pain medications. No aberrant pain behaviour noted. Driving is not affected. She does not have bottles review. Dr. Carlton at Rehab center prescribed last and this month's prescription for Nucynta.

ROS:

*:

Patient c/o back pain.

Constitutional:

Patient denies change in appetite, chills, fatigue, fever, headache, night sweats, sleep disturbance, weight change, weight loss.

Opted Management:

Patient denies breathing difficulty, sedation/sleepy feeling, itching, constipation, nausea/vomiting, hallucination/weird dreams, blurred vision, peripheral edema, use of recreational drugs. Patient admits functional pain relief.

Psychology:

Patient denies stressors, substance abuse, suicidal thoughts, depressed mood.

Medical History: Hyperthyroidism, Hypertension.

Family History:

Social History:

Tobacco Use: Tobacco Use/Smoking Are you a current smoker.

Social History: Social Hx: alcohol use(Denies) illegal drug use(Denies) tobacco use(Denies).

Medications: Vibryd, Nucynta 75 mg Tab One by mouth every 8-12 hours, Tapazole 100 mg HS, Klonopin 1 mg HS, trazodone, Norvasc, Aldactone, Potassium Acetate, Medication List reviewed and reconciled with the patient.

Allergies: Penicillin: rash: Allergy, Demerol: rash: Allergy, Codeine Phosphate.

Objective:

Vitals: HR 68 /min, BP 154/89 mm Hg, Ht 62 in, Wt 107 lbs, BMI 19.57 Index.

Examination:

Exam:

GENERAL APPEARANCE: alert, pleasant, well nourished, in no acute distress. PSYCH: cognitive

function intact, cooperative with exam, good eye contact, judgement and insight good. SKIN: no rashes/erythema noted. HEENT: conjunctiva is pink. LUNGS: no wheezing, breathing non-labored. LOWER BACK: Tenderness over left lower back and left SI joint area. SLR is mildly positive. NEUROLOGIC: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes. .

Diagnostic Results:

* MRI Lumbar Spine: ..

Assessment:**Assessment:**

1. Thoracic or lumbosacral neuritis or radiculitis, unspecified - 724.4 (Primary)
2. Degeneration of lumbar or lumbosacral intervertebral disc - 722.52
3. Chronic pain syndrome - 338.4

Ms. Lettie Spencer is a 65 year old female with work related injury on 05/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psychologist in Charlotte once and he recommended for inhouse rehab. She is not a surgical candidate.

She has finished rehab program at Charlotte and doing overall better. Her strength is better, posture is better. She is feeling less depressed. Using TENS unit. She thinks her pain is manageable with pain meds and TENS unit.

Plan:**1. Chronic pain syndrome**

She do not need pain meds today.

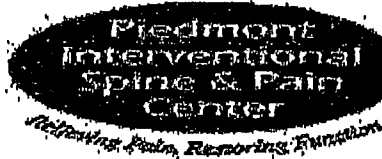
Immunizations:**Therapeutic Injections:****Labs:****Preventive:**

long term prognosis discussed.

Follow Up: 4/8 weeks (Reason: Med Refill)

Provider: Sanjay G Nandurkar, MD
Patient: Spencer, Lettie B DOB:

Date: 10/10/2013



Spencer, Lettie B

Home:

Guarantor: Spencer, Lettie B Insurance: Premier Group
 Ins Payer ID: PAPER
 Referring: William L Lehman, MD
 Appointment Facility: Piedmont Interventional Spine Pain

12/09/2013

Progress Notes: Sanjay G Nandurkar, MD

Current Medications

Nucynta 76 MG Tablet: 1 tablet 2-3 times day
 Vlibryd
 Tapazole 100 mg HS
 Klonopin 1 mg HS
 trazodone
 Norvasc
 Aldactone
 Potassium Acetate
 Medication List reviewed and reconciled with the patient

Past Medical History

Hyperthyroidism
 Hypertension

Surgical History

hysterectomy
 neck surgery

Social History**Tobacco Use:**

Tobacco Use/Smoking: Are you a current smoker? How often do you smoke cigarettes? every day, How many cigarettes a day do you smoke? 5-10, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, Are you interested in quitting? Not ready to quit.

Social History

Social Hx: alcohol use(Denies) illegal drug use(Denies) tobacco use(Denies).

Allergies

Pericillin: rash: Allergy
 Dextrol: rash: Allergy
 Codeine Phosphate

Review of Systems

2 Patient c/o back pain.

Constitutional:

Patient denies change in appetite, chills, fatigue, fever, headache, night sweats, sleep disturbance, weight change, weight loss.

Oral Management:**Reason for Appointment**

1. Back pain

History of Present Illness**Pain Management:**

Pain located over lower back. The pain intensity has worsened since last visit. She states this is due to her having a cold, when she coughs it makes her pain worse. The pain quality is described as dull. The severity of the pain is 5/10 average. Pain is constant. The pain is radiating left calf. The pain is associated with weakness in left leg. The pain is worse at the end of the day. The pain is aggravated by standing. The pain is better with TENS, lying down. Patient does not c/o severe weakness, extreme pain, fever. Current management includes: Nucynta and membrane stabilizers, home exercise program, back brace, TENS unit, she states it is not helping as much as it was before.

She thinks she is more depressed when pain is worse. Her TENS units is not working properly. One side does not work.

Medication Management:

Patient is prescribed medications through the PISPC: Yes. Patient is not having difficulty with medications: No. The medications are effective without any side effects. Yes. Pt denies getting pain meds from other sources: Yes. ADLs are improved with medications: Yes. Aberrant behaviour noted: No. Driving ability is affected: No. Medication bottle is available: Yes.

Vital Signs

HR 85 /min, BP 144/80 mm Hg, Ht 62 in, Wt 107 lbs, BMI 19.57
 Index, Pain scale 6-10.

Examination**Exam:**

GENERAL APPEARANCE: alert, pleasant, well nourished, in no acute distress. PSYCH: cognitive function intact, cooperative with exam, good eye contact, judgement and insight good. SKIN: no rashes/erythema noted. HEENT: conjunctiva is pink. LUNGS: no wheezing, breathing non-labored. LOWER BACK: Tenderness over left lower back and left SI joint area. SLR is mildly positive. NEUROLOGIC: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes.

Patient: Spencer, Lettie B DOB:

Progress Notes: Sanjay G Nandurkar, MD 12/09/2013

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

Patient denies breathing difficulty, sedation/sleepy feeling, itching, constipation, nausea/vomiting, hallucination/weird dreams, blurred vision, peripheral edema, use of recreational drugs. Patient admits functional pain relief.

Psychology:

Patient denies stressors, substance abuse, suicidal thoughts, depressed mood.

Diagnostic Results:

* MRI Lumbar Spine: report dated 09/12/2012 reviewed.
Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

Assessments

1. lumbosacral Radiculopathy - 724.4 (Primary)
2. Lumbar DDD/Bulge - 722.52
3. Chronic pain syndrome - 338.4
4. Lumbosacral spondylosis - 721.3

Ms. Lettie Spencer is a year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psychologist in Charlotte once and he recommended for inhouse rehab. She is not a surgical candidate.

She has finished rehab program at Charlotte and doing overall better. Her strength is better, posture is better. She is feeling less depressed. Using TENS unit.

She thinks her pain is getting worse gradually as TENS unit is not working properly.

Treatment

1. Chronic pain syndrome

she needs new TENS unit so all 4 pads are working.
we have discussed SCS trial per her request but will wait till her TENS unit is fixed and see how she is doing.

2. Others

Refill Nucynta Tablet, 75 MG, 1 tablet, Orally, every 8 hours, 30 days, 90, Refills 0
Start Gabapentin Capsule, 300 MG, 1 capsule, Orally, Three times a day, 30 day(s), 90, Refills 1
Will increase her nucynta to 3 times a day.

Preventive Medicine

remain active within limit of pain. Adv to continue home stretching exercise., # Narcotic precautions discussed, # long term prognosis and diff Rx options discussed. Patient understands., # Chronic pain syndrome and depression discussed. Need for mental health support discussed.

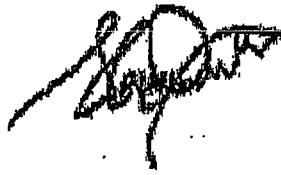
Follow Up

2 Months (Reason: Follow Up)

Patient: Spencer, Lettie B DOB

Progress Note: Satjay G Nandurkar, MD 12/09/2013

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



Electronically signed by Sanjay Nandurkar, MD on
02/07/2014 at 02:06 PM EST

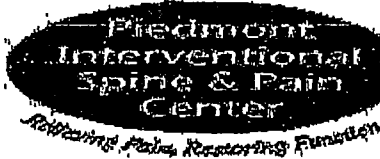
Sign off status: Completed

Piedmont Interventional Spine Pain
834 West Meeting Street Ste A
Lancaster, SC 297206451
Tel: 803-289-7246
Fax: 803-289-1622

Patient: Spencer, Lettie B DOB:

Progress Note: Sanjay G Nandurkar, MD 12/09/2013

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



Spencer, Lettie B

Home:
 Guarantor: Spencer, Lettie B Insurance: Premier Group
 Ins Payer ID: PAPER
 Referring: William L Lehman, MD
 Appointment Facility: Piedmont Interventional Spine Pain

02/06/2014

Sanjay G Nandurkar, MD

Current Medications

Vibryd
 Tylenol 100 mg HB
 Monopin 1 mg HB
 trazodone
 Norvasc
 Aldactone
 Potassium Acetate
 Gabapentin 300 MG Capsule 1 capsule Three times a day
 Nucynta 75 MG Tablet 1 tablet every 8 hours
 Medication List reviewed and reconciled with the patient

Past Medical History

Hypothyroidism
 Hypertension

Surgical History

hysterectomy
 neck surgery

Allergies

Penicillin: rash: Allergy
 Demerol: rash: Allergy
 Codeine Phosphate

Review of Systems

PM
 Patient c/o back pain.

Constitutional:

Patient denies change in appetite, chills, fatigue, fever, headache, night sweats, sleep disturbance, weight change, weight loss.

Opoid Management:

Patient denies breathing difficulty, sedation/sleepy feeling, itching, constipation, nausea/vomiting, hallucination/weird dreams, blurred vision, peripheral edema, use of recreational drugs. Patient admits functional pain relief.

Psychology:

Patient denies stressors, substance

Reason for Appointment

1. Back pain

History of Present Illness**Pain Management:**

Pain located over lower back. The pain intensity has remained the same. The pain quality is described as aching, stabbing, squeezing. The severity of the pain is 6/10 average. Pain is constant. The pain is radiating left calf. The pain is associated with weakness in left leg, muscle spasms, muscle cramps. The pain is worse at the end of the day. The pain is aggravated by standing. The pain is better with TENS, lying down. Patient does not c/o severe weakness, extreme pain, fever. Current management includes: Nucynta and membrane stabilizers, home exercise program, back brace, TENS unit. She is wearing that today.

She thinks she is more depressed when pain is worse. Her TENS unit is working properly. She says her lawyer is trying to close her WC case. - SIN.

Medication Management:

Patient is prescribed medications through the PISPC: Yes. Patient is not having difficulty with medications: No. The medications are effective without any side effects. Yes. Pt denies getting pain meds from other sources: Yes. ADLs are improved with medications: Yes. Aberrant behaviour noted: No. Driving ability is affected: No. Medication bottle is available: Yes. Pill count is consistent.

Opioid Monitoring:

* SOAPP/ORT Questionnaire Score: 3/1. Mild risk for COT, Opioid Contract: Yes, PDQ Score: 02/24/2014 No change from initial visit. Today 115/150. (severe disability).

Vital Signs

HR 94 /min, BP 130/67 mm Hg, Ht 62 in, Wt 107 lbs, BMI 19.57 Index, Pain scale 6-10.

Examination**Exam:**

GENERAL APPEARANCE: alert, pleasant, well nourished, in no acute distress. PSYCH: cognitive function intact, cooperative with exam, good eye contact, judgement and insight good. SKIN: no rashes/erythema noted. HEENT conjunctiva is pink. LUNGS: no

Patient: Spencer, Lettie B DOB:

Progress Note: Sanjay G Nandurkar, MD 02/06/2014

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

abuse, suicidal thoughts, depressed mood.

wheezing, breathing non-labored. LOWER BACK: Tenderness over left lower back and left SI joint area. SLR is mildly positive, paraspinal muscle spasm on the LEFT, paraspinal muscle spasm on the RIGHT. Lum extension is almost 0. NEUROLOGIC: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes.

Diagnostic Results:

* MRI Lumbar Spine: report dated 09/12/2012 reviewed.
Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

Assessments

1. lumbosacral Radiculopathy - 724.4 (Primary)
2. Lumbar DDD/Bulge - 722.52
3. Chronic pain syndrome - 338.4
4. Lumbosacral spondylosis - 721.3

Ms. Lettie Spencer is a year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psychologist in Charlotte once and he recommended for in house rehab. She is not a surgical candidate. She has finished rehab program at Charlotte and doing overall better. She is feeling less depressed. Using TENS unit.

Treatment

1. Chronic pain syndrome

will add zanaflex for her muscle spasms.

2. Others

Refill Nucynta Tablet, 75 MG, 1 tablet, Orally, every 8 hours (valid 2-6-14), 30 days, 90, Refills 0.0
Refill Gabapentin Capsule, 300 MG, 1 capsule, Orally, Three times a day, 30 day(s), 90, Refills 5
Start Zanaflex Capsule, 4 MG, 1 capsule as needed, Orally, 2-3 times day, 30 days, 90, Refills 1

Preventive Medicine

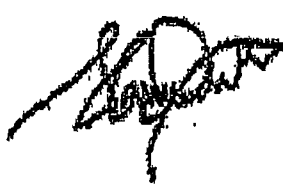
remain active within limit of pain. Adv to continue home stretching exercise, # Narcotic precautions discussed, # long term prognosis and diff Rx options discussed. Patient understands, # Continue home exercise as shown and discussed.
She has reached MMI as far as pain symptoms are concerned. and will do impairment rating for her.

Follow Up

4/8 weeks (Reason: Follow Up)

Patient: Spencer, Lettie B DOB:

Progress Note: Sanjay G Nandurkar, MD 02/06/2014
Note generated by EMPI/PM Software (www.eClinicalWorks.com)



Electronically signed by Sanjay Nandurkar, MD on
02/26/2014 at 05:27 AM EST
Sign off status: Completed

Piedmont Interventional Spine Pain
834 West Meeting Street Ste A
Lancaster, SC 297206252
Tel: 803-289-7246
Fax: 803-285-1522

Patient: Spencer, Lettie H DOB

Progress Note: Sanjay G Nandurkar, MD 02/06/2014

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

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov



Physician's Statement

Claimant's Name: Lettie Spencer
Physician's Name: Sanjay Nandurkar, M.D.
Practice/Clinic: Piedmont Interventional Spine & Pain Care
Preparer's Name: _____
Phone: (____) _____

Employer's Name: National Health Care
Insurance Carrier: Premier Group Insurance
SCWCC File No: 1120778

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 first office visit: 1/28/13 Date of last visit: 2/6/14 Date of Injury or Illness: June 22
Diagnosis or nature of injury or illness: Lumbar DDD, lumbar radiculopathy, chronic pain
Body part(s) injured: low back Body part(s) affected: left leg (radiculopathy)
Date of Maximum Medical Improvement: 2/6/14
Based on the AMA Guidelines, the claimant has sustained a _____ % medical impairment to _____ injured body part(s) and a 13 % medical impairment to WFL 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.
less than sedentary restriction

As of the date I last saw this patient, it is my professional medical opinion the claimant:

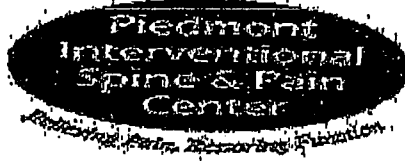
____ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☒ 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:

pain management, periodic spinal injections, medication
physical therapy, spinal cord stimulator

Treating Physician: [Signature]

2/2/14
Date



Spencer, Lettie B

Old Female DOB:

Home:

Guarantor: Spencer, Lettie B Insurance: Premier Group

Ins Payer ID: PAPER

Referring: William L. Lehman, MD

Appointment Facility: Piedmont Interventional Spine Pain

04/08/2014

Progress Note: Sanjay G Nandurkar, MD

Current Medications

Vibryd
Tapazole 100 mg HS
Klonopin 1 mg HS
triazodone
Norvasc
Aldactone
Potassium Acetate
Gabapentin 300 MG Capsule 1 capsule Three times a day
Zanaflex 4 MG Capsule 1 capsule as needed q-3 times day
Nucynta 75 MG Tablet 1 tablet every 8 hours

Past Medical History

Hyperthyroidism
Hypertension

Allergies

Fentanyl rash: Allergy
Demerol rash: Allergy
Codeine Phosphate

Review of Systems

•

Patient c/o back pain.

Constitutional:

Patient denies change in appetite, chills, fatigue, fever, headache, night sweats, sleep disturbance, weight change, weight loss.

Opioid Management:

Patient denies breathing difficulty, sedation/sleepy feeling, itching, constipation, nausea/vomiting, hallucination/weird dreams, blurred vision, peripheral edema, use of recreational drugs. Patient admits functional pain relief.

Psychology:

Patient denies stressors, substance abuse, suicidal thoughts, depressed mood.

Reason for Appointment

1. Back pain

History of Present Illness

Pain Management:

Pain located over lower back. The pain intensity has remained the same. The pain quality is described as aching, stabbing, squeezing. The severity of the pain is 6/10 average. Pain is constant. The pain is radiating left calf. The pain is associated with weakness in left leg, muscle spasms, muscle cramps. The pain is worse at night. The pain is aggravated by standing. The pain is better with TENS, lying down. Patient does not c/o severe weakness, extreme pain, fever. Current management includes: Nucynta and membrane stabilizers, home exercise program, back brace, TENS unit. She is wearing that today.

-ahm She thinks she is more depressed when pain is worse. Her TENS units is working properly. She says her lawyer is trying to close her WC case.

Medication Management:

Patient is prescribed medications through the PISPC: Yes. Patient is not having difficulty with medications: No. The medications are effective without any side effects. Yes. Pt denies getting pain meds from other sources: Yes. ADLs are improved with medications: Yes. Aberrant behaviour noted: No. Driving ability is affected: No. Medication bottle is available: Yes. Pill count is consistent, Patient has taken narcotic pain meds on 4/8/14, Patient is taking her/his pain meds daily.

Opioid Monitoring:

* SOAPP- R Questionnaire Score: 3/1, Mild risk for COT, Opioid Contract: Yes, PDQ Score: 02/24/2014 No change from initial visit. Today 115/150. (severe disability).

Vital Signs

HR 67 /min, BP 130/55 mm Hg, Ht 62 in, Wt 107 lbs, BMI 19.57 Index, Pain scale 6 1-10.

Examination

Exam::

GENERAL APPEARANCE: alert, pleasant, well nourished, no acute distress. PSYCH: cognitive function intact, cooperative with exam, good eye contact, judgement and insight good. SKIN: no

Patient: Spencer, Lettie B DOB:

Progress Note: Sanjay G Nandurkar, MD 04/08/2014

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rashes/erythema noted. HEENT: conjunctiva is pink. LUNGS: no wheezing, breathing non-labored. LOWER BACK: Tenderness over left lower back and left SI joint area. SLR is mildly positive, paraspinal muscle spasm on the LEFT, paraspinal muscle spasm on the RIGHT. Lum extension is almost O. NEUROLOGIC: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes.

Diagnostic Results:

* MRI Lumbar Spine: report dated 09/12/2012 reviewed.
Impression: L4-5 DDD/facet arthritis with mild canal stenosis.
InfluX UDS: 04/08/2014 Positive for -, BZO, TCA, Negative for-
QXY, OFI/MOR, THC, COC, MET, AMP, MDMA, BAR, MTD, PCP.
This was sent to the lab for confirmation.

Assessments

1. lumbosacral Radiculopathy - 724.4 (Primary)
2. Lumbar DDD/Bulge - 722.52
3. Chronic pain syndrome - 338.4
4. Lumbosacral spondylosis - 721.3
5. Drug Monitoring Encounter - V88.83

Ms. Lettie Spencer is a 66 year old female with work related injury on 05/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psychologist in Charlotte once and he recommended for in house rehab. She is not a surgical candidate. She has finished rehab program at Charlotte and doing overall better. She is feeling less depressed. Using TENS unit.

Treatment

- 1. Drug Monitoring Encounter**
LAB: * Urine Screen IH

2. Others

Refill Zanaflex Capsule, 4 MG, 1 capsule as needed, Orally, 2-3 times
day, 30 days, 90, Refills 1
Refill Nucynta Tablet, 75 MG, 1 tablet, Orally, every 8 hours (valid
4/9/14), 30 days, 90, Refills 0.0

Preventive Medicine

remain active within limit of pain. Adv to continue home stretching exercise, # Narcotic precautions discussed. # Remain active within limit of pain, # long term prognosis and diff rx options discussed. Patient understands.

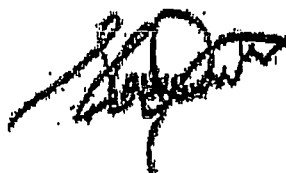
Follow Up

4/8 weeks (Reason: Follow Up)

Patient: Spencer, Lellie B DO.

Progress Note: Sanjay G Nandarkar, MD 04/08/2014

Progress Note: Sanjiv G Nandurka
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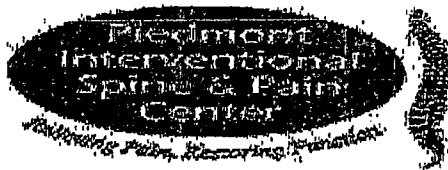
Electronically signed by Sanjay Nandurkar, MD on
04/08/2014 at 12:26 PM EDT
Sign off status: Completed

Piedmont Interventional Spine Pain
834 West Meeting Street Ste A
Lancaster, SC 29706251
Tel: 803-289-7246
Fax: 803-285-1322

Patient: Spencer, Lettie B DOB:

Progress Note: Sanjay G Nandurkar, MD 04/08/2014

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



Spencer, Lettie B

67 Y old Female, DOB:

Account Number: 102226

Home:

Guarantor: Spencer, Lettie B Insurance: Premier Group

Ins Payer ID: PAPER

Referring: William L Lehman, MD

Appointment Facility: Piedmont Interventional Spine Pain

06/05/2014

Sanjay G Nandurkar, MD

Current Medications

Taking Vildryd
Taking Tylenol 100 mg HB
Taking Monopin 1 mg HS
Taking tramadol
Taking Norvasc
Taking Aldactone
Taking Potassium Acetate
Taking Gabapentin 300 MG Capsule 1 capsule Three times a day
Taking Zanaflex 4 MG Capsule 1 capsule as needed 2-3 times day
Taking Nucynta 78 MG Tablet 1 tablet every 8 hours (valid 5/9/14)
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
Hypertension

Allergies

Penicillin: rash: Allergy
Demerol: rash: Allergy
Codeine Phosphate

Review of Systems

2
Patient c/o back pain.
Constitutional:
Patient denies change in appetite, chills, fatigue, fever, headache, night sweats, sleep disturbance, weight change, weight loss.

Opioid Management

Patient denies breathing difficulty, sedation/sleepy feeling, itching, constipation, nausea/vomiting, hallucination/weird dreams, blurred vision, peripheral edema, use of recreational drugs. Patient admits functional pain relief.

Psychology

Patient denies stressors, substance

Reason for Appointment

1. WC Back pain

History of Present Illness

Pain Management:

Pain located over lower back. The pain intensity has gradually worsened since last visit. She has now some bladder issues and her pain is getting worse. She is seeing Dr Magura for that. The pain quality is described as aching, stabbing, squeezing. The severity of the pain is 7/10 average. Pain is constant. The pain is radiating left calf. The pain is associated with weakness in left leg, muscle spasms, muscle cramps. The pain is worse at night. The pain is aggravated by standing. The pain is better with TENS, lying down. Patient does not c/o severe weakness, extreme pain, fever. Current management includes: Nucynta and membrane stabilizers, home exercise program, back brace, TENS unit.

-jm.

Medication Management:

Patient is prescribed medications through the PISPC: Yes. Patient is having difficulty with medications: No. The medications are effective without any side effects: Yes. Pt denies getting pain meds from other sources: Yes. ADLs are improved with medications: Yes. Aberrant behaviour noted: No. Driving ability is affected: No. Medication bottle is available: Yes Last UDS is consistent done on: 4/8/14.

Opioid Monitoring:

* SOAPP- R Questionnaire Score: 3/1, Mild risk for OOT, Opioid Contract: Yes.

Vital Signs

HR 70 /min, BP 80/62 mm Hg, Ht 62 in, Wt 107 lbs, BMI 19.57 Index.

Examination

Exam:

GENERAL APPEARANCE: alert, pleasant, well nourished, in no acute distress. PSYCH: cognitive function intact, cooperative with exam, good eye contact, judgement and insight good. SKIN: no rashes/erythema noted. HEENT: conjunctiva is pink. LUNGS: no wheezing, breathing non-labored. LOWER BACK: Tenderness over left lower back and left SI joint area. SLR is mildly positive, paraspinal muscle spasm on the LEFT, paraspinal muscle spasm on the RIGHT.

Patient: Spencer, Lettie B DOB:

Progress Note: Sanjay G Nandurkar, MD 06/05/2014

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

abuse, suicidal thoughts, depressed mood.

Lum extension is almost 0.. **NEUROLOGIC:** Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes. .

Diagnostic Results:

* MRI Lumbar Spine: report dated 09/12/2012 reviewed.

Impression: L4-5 DDD/facet arthritis with mild canal stenosis. .

Assessments

1. lumbosacral Radiculopathy - 724.4 (Primary)
2. Lumbar DDD/Bulge - 722.52
3. Chronic pain syndrome - 338.4
4. Lumbosacral spondylosis - 721.3

Ms. Lettie Spencer is a ... year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psychologist in Charlotte once and he recommended for in house rehab. She is not a surgical candidate. She has finished rehab program at Charlotte and doing overall better. She is feeling less depressed. Using TENS unit.

Treatment

1. Chronic pain syndrome

Refill Nucynta Tablet, 75 MG, 1 tablet, Orally, every 8 hours (valid 6/10/14), 30 days, 90, Refills 00

Refill Zanaflex Tablet, 4 MG, 1 tablet as needed, Orally, 3 times a day, 30 days, 90 Tablet, Refills 1

Preventive Medicine

*Counseling: *Fall Risk Screening Fall Risk Assessment: No falls in the past year. *Smoking: Patient counselled on the dangers of tobacco use and urged to quit. 06/05/2014. *Social: alcohol and drugs: # Narcotic precautions discussed. , exercise: Discussed the benefits of regular back stretching and exercise. *Communication to patient: Chronic Pain # Narcotic precautions discussed. # Remain active within limit of pain., # long term prognosis and diff Rx options discussed. Patient understands..

Follow Up

4/8 weeks (Reason: Med Refill)

Patient: Spencer, Lettie B DOB:

Progress Note: Sanjay G Nandankar, MD 06/05/2014

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Electronically signed by Sanjay Nandurkar, MD on
06/05/2014 at 11:34 AM EDT

Sign off status: Completed

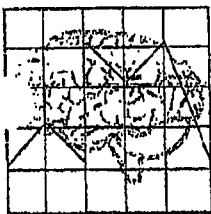
Piedmont Interventional Spine Pain
834 W MEETING ST
LANCASTER, SC 29720-6220
Tel: 803-289-7246
Fax: 803-285-1522

Patient: Spencer, Leticia B DOB:

Progress Note: Sanjay G Nandurkar, MD 06/05/2014

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APPEAL



Health & Rehabilitation Psychologists
of Charlotte, P.A.

INITIAL PSYCHOLOGICAL EVALUATION

PATIENT: Lettie Spencer
CHART #: 12615
DATE: 3-7-2013

This -year-old woman was seen for a psychological evaluation and recommendations regarding treatment. She reported promptly for her appointment and remained cooperative throughout. Her affect was dulled, her mood depressed. She was fully oriented.

Medical records were reviewed at the completion of Ms. Spencer's psychological evaluation. These included office notes from Carolina Occupational Healthcare, neurosurgical evaluation by Richard Dyer, M.D., progress notes by Tony Owens, M.D., physical therapy notes from Select Physical Therapy, office records from William Lehman, M.D., and a deposition of Dr. Lehman.

HISTORY:

Ms. Spencer reports that her present difficulties began secondary to an industrial injury which occurred on June 22, 2011, while employed by NHC. Ms. Spencer indicates that she was injured while pushing a medication cart, when the wheels became caught on a strip on the floor. As she pushed to free the cart, she experienced the immediate onset of low back and left leg pain. Ms. Spencer was seen at Carolina Occupational Healthcare by Dr. Thomas Motyka. She was diagnosed with a lumbar strain and possible radiculopathy. She was provided medication and referred to physical therapy. When her symptoms persisted, an MRI was obtained, which revealed mild degenerative disc disease of the lumbar spine, most prominent at L4-5. Ms. Spencer was referred to Randall G. Drye, M.D., for neurosurgical evaluation. Dr. Drye saw Ms. Spencer on 8-31-2011. Dr. Drye reviewed Ms. Spencer's MRI. He indicated that Ms. Spencer was not a candidate for neurosurgical intervention. Dr. Drye recommended additional physical therapy and pain management. Ms. Spencer was seen for pain management by Tony Owens, M.D. Dr. Owens provided a left sacroiliac joint injection, which provided transient relief. Dr. Owens then performed lateral branch radiofrequency ablation, which did not provide significant relief. Medication management was initiated. Ms. Spencer was referred for orthopedic evaluation to William Lehman, M.D. Dr. Lehman recommended a selective nerve root block, which resulted in improvement of Ms. Spencer's left leg pain. Dr. Lehman also recommended that Ms. Spencer undergo a lumbar CT myelogram and pain management through Dr. Nandurkar. He also noted that Ms. Spencer had become depressed and had lost a considerable amount of weight because of pain. The CT myelogram showed mild stenosis at L4-5. Dr. Lehman believed that Ms. Spencer would benefit from repeat selective nerve root blocks.

At the present time, Ms. Spencer complains of left low back and leg pain. She also reports significant weight loss and depression. Ms. Spencer describes her pain as constant, although she notes that her left leg pain has improved with the selective nerve root blocks. Her pain is increased by walking, standing, sitting and riding in the car. Her pain is decreased by staying in the bed and curling into a fetal position. Present medications include Nucynta 75 mg b.i.d.,

The Rehab Center

2610 East Seventh Street ♦ Charlotte, North Carolina 28204
704/375-8900 ♦ 800-968-6738 ♦ 704/335-7178 (fax)
Page 000158

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Initial Psychological Evaluation
Name - Lettie Spencer
Chart # - 12615
Page 2 of 3

trazodone 100 mg h.s., Klonopin 0.5 mg h.s., Norvasc 10 mg (discontinued) and Neurontin 800 mg t.i.d. Ms. Spencer indicates that she had unsuccessful trials of OxyContin and Cymbalta, which were discontinued due to side effects. Ms. Spencer described her pain on a scale from 0 to 10 as 8 today, with an average pain of 8 and a range of 0-10. She noted that her pain is often a 0 when she wakes up and increases during the first two hours of the day.

SOCIAL:

Ms. Spencer is married and lives with her husband of seven years. She has two children, ages 47 and 49. At the time of her injury, she was employed as a nurse on the dementia unit of NHC, which is a long-term care center. She had worked in this capacity for 13 years at the time of her injury. She expressed interest in returning to work as soon as she is able to do so.

Ms. Spencer reports profound limitation of her function. She estimates she is capable of 1-2 hours of productive activity per day. She estimates that she is in bed for 18 or more hours a day. She is capable of 15-20 minutes of sustained activity. She is able to walk around her home and do light housekeeping. Educationally, Ms. Spencer completed a GED and training to obtain her LPN. She has 30 years' experience in nursing.

EMOTIONAL/COGNITIVE:

Ms. Spencer describes herself as depressed secondary to her chronic pain and associated dysfunction. She indicates that she is no longer active. She struggles with persistent, severe pain. She can no longer do many of the things that she once enjoyed. She has experienced a loss of interest and has become apathetic. She has become increasingly isolated and withdrawn.

Ms. Spencer denied suicidal ideation. She did comment that she has frequently thought that it may be better if she were no longer living. She denied previous psychiatric history or family history of psychiatric illness. She denied increased irritability. Ms. Spencer experiences an episodic sleep disorder involving early and middle insomnia. She receives an average of six hours' sleep per night. Her appetite is decreased. She has lost 35 lbs since her injury. She now weighs 102 lbs. Ms. Spencer indicates that her husband has been variably supportive. She does note that her son stays with her to provide support.

Ms. Spencer complained of the moderate diminution of short-term memory and concentration. She is using compensatory strategies. She attributed her diminished cognitive function to her degree of dysfunction. No specific deficits in cognitive function were noted during the course of today's evaluation.

With regard to substance use, Ms. Spencer drinks one cup of coffee per day. She does not use alcohol. She smokes one-half package of cigarettes per day. She has smoked for 40 years and indicates that she has no interest in quitting.

Ms. Spencer was asked about her goals and expectations for treatment. She indicated she would like to achieve the following:

1. Be less depressed.
2. Improve her motivation.
3. Increase her function and activity.
4. Be less isolated.

Initial Psychological Evaluation
Name - Lettie Spencer
Chart # - 12615
Page 3 of 3

IMPRESSIONS AND RECOMMENDATIONS:

Ms. Spencer is suffering from a major depressive disorder and a pain disorder associated with psychological factors and general medical condition secondary to her industrial injury of 6-22-2011. Thus far, Ms. Spencer's chronic low back and leg pain has been unresponsive to physical therapy, medication management and interventional pain management. With the exception of a recent selective nerve root block, Ms. Spencer's pain has been refractory to treatment thus far. Ms. Spencer has demonstrated a pattern of progressive dysfunction, with her now spending 18-20 hours a day in bed. This has further contributed to a decline in her overall physical status and a worsening of her depression.

At this juncture, Ms. Spencer would benefit from a course of psychotherapy to assist her in reducing her depression and developing more effective strategies for management of her chronic pain. Given the degree of decline in Ms. Spencer's overall function, she will likely require a more comprehensive pain rehabilitation program to achieve substantive improvement in her overall level of function, allowing her to return to gainful employment.

In response to Mr. McCants' inquiries, Ms. Spencer's current depression is the direct consequence of her low back pain associated with her industrial injury of 6-22-2011. Ms. Spencer has not reached maximum medical improvement from a psychological perspective. Whether Ms. Spencer has sustained permanent impairment psychologically will depend upon her response to treatment. Treatment recommendations were mentioned above. At this juncture, I do not believe that Ms. Spencer would be successful in returning to work, given her depression and degree of physical decline.

A conference was held following today's evaluation with Ms. Spencer and Patti Chambers, R.N., Ms. Spencer's medical case manager. Diagnostic impressions and treatment recommendations were discussed.

Thank you for the opportunity to evaluate this pleasant woman. If I can be of further assistance in her care, please do not hesitate to contact me.

Electronically Signed by:

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

WBO:rdh

THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

CLIENT: Lettie Spencer
CHART #: 12615
DATE: 6-3-2013

Ms. Spencer was seen in psychological follow-up today. She reports little change in her status since her last visit. Ms. Spencer was scheduled for today's appointment to discuss treatment options. At the time of her independent psychological evaluation, it was suggested that Ms. Spencer would benefit from participation in a pain rehabilitation program. Dr. Nandurkar, Ms. Spencer's pain management specialist, concurred with this recommendation.

Ms. Spencer indicates she was able to drive to today's appointment, but did so with difficulty. She describes her pain as 9 today on a scale from 0 to 10, with an average pain of 8. She continues to spend most of her time at home. She estimates she is active for 2-3 hours per day. Present medications include Nucynta 75 mg b.i.d., trazodone 100 mg h.s., Klonopin 0.1 mg h.s., Norvasc 5 mg q.d. and Neurontin, recently discontinued secondary to positive response from recent nerve root blocks.

The pain rehabilitation program was discussed at length with Ms. Spencer today. The relevance of the program for her, given her ongoing pain and limited function, was emphasized. Ms. Spencer does not believe that she would be able to tolerate the pain rehabilitation program at this time. She indicated that she believed that with prescription of antidepressant medication by her primary care physician, she could gradually improve her overall level of function. Ms. Spencer was encouraged to discuss potential referral for psychological counseling with her primary physician, as well.

Ms. Spencer continues to require a multifaceted approach to her pain, dysfunction and depression. I continue to believe that the most efficient form of treatment for her would be participation in a rehabilitation-focused pain management program. She was encouraged to discuss this option with Dr. Nandurkar and her primary care physician. Ms. Spencer may be more receptive to additional rehabilitation once her depression is under better control.

Thank you for the opportunity to participate in Ms. Spencer's care. If I can be of further assistance, please do not hesitate to contact me.

Electronically Signed by:

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

WBO:dsh

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THE REHAB CENTER

INCORPORATED

2610 East Seventh Street
Charlotte, NC 28204

704.375.8900 tel/
800.968.6738 toll free
704.335.7178 fax

www.therehabcenter.com

INITIAL PHYSICAL THERAPY EVALUATION

PATIENT: Lettie Spencer
CHART#: 12615
DATE: 8-16-2013
DOB:

SUBJECTIVE:

Patient reports that on June 22, 2011, she was pushing a medication cart while working, and the wheels became caught on a strip on the floor. She states she did not fall but felt a pain in her back. She reports constant lumbar pain that worsens throughout the day. She states that she has mainly left lumbar pain and left lower extremity pain, which she says radiates. She states that the longer she is up, the worse the pain gets. She denies having any paresthesias, but she states that she does have weakness in both lower extremities. She states the pain increases when riding in a car and that she has lost 35 lbs since the injury. She reports that her pain is increased when she stands for 30 minutes or more or sits for 30 minutes or more, and her pain is decreased when she lies on her side with a pillow between her knees or uses pain medication. She reports that nerve blocks have helped with her left lower extremity pain and that she occasionally uses a TENS unit to help with pain. Pain level currently is 7/10. At its worst it is a 10/10 and at its best a 7/10. She reports the pain delays her ability to fall asleep and interrupts her sleep at night, occasionally, but that she gets 6-8 hours of sleep per night.

Prior Functional Level: She worked as an LPN at NHC Parklane in the dementia care unit. She reports working 40 or more hours per week. She states that she has worked there for 13 years at regular duty. Her preinjury avocational interests included gardening, watching movies and going to historical places.

Current Functional Level: She reports that she is sometimes in the bed for 18 or more hours per day. She states that she lives in a one-level home with three steps to enter, that her grandson helps her and that she her son and her grandson live with her. She states her grandson mows the lawn, vacuums, shampoos the carpet, and helps with cooking, dishwashing and bathing her dogs. She states that she is married, but her husband is a long-distance truck driver and is at the home infrequently.

Patient's Goals: Her goals include wanting to return to work.

PAST MEDICAL/PAST SURGICAL HISTORY:

1. Lumbar strain, 6-22-2011.
2. Lumbar spondylosis with L4-L5 disc protrusion.
3. Depression.
4. Hypertension.
5. Hyperthyroidism.

OBJECTIVE:

Observation: The patient is a right-hand dominant female who presents with a lumbar-flexed posture. She frequently changes positions throughout the evaluation, including getting down into a crouching position on one knee on the floor. She is wearing a TLSO. She requires increasing time to complete any transitional movements.

Active Range of Motion:

Lumbar:	Flexion	40% with pain
	Extension	40% with pain
	Right lateral flexion	50% with pain
	Left lateral flexion	40% with pain

Strength:

Lumbar:	Flexion	4-/5
	Extension	3+/5 with pain
	Right lateral flexion	3+/5 with pain
	Left lateral flexion	3+/5 with pain

Reflexes: 2+ and symmetrical in bilateral patellar tendons.

Palpation: Patient has severely decreased muscular extensibility with palpation of paraspinals L2-L3, L3-L4, L4-L5 and L5-S1. Patient has guarding with attempts to perform any palpation and reports moderate tenderness. Sensation is intact to light touch in lumbar region and bilateral lower extremities.

Balance: Single-limb stance on the right is 6 seconds and on the left is 5 seconds. She is unable to heel- and toe-walk any distances without loss of balance.

Special Testing: SLR testing presents with hamstring tightness in bilateral lower extremities.

ASSESSMENT:

Patient is a right-hand-dominant female who sustained a work-related injury. She is a good candidate for the functional restoration program. She presents with the following deficits:

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

GOALS (To Be Met in 20 Days):

1. Patient to report a reduction in verbal and physical indicators of pain.
2. Patient to complete 30 minutes of aerobic activity without breaks for improved endurance and ease with daily activities.

3. Patient to perform activities to increase lumbar active range of motion to within functional limits for improved mobility with lifting, carrying and pushing/pulling 10 lbs or more.
4. Patient to perform activities to increase lumbar strength to within functional limits for improved stability with reaching, carrying and pushing/pulling 10 lbs or more.
5. Patient to perform activities to increase bilateral lower extremity strength to within functional limits for improved stability with ambulation, balance and transitional movements.
6. Patient to perform activities to increase core strength, to include proper transversus abdominus activation, for improved stability with reaching, carrying and pushing/pulling 10 lbs or more.
7. Patient to maintain neutral spine positioning and demonstrate proper body mechanics with lifting, carrying and pushing/pulling daily activities and transitional movements.
8. Patient to demonstrate improved positional tolerances: sitting for 60 minutes, standing for 30 minutes and walking for 20-30 minutes.
9. Patient to ambulate community distances over even/uneven surfaces without VCs for proper gait pattern and normal cadence.
10. Patient to perform dynamic standing balance activities without loss of balance for safety with navigation over even/uneven and inclining/declining surfaces.
11. Patient to be independent with her home exercise program and flare-up management program.

PLAN:

Patient to begin the 20-day functional restoration program, with emphasis on return to independence with daily functional activities and gainful employment, utilizing the goals as listed above.

Electronically Signed by:

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

2610 East Seventh Street
Charlotte, NC 28204

704.375.8900 tel
800.960.6738 toll free
704.335.7178 fax

www.therehabcenter.com

INITIAL PHYSICAL MEDICINE AND REHABILITATION EVALUATION

PATIENT: Lettie Spencer
CHART #: 12615
DATE: 8-16-2013

HISTORY OF PRESENT ILLNESS:

Ms. Spencer is a year-old right-handed female referred for a physical therapy and pain management evaluation. She says her problem started on June 22, 2011, when she was pushing a med cart. She said that it got stuck, and when she had to push a little harder, she felt a sharp pain in her back. She says she has been out of work now for almost two years. She says the pain has persisted. She describes her pain as throbbing, and she rates it a 6. The pain is in her lower back in the midportion. Occasionally, she gets a sharp, shooting pain down her left buttock and thigh. This is usually brief, but it does occur on a daily basis. She says the left leg feels weak. It does not feel numb. She denies any bowel or bladder incontinence. She says that standing or sitting for long periods of time, 30 minutes or more, makes it worse. She says it feels better for her to bend forward. She says she developed depression after her injury due to her pain and dysfunction. She said she never had depression before. She denies any thoughts of suicide, but she says she is often tearful. She says she has tried numerous injections and procedures, and only one of them helped, but it was temporary and only lasted about three days. She says the pain gets worse as the day progresses. She says that riding in a car makes it worse. She says the pain is severe, and it comes and goes. She says she does not normally change the way she washes or dresses herself, even though it causes some pain. She said she can lift only very light weights. She says pain prevents her from walking long distances. She says pain prevents her from sitting for more than an hour. She says pain prevents her from standing for more than half an hour. She says she gets pain in bed, but it does not prevent her from sleeping well. She says pain prevents her from participating in more energetic activities. She said she can perform most of her job and homemaking duties, but pain prevents her from performing more physically stressful activities.

REVIEW OF MEDICAL RECORDS:

Extensive records are included, and these are reviewed. A cover letter to Dr. O'Malley is reviewed from Attorney McCants. Dr. O'Malley's psychological evaluation is reviewed. He saw her on 3-7-2013 and noted she was suffering from a major depressive disorder and a pain disorder associated with psychological factors and a general medical condition secondary to her industrial injury. He recommended psychotherapy. He also felt she would require a more comprehensive pain rehabilitation program. He felt that her depression was a direct consequence of her low back pain. A deposition of William Lehman, M.D., is reviewed from January 9, 2013. His treatment of Ms. Spencer was discussed. Her imaging studies were reviewed. Work restrictions were reviewed. Dr. Lehman recommended an epidural steroid injection. They also discussed a spinal cord stimulator in the deposition. Dr. Lehman did not feel that she was a surgical candidate. The spinal cord stimulator implant was discussed. Dr. Lehman also noted that Ms. Spencer was depressed. It was noted that Dr. Dyer did not feel that she was a surgical candidate. Dr. Lehman also said that he felt Ms. Spencer was capable of performing sit-down work only. It was hoped that if she could get back to some type of work, it would help her both

physically and emotionally. Dr. Lehman did think she would have some permanent impairment. He discussed a possible rating of 5-8% of the whole person. Dr. Lehman did feel that the accident aggravated her degenerative conditions or cause her back pain or radicular symptoms. He also felt that the chronic pain at least contributed to her depression. He felt that it would be beneficial for her to be evaluated by a psychiatric professional to treat her depression. A CT myelogram report dated 9-11-2012 is reviewed. The L4-5 level was noted to show mild central canal stenosis related to annular disc bulging and facet arthropathy, with an AP diameter of the spinal canal of 9 mm at the area of maximum pathology. Notes are reviewed from Springs Memorial Hospital, where the myelogram was performed. Notes are reviewed from Dr. Lehman. She was given Nucynta for pain. He reviewed her work restrictions. He recommended a nerve block. He gave her a trial of Neurontin. It was noted that she had lost a lot of weight. Her Neurontin was increased. A trial of a spinal cord dorsal column stimulator was discussed, as well. Physical therapy notes are reviewed. Notes are reviewed from Dr. Owens with South Carolina Pain Associates. She tried OxyContin. She tried hydrocodone. She had a sacroiliac joint injection, but it was noted that the benefit was short-lived. Notes are reviewed from Dr. Drye, who saw her on 8-31-2011. He is with Columbia Neurosurgical Associates. He noted that her spine appeared very intact and relatively healthy and appeared younger than her stated age. He felt that she had a severe lumbar strain. He did not feel that she was a surgical candidate. He recommended physical therapy. An MRI on 7-22-2011 showed mild degenerative disc disease of the lumbar spine, most prominent at L4-5. There was a broad-based disc bulge at L4-5. It was noted that there was a component of inferior neural foraminal narrowing bilaterally as well as a component of lateral recess narrowing, left greater than right. She had some hypertrophic facet change and ligamentum flavum thickening. A TENS unit was recommended. Notes are reviewed from Carolina Occupational Healthcare. She tried tramadol. She had physical therapy. She was referred to orthopedics. She also tried cyclobenzaprine. She also tried a steroid taper. I also reviewed cover letters and notes from Dr. O'Malley.

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

ALLERGIES: Penicillin, codeine and Demerol.

PAST MEDICAL HISTORY: She reports a history of bronchitis and hypertension and a history of a hiatal hernia. She also has a history of hyperparathyroidism.

SOCIAL HISTORY: She lives in Richburg, South Carolina with her spouse, her son and her grandson. She worked as a nurse. She does not drink alcohol. She denies the use of illegal drugs. She denies any history of alcohol abuse or substance abuse. She reports an eighth grade education but says she has a GED. She smokes half a pack of cigarettes per day.

FAMILY HISTORY: Positive for cancer in her brother and stroke in her mother. Her mother and father had heart disease.

REVIEW OF SYSTEMS: Negative for exertional chest pains or palpitations. She said she had some changes in her heartbeat and underwent a cardiac evaluation, but it was negative and she does not have any cardiac restrictions. She reports that she lost about 30 lbs but has recently gained about 7 lbs. She attributes it to a loss of appetite after her injury.

PHYSICAL EXAMINATION

This is a pleasant lady with a very flat affect. Her weight is 107 lbs. Her blood pressure is 130/88. Her heart has a regular rate and rhythm. Her lungs are clear. There are no carotid bruits. She has good cervical range of motion. She sits with a markedly forward flexed posture. At times, she is

Initial Physical Medicine and Rehabilitation Evaluation

Name - Lettie Spencer

Chart # - 12615

Page 3 of 3

bent over so far that her spine is parallel to the ground. She is able to extend to neutral while seated and while standing. She has mild lumbar tenderness in the paraspinals, more on the left than on the right, but is not tender over the spine. There is no SI tenderness. Straight leg raising is negative for radicular pain. Patrick's test slightly increases her pain. Her reflexes are 2+ and symmetrical. Her sensation is intact to light touch, pinprick, vibration and temperature. Her strength tests 5/5 throughout. Her gait is slightly slow and mildly antalgic. There is slight guarding with her movements. Her respirations are normal. Her speech is fluent.

IMPRESSION:

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

PLAN:

I discussed Ms. Spencer's case with Dee Payne, P.T., and Brian O'Malley, Ph.D. We then held a conference with Ms. Spencer and her case manager, Patti Chambers, R.N. We recommended a comprehensive pain rehabilitation program. We reviewed with her realistic expectations and goals. The emphasis will be on functional restoration and appropriate pain management strategies. We also talked about the role that depression can play in chronic pain. She is going to continue to get her medications from her treating physician. She was told to call if she has any further questions or concerns.

Electronically Signed by:

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

TKC:dsb

cc: William Lehman, M.D. - Fax: (803) 329-2611



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 1

Date: 8-20-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

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

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

- ☐ Rounds
☐ Team Conference
☐ Individual Psychotherapy

Comments:

Electronically Signed by:

W. Brian O'Malley, Ph.D.

Daily Progress Note



Name: Lettie Spencer MRN: 12815 Tx Day: 1 Date: 8/20/2013
 DOB: Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program Attendance: Full Day

Notes

Mrs. Spencer began program orientation today. She viewed the lumbar stabilization video and began initial program instruction. She completed the MMP1. Began initial instruction on postural correction with emphasis on limiting lumbar flexion posture and B scapular protraction. DP

Patient began bike activity and demonstrated forward flexed position. She was requested to try to maintain more upright posture to decrease the strain on her back. She stated that it "hurts my tailbone". We added a pillow to her seat, which helped minimally. Following this activity she is noted to perform a full squat and then into a half kneel for approximately 10 seconds. She then arose to standing independently. While patient is standing and talking with the therapist, she is noted to assume a forward flexed position in her trunk. /rh

Patient states that at home, she sits in a recliner, which is the most comfortable position for her. When riding in the car or when sitting any other chair, she sits on a pillow. /rh

Prior to Relaxation class, pt stated: "I need to lie down." She was encouraged to participate in class and use ice as needed. She stated that she would try to complete the class, but refused ice, stating that it has not been beneficial. Pt reported continued lumbar pain after class and was taken to a treatment room at 3:10 and assumed a left side-lying position with a pillow between her knees. Upon assessment at 3:30, she stated she was beginning to feel better. At 3:45, she said that being able to stay in that position for that time was helpful and returned to the PT gym. She appeared more lucid after the session and began to write down the activities she had forgotten to document in the midst of the flare-up. DP

Physical Therapy - Goal: Improve Physical Condition

Bicycle

Minutes: 9 MPH: Distance:

Balance Training

Minutes: 2 Balance Type Dynamic Position: Standing Notes: toe taps on steps

Standing

Minutes: 15 Notes: Name/MRN/Pegboard

Physical Therapy - Goal: Improve Functional Status

Patient Education: Dynamic Lumbar Stabilization Video

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

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

Daily Progress Note



Name: Patricia "Dawne" Johnson MRN: 12837 Tx Day: Date: 8/20/2013
 DOB: Age At Visit: Sex: F
 Type of Program: Comprehensive Rehabilitation Program Attendance Absent

Notes

Physical Therapy - Goal: Improve Physical Condition

Physical Therapy - Goal: Improve Functional Status

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

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 1

Date: 8-20-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. I oriented her to the program. I reviewed with her treatment plans and goals. We discussed the policies and procedures of the facility. Her affect is brighter. She appears motivated. I told her to notify the therapists if she has difficulty with any of her activities. We will also pace her activities carefully. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettie Spencer **MRN:** 12816 **Tx Day:** 2 **Date:** 8/21/2013
DOB: **Age At Visit:** **Sex:** F
Type of Program: Comprehensive Rehabilitation Program **Attendance:** Full Day

Notes

Patient states that she is feeling a little better this morning. She states that mornings are always better, though. She is reminded to always communicate with the therapists if any of her activities provoke increased symptoms. /rh

Pt. attempted to participate in core stabilization class but was unable to secondary to increased lumbar pain. Pt. was observed lying on R side with pillow between her knees for the remainder of class./ms

Additional instruction given for balance activities. Pt. began both forward tandem walking and side stepping 3 times. Noted increased difficulty and LOB when performing forward tandem walking between the two mat tables. Pt. stated it was much easier performing side-stepping leading with R LE. Pt. reported afterwards she began experiencing increased low back pain./ms

Patient is noted to be standing in a forward flexed position while performing standing upper body exercises. When asked, she stated that her pain was becoming severe. She was requested to perform her exercises in sitting if that would help manage her pain. She stated that sitting was too uncomfortable as well. She is requested to assume a side lying position and begin with clam shells and UE stretching. We also discussed pacing so that she can get through the day without flaring up her symptoms. Ice pack is recommended to patient but she states that she cannot tolerate ice. /rh

Initial instruction provided for individual exercises. Pt. has just finished lecture and had asked if she would be able to perform the exercises in standing. Pt. was reminded to vary her positioning if possible during the day. Pt. was able to maintain upright posture initially but later was observed in forward flexed posture. Exercises were modified and were completed in side lying. Pt. was appreciative and reported relief/ms

Pt. stated while completing side-lying arm circles that she was having difficulty allowing her back muscle to relax. Pt. unsure as to why she is experiencing the increased muscle tension/ms

Pt. observed during various times during the day assuming a crouched position, with her knees up to her chest. Pt. reports that she "could sit like this all day." Pt. reported during lecture she sat in the chair with her knees up to her chest as this is very comfortable/ms

Pt. instructed on postural correction to help eliminate scapular protraction and lumbar flexion posture. She was given tactile cues to minimize B UT elevation and superior positioning of B scapulae. Will add a postural segment to the pt's schedule. DP

Patient stated at the end of the day that she felt better than yesterday and realizes that pacing and practicing flare up management activities really do help. /rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Required Verbal Cueing, Initial instruction - 3 exercises completed

Walking

Minutes: 15 Distance:

Balance Training

Minutes: 20 Balance Type Dynamic Position: Standing Notes:

Standing

Minutes: 14 Notes: Pegboard

Minutes: 10 Notes: Couplings

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise

Wand Overhead

Wall Claps

Feeling

Pulleys

Up & Down

Minutes

Description

3 x 3 sec

6

5:30

6

Daily Progress Note

Page 1 of 2

Page 000172

ROA 310

Name: Lettie Spencer

MRN: 12615

Tx Day: 2

Date: 8/21/2013

IB.

Age At Visit:

Sex: F

BTE

Min
6/6/6

Attachment Description
122

Position
Sitting

Height Torque
21 8.0

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

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



VOCATIONAL GROUP NOTE

NAME: Lettie Spencer
CHART #: 12615
DAY OF TREATMENT: 3
DATE: 8-22-2013

VOCATIONAL GROUP:

The focus of the vocational group today was exploring tips that will lead to being hired. A video was viewed by the group that offered advice from actual employers on what job seekers can do before, during, and after job interviews to enhance hiring opportunities. A group discussion followed the video.

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

Participation: Patient interacted consistently and appropriately and integrated material.

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

Comments: N/A

Electronically Signed By:

Sabrena Bagby, M. Ed., C.R.C., C.C.M.
Vocational Specialist

CONFIDENTIAL

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: 3 Date: 8/22/2013
 DOB: Age At Visit: Sex: F
Type of Program: Comprehensive Rehabilitation Program Attendance Full Day

Notes

BP @ 8:30 am 132/74 mm Hg

Patient states that on the drive in today, her driver had to put on the brakes suddenly and she was thrust forward. She reports increased back pain today. She is demonstrating a more forward flexed posture in standing and walking./rh

Rounds completed with pt and program team. She is demonstrating good effort with initial program activities despite mechanical and postural indicators of pain. She states the incident with the driver as listed above has caused increased lumbar pain. Pt was taken to a treatment room and given ice for her lumbar region x 20 minutes. She states that the ice was beneficial in helping to decrease her lumbar pain exacerbation. Will continue to work on the goals of postural correction, proper bed positioning, body mechanics training and gradual increases in endurance activity duration. DP

Initial instructions began with weight training activities. Pt. required frequent rest breaks to change positions and stretch out lumbar back. Attempted exercises in seated and standing position but pt. continues to experience "lightening like" muscle spasm and pain. Pt. attempted to correct forward flexed posture but only was able to maintain neutral spine for approximately 5 seconds before resuming forward flexion. LE exercises with theraband were initiated with frequent rest breaks required for positional changes/ms

Patient is noted to be standing with a flexed forward position. She states that she has not been able to do her side-lying exercises today and her pain is still severe from this morning. She is requested to lie in side-lying for the last session of the day. Patient is also requested to bring her TENS unit tomorrow. She states that the TENS really does help her pain./rh

Patient participates in tal chl exercises in side lying position./rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Spinal Stabilization: 25 min. supine, standing

Walking

Minutes: 30 Distance:

Weight Training: Required Verbal Cueing for Initial instruction: 3 exercises completed - 1lb free weight; red theraband

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Wall chain		6	
Pulley		7	
Kneeling Tall		6	

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

Signatory Name	primaryFlag	Signature
Ryanne Hitzeman, P.T.	☐	<i>Ryanne Hitzeman, P.T.</i>
	☐	<i>Sue Paym, P.T., M.S.</i>

Name: Lettie Spencer

MRN: 12615

Tx Day: 3

Date: 8/22/2013

DOB:

Age At Visit:

Sex: F

<i>Bill Payne, P.T., MS.</i>		
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 3

Date: 8-22-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Team rounds were held today. We reviewed team conference treatment plans and goals. We discussed medical, psychological, physical therapy and vocational issues. Lettie is off to a good start. Her effort is excellent. She participates well in the groups and lectures and in the gym. We discussed a flare-up plan. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettie Spencer
DOB:

MRN: 12615
Age At Visit:

Tx Day: 4
Sex: F

Date: 8/23/2013

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

BP @ 8:39 am 140/66 mm Hg

Patient states that her back is still flared up from yesterday's ride to the clinic. She brings her TENS unit in today. She states that it does not give her a "deep enough" current to provide relief. We used one of the clinic TENS today, and she reported greater pain alleviation. We used 2 channel, 4 electrode placement, amplitude to patient tolerance. /rh

TUG Test: 22:50 seconds

Pt was taken to a treatment room twice today (2:00-2:20, 3:25-3:55) per o/c lumbar pain flare-ups to use ice on the lumbar region in a left side-lying position with a pillow between her knees. She reported pain relief after utilization both times. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Spinal Stabilization: 25 min. supine, standing

Weight Training: Required Verbal Cueing for additional instruction - 6 exercises completed - 1lb free weight, yellow theraband

Modalities

Notes: Modality: Placement: Position:

Balance Training

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

Standing

Minutes: 15/5 Notes: standing, walking, pegboard

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Wand Overhead	3		30 second hold
Kneeling Tall		6	

BTE

Min	Attachment Description	Position	Height	Torque
8	122/UBE	Sitting	212.0	

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

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

Name: Lettie Spencer

MRN: 12615

Tx Day: 4

Date: 8/23/2013

IB:

Age At Visit:

Sex: F

Rayanne Higman, PT

Marisa T. Sheppard, LPTA



Marisa T. Sheppard, LPTA



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 4

Date: 8-23-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

- ☒ Learning and Pain Behavior: Principles of learning theory were presented and explained in this group discussion, with applications to pain behavior and pain management. Principles of reinforcement, extinction and punishment, as well as schedules of reinforcement, were presented in order to demonstrate the ways in which behavior is shaped by the environment and the responses of others around us. We discussed the ways in which this can lead to shaping and increasing pain behavior, but also how knowledge of these principles can allow patients to alter their environments so as to facilitate improved functional behavior while diminishing pain behaviors.

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

Electronically Signed by:

W. Brian O'Malley, Ph.D.



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 4

Date: 8-23-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

☒ Rounds

- ☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says she is feeling fairly fatigued and tired, but she says she can tell that she is getting stronger. She says that, yesterday, when she was driven to the clinic, the driver had to slam on the brakes and it jerked her back. She says that she thinks this aggravated her back pain, but she thinks she will be fine. She applied ice. She does feel that she is having a little more back pain from this incident, but there is no change neurologically. There is no spasm. Her effort has been excellent. She participates well in the groups and lectures. We will continue with our plan of care. I encouraged her to follow her exercise regimen over the weekend.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: LITTLE Spencer MRN: 12815 Tx Day: 5 Date: 8/26/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program Attendance Full Day

Notes

BP @ 8:34 135/85 mm Hg

Verbal cueing given for proper performance of wand over head activities. Pt was observed performing AAROM shoulder flexion multiple times. Pt. was instructed to utilize a timer and attempt to hold the wand for 30 seconds and then relax and repeat as previously completed. /ms

Dr. Carlton states he wants the BTE maneuvers discontinued per pt's o/o cervical and L UT pain exacerbation. The activity was taken off the board. DP

Pt o/o lumbar pain and requested a TENS unit. The electrodes were placed as listed below. DP

Functional lifting tasks initiated with pt. requiring cueing for maintaining upright posture as repetitions progressed. Pt. also noted to demonstrate slight lurch to the right while completing level lifting and 1 hand carry with pt. stating she was getting tired./ms

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: 3 exercise completed

Spinal Stabilization: 25 min. supine, standing, sidelying

Light Training: Demonstrated Good Technique. 2 exercises completed 1lb free weight

Modalities

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

Balance Training

Minutes: 3 mins Balance Type Dynamic Position: Standing Notes: red disc
 Minutes: 6x Balance Type Dynamic Position: Standing Notes: tandem gait on blue foam beam
 Minutes: 6x Balance Type Dynamic Position: Standing Notes: side stepping on blue foam beam
 Minutes: 6x Balance Type Dynamic Position: Standing Notes: tandem gait
 Minutes: 10x Balance Type Dynamic Position: Standing Notes: toe touch on step

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	9	3
1 Hand Carry	3	3
Push/Pull Cart	25	2

Circuit

Exercise	Up & Down	Minutes	Description
Wand Overhead	3		30 second hold
Wall Clips		6	
Kneeling Tall		6.5	
Pulleys		7	

BTE

Attachment Description	Position	Height	Torque
122/UBE	Sitting	21	3.0

Daily Progress Note

Page 1 of 2

Name: Lettie Spencer

MRN: 12615

Tx Day: 5

Date: 8/26/2013

OB: [illegible]

Age At Visit: [illegible]

Sex: F

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



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Little Spencer

Chart No: 12615

Days Tx: 5

Date: 8-26-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

☒ Resistance/Interpersonal Influence: This group lecture was designed to educate patients about the concept of resistance to change and to improve their receptivity to treatment and rehabilitation. Issues pertaining to perceptions of expertise, trustworthiness and similarity as they relate to patient experiences with healthcare providers, resultant compliance with treatment and treatment outcomes were addressed.

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

Electronically Signed by:

W. Brian O'Malley, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 5

Date: 8-26-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in good spirits. She said she had an uneventful weekend. She has been working on the BTE and says it is making her wrist and shoulder a little bit sore, so I told her to discontinue this. I also discussed this with her physical therapist. She says she is trying to cut back on the Nucynta, and did so over the weekend. Mentally, she says, she is better, and it is helping her to be around other people. She says she is having fatigue, especially at the end of the day, and I explained to her that this is normal but to let us know if she has any problems with any of the activities. There is no change neurologically in her exam. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: 6 Date: 8/27/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

BP @ 8:34 am 138/68 mm Hg

Patient introduced to "position of comfort" (i.e. supine with hips and knees in 90 degrees) which patient reported is comfortable for her back. She is begun on calf presses, hip rolls, pelvic tilts, and AAROM for bilateral shoulders using dowel. She demonstrated good technique with no increased discomfort. She is advised to assume this position every day in order to unweight her spine and perform spine stabilization in a more appropriate position. She is agreeable./rh

Pt observed pulling a chair across the room while performing retro-ambulation. She was told that a staff member could move the chair instead. She then said: "I can handle it. This gives me a chance to work on my backwards walking." She was able to complete the activity with SPV, no LOB. DP

Pt. stated during lunch that she feels much better after assuming supine 90/90 position with B LE supported on green physio ball. Pt. is shocked that it made her back feel this good. Pt. reports she is going to purchase one this weekend/mis

Pt. commended for remembering to utilize the green physio ball during core stabilization. Pt. usually completes the class in side-lying. Pt. was able to complete most exercises with small modification/mis

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Core Stabilization: 25 min. supine, standing

Balance Training

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

Standing

Minutes: 15/5 Notes: standing/walking/pags

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Overhead Activities			Wand, 2 x 30 sec
Wall Clips		6	
Wand overhead	2		30 second hold
Tail Kneeling		6:43	

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

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

Name: Lettice Spencer

MRN: 12815

Tx Day: 6

Date: 8/27/2013

B:

Age At Visit:

Sex: F

Marisa T. Sheppard, LPTA



Marisa T. Sheppard, LPTA

THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

CLIENT: Lettie Spencer
CHART #: 12615
DATE: 8-27-2013

Ms. Spencer was seen in individual psychotherapy today. She indicates that she is adjusting well to the functional restoration program. She indicates that the activities involved in the program have been challenging, but she believes that she is doing better overall.

Ms. Spencer had questions about her current pain medication. She is taking Nucynta ER 75 mg. She was encouraged to discuss her questions and concerns with Dr. Carlton. An overall goal of reducing her medication intake was discussed with her.

Ms. Spencer has demonstrated a brightening of her mood and affect. Her participation in groups has been excellent.

Electronically Signed by:

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

WBO:dsh



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 6

Date: 8-27-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

☒ Rounds

- ☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says she is doing better today. I reexamined her, and there is no change neurologically. She says the ice helps her at the end of the day; that is when she has more of her pain. She does have some diffuse lumbar tenderness but no palpable spasm. I talked to her about her thyroid problems, and she said her TSH level was normal about two weeks ago. She is not doing the BTE today, and her shoulder and wrist are better. She got back a little bit on the Nucynta over the weekend. She said usually, however, she needs 3 a day. She says she takes the trazodone and the Klonopin for her restless leg syndrome. She says that when she flexes forward, she feels some improvement in her back, but she also gets the same effect when she flexes her hips. We reviewed her mechanics and talked about the importance of proper body mechanics. We will continue with our plan of treatment.

Electronically Signed by:

T. Kern Carlton, III, MD



THE REHAB CENTER
INCORPORATED

VOCATIONAL GROUP NOTE

NAME: Lettie Spencer
CHART #: 12615
DAY OF TREATMENT: 7
DATE: 8-28-2013

VOCATIONAL GROUP:

The focus of the vocational group today was skill identification. We discussed how individuals often limit their perception of skills to job specific or job content skills. I explained the concept of transferable skills and demonstrated ways to identify them.

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

Participation: Patient interacted consistently and appropriately and integrated material.

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

Comments: N/A

Electronically Signed By:

Sabrina Bagby, M. Ed., C.R.C., C.C.M.
Vocational Specialist

Daily Progress Note



Name: LITTLE Spencer MRN: 12615 Tx Day: 7 Date: 8/28/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

BP @ 8:32 am 132/70 mm Hg

Pt continues to be willing to add new activities without increased c/o. She is slow but deliberate in her actions. She was able to perform/progress her spinal stabilization exercises today in supine with a large physoball, perform her bridging without increased pain sx noted.

Pt. observed completing balance activities demonstrating improved upright posture when completing tandem walking. Pt. utilized two fingers touching the wall for balance. No LOB noted. Pt. movements are slow and she continues to require numerous rest breaks for lumbar stretching/ms

Functional lifting activities with emphasis on body mechanics was progressed as listed below. Level lifting was increased to 4 lbs without c/o increased pain. She exhibited lumbar extension when beginning 1-hand carry and level lifting. Inconsistent heel to toe excursion was displayed with 1-hand carry maneuvers with cueing required for proper B LE initial contact sequencing. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Visual Exercises: Demonstrated Good Technique. Pt completed 7 exercises

Spinal Stabilization: 25 min. supine

Walking

Minutes: 15 Distance:

Weight Training: Performed 1 exercises

Balance Training

Minutes: 15 Balance Type Dynamic Position: Standing Notes: beginner level activities

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	4	2
1 Hand Carry	3	2/2
Push Cart	30	2

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	5x		
Wall Claps		6:30	
Kneeling Half		6:30	

Added stair climbing today with no problems noted and a step over pattern.

Patient Education: Postural Reeducation

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

Name: Lettle Spencer MRN: 12615 Tx Day: 7 Date: 8/28/2013
JB: Age At Visit: Sex: F

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

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: 8 Date: 8/29/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

Patient states that she went to bed last night at 7:30 but didn't fall asleep until 11:00. She states that her back was bothering her, and she feels that the TENS unit was "irritating" her back. She declines TENS during morning session. However, following lunch, she requested therapist to apply TENS. TENS applied, 2 channel, 4 electrode placement to LB, amplitude to patient tolerance. /rh

BP @ 8:40 am 132/74 mm Hg

Pt. c/o of increased low back pain this morning. Pt. requested PTA to examine her back for palpable muscle spasm as the pt. stated she felt like her muscles were tight and "jumping." Examined pt. back and noted palpable spasm but increased tightness in lumbar region. Pt. was required to begin circuit activities which were modified and pt. performed supine individual exercises focusing on lumbar stretches as well as physio ball exercises with hips/knees in 90 degrees while lying on a ice pack/ms

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 8 exercises completed

Spinal Stabilization: 25 min. supine, standing

Walking

Minutes: 15 Distance:

Balance Training

Minutes: 15 Balance Type Dynamic Position: Standing Notes: beginner level activities

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercises	Up & Down	Minutes	Description
Wall Clips		6	
Kneeling Tall		6	

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

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



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 8

Date: 8-29-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says that she has been having more pain today. She said she did some stair climbing yesterday in the gym and thinks this may have aggravated her symptoms. She has not had any neurological changes, and on exam there is no neurological change. She does have a little more tenderness. She has tried ice. She has been using her TENS unit. She is also taking her pain medicine. She requested an injection, and after obtaining informed consent and prepping the area with alcohol, I injected 30 mg of Toradol IM, which she tolerated well. I reviewed with her a flare-up plan, and we will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: LITTLE Spencer MRN: 12615 Tx Day: 9 Date: 8/30/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

Patient states that the Tardol Injection she received yesterday afternoon was helpful. She states "I went to bed at 7:30 last night and slept well". She states that she having some difficulty "getting started" this morning. She states that she can use the TENS unit only on a limited basis./rh

Patient arrives to the clinic wearing a back brace. She states that she wears it for the ride to the clinic in the morning because riding in a car really increases her back pain./rh

BP @ 8:41 am 130/64 mm Hg

Pt reports feeling "tired" today; Pt asked for asst to apply "pain patch" just given to her by Dr. Carlton. Pt spending much of am walking in gym w/ ice pack to low back. Pt shortened wt trng due to o/o "cramping" L lower leg; requested to "walk". / JB

Pt states: "I am physically exhausted." Discussed flare-up management with the pt. She refused TENS utilization, stating that it sometimes irritates her muscles, but is using ice. She says that nothing is really helping with her pain and that she "is just tired." Dr. Carlton was notified. DP

Per Dr. Carlton's request, STM performed on patient. We concentrated on low back, L piriformis. Patient tolerated only side-lying position at first, but we transitioned to prone on 2 pillows, and she tolerated that position for 5 minutes. Gentle LP traction and L LE long axis traction performed with patient in prone. Following session, patient stated "this is how I feel in the morning...more upright and less pain." Discussed with patient how her forward flexed posture in standing and walking tend to put strain on her spine and create the tightness in her back muscles secondary to an anterior center of gravity. We discussed trying to assume a prone on pillows position once per day. She is agreeable./rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: 6 exercises completed

Weight Training: 1 exercise completed - 11lb free weight

Balance Training

Minutes: 10 Balance Type Dynamic Position: Standing Notes: beginner level activities

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	4	3/3
1 Hand Carry	4	2
Push	35	3

Push - 13.2

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

Signatory Name	primaryFlag	Signature
Rayanne Hitzeman, P.T.	☐	<i>Rayanne Hitzeman, PT</i>

Name: Lettie Spencer

MRN: 12615

Tx Day: 9

Date: 8/30/2013

B:

Age At Vist:

Sex: F

Dee Payne, P.T., M.S.	☐	<i>Dee Payne, P.T., M.S.</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>
Jo Anne Baucom, LPTA	☐	<i>Jo Anne Baucom, LPTA</i>



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 9

Date: 8-30-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says she is completely exhausted. She said the injection helped her, and she slept well last night. She is not sure if she is coming down with an upper respiratory infection, but she says she has had a little bit of congestion and cough. She is afebrile. She says she has been having some spasms. I did reexamine her, and she is tender in her paraspinals. I talked to her about different approaches for the spasms. She requested a prescription for a muscle relaxant. We did not have any samples of a muscle relaxant, so I gave her a sample of a Lidoderm patch and instructed her in the appropriate application of this. We will also consider a trial of cyclobenzaprine if the spasms persist.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettle Spencer MRN: 12615 Tx Day: 10 Date: 9/3/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

PT reported that she experienced increased low back pain on Saturday. PT stated she didn't get much done at home on Saturday but was able to complete some light grocery shopping on Monday/mo

BP @ 8:30 am 125/65 mm Hg

Patient stated that the soft tissue mobilization on Friday was helpful for her. She states that she also tried lying prone over 2 pillows, as we discussed on Friday. She is walking more upright during morning session today./rh

Patient asked to try TM activity. As patient was ready to go on break, deferred activity./MP

Instructed pt. on use of TM. Pt. was reminded to hold onto either set of handlebars. Pt. tolerated approximately 10 seconds of the TM at .5 mph reporting that this was too fast for her to walk without increased low back pain. Pt. is observed demonstrating decreased B LE step length. Pt. dismounted the TM and stride length increased./ms

TENS application to lumbosacral area with 2 channels. Amplitude to patient tolerance./MP

Noted lumbar flexion and posterior pelvic tilt with pull/pull activity. Patient cued to hold spinal neutral./MP

Patient reported of cramps in calf after balance activity on balance beam. Also noted labored gait and stair climbing. Patient was asked to perform therapeutic exercises on the mat./MP

Yocal Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 6 exercises completed

Spinal Stabilization: 25 min. supine, side lying, standing

Weight Training: 3 exercises completed.

Balance Training

Minutes: 20 Balance Type Dynamic Position: Standing Notes: beginner level activities. Progressed with less UE support during exercises.

Standing

Minutes: 10 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	4	3
1 Hand Carry	?	5/R
Push/Pull Sled	35	6

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	2		
Overhead Activities		2:30	
Kneeling Tall		6	

Name: Lettie Spencer

MRN: 12615

Tx Day: 10

Date: 9/3/2013

DOB:

Age At Visit:

Sex: F

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



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 10

Date: 9-3-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. I called in some cyclobenzaprine for her over the weekend, and she did get this prescription and did start taking it. Her movements are more fluid. She still has an antalgic gait. She did get some manual therapy on Friday. She is using the TENS unit. We will continue with our plan of treatment.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: Date: 9/4/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program Attendance Absent

Notes

Physical Therapy - Goal: Improve Physical Condition

Physical Therapy - Goal: Improve Functional Status

Signatory Name	primaryFlag	Signature
Mamta Patel, P.T.	☐	<i>Mamta Patel, P.T.</i>
Rayanne Hitzeman, P.T.	☐	<i>Rayanne Hitzeman, P.T.</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>
Kim Dunn, P.T.	☐	<i>Kim Dunn, P.T.</i>



VOCATIONAL GROUP NOTE

NAME: Lettie Spencer
CHART #: 12615
DAY OF TREATMENT: 11
DATE: 9-5-2013

VOCATIONAL GROUP:

The focus of the vocational group today was developing effective resumes, cover letters and thank-you notes. We also reviewed the utilization of electronic resumes.

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

Participation: Patient interacted consistently and appropriately and integrated material.

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

Comments: N/A

Electronically Signed By:

Sabrena Bagby, M. Ed., C.R.C., C.C.M.
Vocational Specialist

Daily Progress Note



Name: Lettie Spencer **MRN:** 12615 **Tx Day:** 11 **Date:** 9/5/2013
DOB: **Age At Visit:** **Sex:** F

Type of Program: Comprehensive Rehabilitation Program **Attendance:** Full Day

Notes

BP @ 8:50 am 120/70 mm Hg

Patient is noted to arrive to the clinic today at 7:50 a.m. When asked about her transportation, she stated that her driver still arrived at her house approximately 6:00 a.m., but she told him that she is not going to come out of her house until 6:30 a.m./rh

Patient states that her back was flared up yesterday and she was unable to come in to the clinic. She states that she performed a higher level balance activity on the foam beam Tuesday afternoon, and by Tuesday night, her pain had increased. She is requested to assume her position of comfort (i.e. lying supine with legs propped up on the physio ball). She also used ice pack and TENS and states that her back pain somewhat abated./rh

Rounds completed today with patient and program team. She reports frustration that she missed yesterday. She states that the soft tissue work was helpful the other day and allowed her to stand up more erect. We discussed her flare up management routine. She states that ice and TENS are helpful, as well as the side-lying position and supine with physio ball position./rh

It is noted that patient is walking with more upright posture. When it is brought to her attention, she states "I am thinking about you said and I am trying to correct" (my forward flexed posture)/rh

Pt reported after morning warm-up that she does not want to perform Tandem walking on the blue balance beam. States this is what she believes aggravated her symptoms yesterday. Reported she has no increase in symptoms when performing side-stepping on the beam. Pt. was advised her schedule would be modified accordingly this morning so that she would be able to utilize an ice pack and assume a position of comfort. Pt. was agreeable/rh

Reported decreased low back pain after strapping an ice pack to her low back/rh

Performed STM and LP distraction with patient prone on 2 pillows. She stated that the traction "felt really good". Following the session, KT taping was applied to LB, 2 horiz. strips at 80% stretch. Patient stated that she felt mitigation of her discomfort./rh

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 4 exercises completed

Spinal Stabilization: 25 min. supine

Walking

Minutes: 20 Distance:

Weight Training: Demonstrated Good Technique. 5 exercises completed 1lb free weight

Modalities

Minutes: PRN Modality: Cold Pack Placement: Lumbar Position: Various

Balance Training

Minutes: 5 Balance Type: Dynamic Position: Standing Notes: marching in place

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
ing Tall		5	

Name: Lettie Spencer

MRN: 12816

Tx Day: 11

Date: 9/5/2013

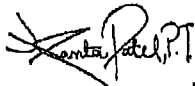
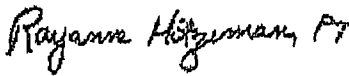
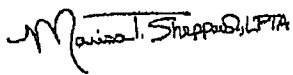
Age At Visit:

Sex: F

Patient Education: Vocational Lecture

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

Met With: Sabrena

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



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 11

Date: 9-5-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Team rounds were held today. We reviewed team conference treatment plans and goals. We discussed medical, psychological, physical therapy and vocational issues. Lettie was absent yesterday due to an increase in her back pain. Initially it was reported that she was sick, but she said her back pain flared up. She is better now. She says the TENS unit helps her. She says the cyclobenzaprine helps. She says she is getting Boost drinks to increase her caloric intake. We will continue with our plan of treatment.

Electronically Signed by:

T. Kem Carlton, III, MD

Daily Progress Note



Name: Leticia Spencer MRN: 12615 Tx Day: 12 Date: 9/8/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program Attendance Full Day

Notes

BP @ 8:46 am 106/64 mm Hg

Pt requested a TENS unit due to increased Sx and still was unable to perform the morning activities. She stopped throughout the am and stretched. /KD

TENS adjusted to allow increased wave width. Patient reported greater comfort./rh

Pt. continues to report relief from utilizing the TENS unit. Pt. continues to sign one out of the clinic and bring back each day. Pt. reports that if she was unable to utilize a TENS unit this morning she would be spending the day lying on the mat table. Pt. is observed ambulating at smoother cadence demonstrating improved upright posture./ms

Pt reports she can see improvement this week in posture and is concentrating on maintaining upright posture and increasing cadence when walking. Pt states she is "going to get back to being fast walker one of these days"/JB

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. Pt performed 2 exercises and stopped due to increased pain. Pt able to complete 10 exercises later.

Core Stabilization: 25 min. side-lying, supine

Weight Training: Pt performed 3 exercises w good technique.

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Overhead Activities	3x10	8	stick overhead
Overhead Activities		8	wall chain
Kneeling Tall			

Signatory Name	primaryFlag	Signature
Rayanne Hitzeman, P.T.	☐	<i>Rayanne Hitzeman PT</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>
Kim Dunn, P.T.	☐	
	☐	

Name: Lettie Spencer

MRN: 12616

Tx Day: 12

Date: 9/6/2013

DOB:

Age At Visit:

Sex: F

Mamta Patel, P.T.



Mamta Patel, P.T.



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 12

Date: 9-6-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says that she is doing better. She says that her flare-up does seem to be gradually resolving. The physical therapists have started some Physio Taping, and hopefully this will be beneficial to her. I stressed to her the importance of following her exercise regimen over the weekend and also talked to her about the importance of increasing her caloric intake. She says the TENS unit has been very helpful. She says she has tried them in the past and they were not beneficial, but the unit that she is using now is helpful. I told her we would prescribe this for her if it continues to be beneficial. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD



THE REHAB CENTER
INCORPORATED

VOCATIONAL GROUP NOTE

NAME: Lettie Spencer
CHART #: 12615
DAY OF TREATMENT: 13
DATE: 9-9-2013

VOCATIONAL GROUP:

The focus of the vocational group today was exploring tips that will lead to being hired. A video was viewed by the group that offered advice from actual employers on what job seekers can do before, during, and after job interviews to enhance hiring opportunities. A group discussion followed the video.

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

Participation: Patient interacted consistently and appropriately and integrated material.

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

Comments: N/A

Electronically Signed By:

Sabrena Bagby, M. Ed., C.R.C., C.C.M.
Vocational Specialist

Daily Progress Note



Name: Lette Spencer
DOB:

MRN: 12615
Age At Visit:

Tx Day: 18
Sex: F

Date: 8/9/2013

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

BP @ 8:37 am 144/72 mm Hg

Pt. observed ambulating in the gym demonstrating improved upright posture with relaxed shoulder and equal B heel toe gait pattern. Pt. was commended for her effort and focusing on her body mechanics/ms

Patient reports that she had a good weekend. Her back pain is at baseline./MP

Noted Improved upright posture. observe patient periodically in a deep squat position to stretch her lumbar spine for pain relief./MP

Pt was instructed on treadmill ambulation today. She completed 10 minutes at 0.5 mph with occasional cueing required for consistent B LE initial contact. No dyspnea was present with ambulation. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique: 15 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill

utes: 10 MPH: 0.5 Distance:

Walking

Minutes: 20 Distance:

Weight Training: Demonstrated Good Technique: 3 exercises completed, 1 lb free weight

Balance Training

Minutes: 20 Balance Type Dynamic Position: Standing Notes:

Standing

Minutes: 10 Notes: Patient was walking during standing time

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Overhead Activities			Wand, 2 x 10 sec
Wall Chain		6:30	
Kneeling Tall		7	

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

Signatory Name

primaryFlag

Signature

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



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

Name: Lettie Spencer

MRN: 12615

Tx Day: 13

Date: 9/9/2013

B:

Age At Visit:

Sex: F

Mamta Patel, P.T.



Mamta Patel, P.T.

Marisa T. Sheppard, LPTA



Marisa T. Sheppard, LPTA



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 13

Date: 9-9-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in good spirits. She says she is feeling much better. She rates her pain level a 6. She says the TENS unit is giving her great relief. She said she would like to have one to use at home, and I wrote a prescription for her. I talked to her about the importance of improving her caloric intake. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: 14 Date: 9/10/2013
 DOB: Age At Visit: Sex: F
Type of Program: Comprehensive Rehabilitation Program Attendance: Full Day

Notes

BP @ 8:48 am 122/88 mm Hg

Patient reports that her pain is manageable but she is taking more medicine. She reports that the progress she sees is increased strength in her LE, improved posture, increased speed of walking and the way she is walking. "I can feel muscle" in the calf./MP

Patient reported that she performed 10 minute on the TM, but she was very tired after the activity./MP

Pt initiates and completes her tasks efficiently but is observed occasionally in a crouched position 4-5 times per day, which she states is pain relieving position. Will continue to focus on finding neutral positions of comfort for lumbar pain reduction. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 13 exercises completed

Treadmill

Minutes: 10 MPH: 0.5 Distance: 0.08

Minutes: 15 MPH: Distance:

Walking

Minutes: 15 Distance:

Weight Training: Demonstrated Good Technique: 5 exercises completed, 1 lb free weight

Balance Training

Minutes: 20 Balance Type Dynamic Position: Standing Notes:

Standing

Minutes: 10 Notes: dynamic-walking

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	5	3
1 Hand Carry	5	R
1 Hand Carry	2.5	L
2 Hand Carry	5	2
Push Cart	35	3

Circuit

Exercise	Up & Down	Minutes	Description
Kneeling Tall		5	

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

Signatory Name primaryFlag Signature

Daily Progress Note

Page 1 of 2

Page 000213

ROA 351

Name: Lettie Spencer

MRN: 12616

Tx Day: 14

Date: 9/10/2013

DOB: 11/28/1947

Age At Visit: 85

Sex: F

Dee Payne, P.T., M.S.	☐	<i>Dee Payne, P.T., M.S.</i>
Rayanne Hitzeman, P.T.	☐	<i>Rayanne Hitzeman, P.T.</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>
Mamta Patel, P.T.	☐	<i>Mamta Patel, P.T.</i>

THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

CLIENT: Lettie Spencer
CHART #: 12615
DATE: 9-10-2013

Ms. Spencer was seen in individual psychotherapy today. Ms. Spencer describes herself as exhausted. She recognizes that the physical demands of her functional restoration program exceed that which she was accustomed to before beginning the program. Ms. Spencer indicates that she has lost 1½ lbs since beginning the program.

Ms. Spencer does note that she has experienced improvement in her posture and gait. She describes her legs as stronger. She also notes that her attitude has improved. Ms. Spencer was encouraged to persist with her present efforts.

Electronically Signed by:

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

WBO:dsb



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 14

Date: 9-10-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12815

Days Tx: 14

Date: 9-10-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in fairly good spirits. She rates her pain level a 6. She says the TENS unit is helping her a great deal. Her gait looks better. I talked to her at length about her weight and her caloric intake. Her weight today is 106.5 lbs. I stressed to her the importance of increasing her calories. I reexamined her, and there is no change neurologically. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lette Spencer MRN: 12615 Tx Day: 15 Date: 9/11/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program Attendance Full Day

Notes

BP @ 8:55am 136/78 mm Hg

Patient is demonstrating consistently more upright posture. She states that her back pain persists unabated. She states that when she uses the TENS, she notes that her posture does improve./m

B distal ILS kinesiotaping was performed at 15% tension, distal to proximal, to provide for muscle inhibition. DP

Pacing of activities continues to be slow with the pt. requiring numerous standing rest breaks to allow for stretching of lumbar region. Pt. tolerated a 5 lb increase in weight for pushing/pulling of the cart. Pt. stated she did not notice the increase in weight until she began pulling the shopping cart. Pt. continues to demonstrate improved upright posture/ms

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique: 8 exercises completed

Core Stabilization: 25 min. supine, standing

Admitt

Minutes: 12 MPH: 0.5 Distance: 0.08

Walking

Minutes: 10 Distance:

Modalities

Minutes: PRN Modality: Tens, 2 channels, 4 electrodes Placement: lumbar Position: various
 Minutes: Modality: Placement: Position:

Balance Training

Minutes: 20 Balance Type Dynamic Position: Standing Notes:

Standing

Minutes: 10 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
1 Hand Carry	5	3R
1 Hand Carry	2.5	2L
Push Cart	40*	2
Pull Cart	40*	1

Push - 13.2

Pull - 14.8

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

Name: Lettie Spencer

MRN: 12615

Tx Day: 15

Date: 9/11/2013

IB:

Age At Visit:

Sex: F

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



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettle Spencer

Chart No: 12815

Days Tx: 15

Date: 9-11-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.

ally Progress Note



Name: Lettie Spencer

MRN: 12615

Tx Day: 16

Date: 9/12/2013

DOB: 1

Age At Visit: 1

Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance 8:10am-4:00pm

Notes

BP @ 8:35 am 138/72 mm Hg

Patient states that her transportation was late this morning. /rh

Rounds were completed with patient and the rehab team. She is commended on her excellent effort and participation in the program. She is using pain management techniques appropriately. She has progressed with her strength, posture and gait. Balance activity was modified due to flareup last week but have initiated uneven surface as this is an important goal for patient. Her fatigue continues to be an issue. She is encouraged to increase awareness of her nutrition. Her program has been modified to allow mal exercises during the day. An extension of the program is recommended for her as she has shown good progress but needs to improve her balance, endurance, strength and functional gait/MP

Patient requested removal of taping on her back, stating that it felt like it was making her back "spasm". /rh

Patient requested TENS unit at 11:00. She was excited that she was able to wait that long before asking for the TENS. Patient also requested the taping in formation of 1st application. KT taping applied to LB, 2 horizontal strips a 80% stretch. /rh

Pt. observed completing functional lifting task demonstrating improved upright posture, increased energy and requiring less breaks for stretching her back. Pt tolerated a increased in weight up to 6lbs while also increasing her reps. by 1 with certain lifts. Pt. observed demonstrating improved control when turning the cart around to pull it in the gym. Pt. was able to complete 2 laps pulling 40lbs in the cart without taking a rest break/me

exhibits improved gait fluidity, including increased B UE swing, with ambulation in the afternoon and improved neutral spine positioning.

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: 7 exercises performed

Spinal Stabilization: 25 min. standing

Treadmill

Minutes: 11:03 MPH: .6 Distance: .09

Weight Training: 3 exercises performed

Standing

Minutes: 15 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	6	4
1 Hand Carry	6	3R
1 Hand Carry	3	3L
Push Cart	40	3
Pull Cart	40	2

Circuit

Daily Progress Note

Page 1 of 2

Page 000221

ROA 359

Name: Lettie Spencer

MRN: 12815

Tx Day: 16

Date: 9/12/2013

B:

Age At Visit:

Sex: F

Exercise

Up & Down

Minutes

Description

Overhead Activities

2x10 sec

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

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

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

APPELLATE CASE NO. 2015-002112

Lettie Spencer,.....Appellant,

v.

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

RECORD ON APPEAL

VOL 3 OF 4

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INDEX FOR RECORD ON APPEAL

I. ORDERS/JUDGMENTS

Order of Commissioner R. Michael Campbell, II,
Commissioner, dated March 12, 2015 1

Appellate Panel Decision and Order of the SCWCC,
dated September 11, 2015 16

II. PLEADINGS

Form 50 of February 28, 2014 22

Form 51 of March 28, 2014 24

Form 30 of March 13, 2015 26

Notice of Appeal of October 9, 2015 28

III. TRANSCRIPTS

Transcript before Commissioner on T. Scott Beck on
September 3, 2014 30

Lettie Spencer – Direct Examination by Andrew Creech 40

Lettie Spencer – Cross Examination by Clarke McCants,
III 72

Lettie Spencer – Redirect Examination by Andrew Creech 106

Lettie Spencer – Re-cross Examination by Clarke McCants,
III 107

Terry Sartin – Direct Examination by Andrew Creech 108

Terry Sartin – Cross Examination by Clark McCants,
III 112

THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.
Psychologist

DA:dsb

CONFIDENTIAL



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 16

Date: 9-12-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

☒ Rounds

- ☐ Team Conference
☐ Patient Education

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

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettie Spencer

MRN: 12615

Tx Day: 17

Date: 9/13/2013

DOB:

Age At Visit:

Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

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

BP @ 8:39 am 144/74 mm Hg

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

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

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Spinal Stabilization: 25 min. supine, standing

admitt

minutes: 12 MPH: 0.5 Distance: .12

Walking

Minutes: 20 Distance:

Weight Training: Demonstrated Good Technique, 5 exercises completed

Standing

Minutes: 20 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Push Cart	40	3
Pull Cart	40	2

Circuit

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

Pain Behavior: Occasional verbal complaints of pain.

Signatory Name

primaryFlag

Signature

Daily Progress Note

Page 1 of 2

Page 000225

ROA 363

Name: Lettie Spencer

MRN: 12615

Tx Day: 17

Date: 9/13/2013

DOB:

Age At Visit:

Sex: F

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



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12815

Days Tx: 17

Date: 9-13-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 17

Date: 9-13-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

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

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: 18 Date: 9/16/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program Attendance: Full Day

Notes
 BP @ 8:45 am 128/68 mm Hg

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

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique, 15 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill
 Minutes: 15 MPH: .5 Distance: .11

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

Standing
 Minutes: 10+15 Notes:

Physical Therapy - Goal: Improve Functional Status

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

Pain Behavior: Occasional verbal complaints of pain.

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



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lottie Spencer

Chart No: 12615

Days Tx: 18

Date: 9-16-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

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

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 18

Date: 9-16-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

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

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lette Spencer MRN: 12615 Tx Day: 19 Date: 9/17/2013
 DOB: Age At Visit: Sex: F
 Type of Program: Comprehensive Rehabilitation Program Attendance Full Day

Notes

BP @ 8:38 am 124/66 mm Hg

TUG Test: 9:09 seconds

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

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

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

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 11 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill

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

Weight Training: Demonstrated Good Technique: 3 exercises completed

Balance Training

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

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

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

*Push Only - 12.2

Circuit

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

Name: Lettie Spencer

MRN: 12615

Tx Day: 19

Date: 9/17/2013

3:

Age At Visit:

Sex: F

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

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



Daily Progress Note

Name: Lettie Spencer

Chart No: 12815

Days Tx: 19

Date: 9-17-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

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

Electronically Signed by:

T. Kern Carlton, III, MD



Daily Progress Note

Name: LITTLE Spencer

Chart No: 12615

Days Tx: 19

Date: 9-17-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.

Daily Progress Note



Name: Lettie Spencer
DOB: [redacted]

MRN: 12615
Age At Visit: [redacted]

Tx Day: 20
Sex: F

Date: 9/18/2013

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

BP: 124/72 am

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

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

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

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

Physical Therapy - Goal: Improve Physical Condition

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

Spinal Stabilization: performed in supine

admitt

utes: 12:33 MPH: 1.3 Distance:

Balance Training

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

Physical Therapy - Goal: Improve Functional Status

Pain Behavior: Occasional verbal complaints of pain.

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



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615 .

Days Tx: 20

Date: 9-18-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.

Daily Progress Note



Name: Lettle Spencer MRN: 12615 Tx Day: 21 Date: 9/23/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

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

am 8:40 BP: 120/65

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

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

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

Core Stabilization: 25 min, supine, standing

Treadmill

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

Modalities

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

Balance Training

Minutes: 15 Balance Type: Dynamic Position: Standing Notes:

Standing

Minutes: 15 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

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

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	4		
Overhead Activities		2x10	stick
Kneeling Tall		8	

Pain Behavior: Occasional verbal complaints of pain.

Name: Lettie Spencer

MRN: 12615

Tx Day: 21

Date: 9/23/2013

B:

Age At Visit:

Sex: F

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



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 21

Date: 9-23-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

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

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettie Spencer MRN: 12815 Tx Day: 22 Date: 9/24/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program Attendance Full Day

Notes

BP @ 8:35 am 104/70 mm Hg

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

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 13 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill

Minutes: 16:24 MPH: 1.2 Distance: .30

Dance Training

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

Standing

Minutes: 16 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

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

Circuit

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

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

Signatory Name

primaryFlag

Signature

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



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

Name: Lettie Spencer

MRN: 12815

Tx Day: 22

Date: 9/24/2013

OB:

Age At Visit:

Sex: F

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



Daily Progress Note

Name: Lottie Spencer

Chart No: 12615

Days Tx: 22

Date: 9-24-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

Appeared visibly relaxed.

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

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

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

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

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12616

Days Tx: 22

Date: 9-24-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

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

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



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

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

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

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

am BP: at 8:40: 110/65

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

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

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

Core Stabilization: Performed in standing

Treadmill

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

Balance Training

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

Standing

Minutes: 15 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

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

Push 12.0

Pull 13.6

Circuit

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

Name: Lottie Spencer

MRN: 12615

Tx Day: 23

Date: 9/25/2013

B:

Age At Visit:

Sex: F

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

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



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 23

Date: 9-26-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.

Daily Progress Note



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

Type of Program: Comprehensive Rehabilitation Program Attendance Full Day

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

BP @ 8:40 am 128/72 mm Hg

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

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

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

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

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique: 3 exercises completed

Spinal Stabilization: 25 min. supine, standing

Bicycle

Minutes: MPH: Distance:

Balance Training

Minutes: 25 Balance Type Position: Notes:

Standing

Minutes: 15 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
1 Hand Carry	7	3R

Circuit

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

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

Signatory Name

primaryFlag

Signature

Daily Progress Note

Page 1 of 2

Page 000248

ROA 386

Name: Lattie Spencer

MRN: 12615

Tx Day: 24

Date: 9/28/2013

DOB:

Age At Visit:

Sex: F

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

THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.
Psychologist

DA:dsh



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 24

Date: 8-26-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

Electronically Signed by:

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

Darcy Alexander, Ph.D.

Daily Progress Note



Name: Lettie Spencer MRN: 12616 Tx Day: 26 Date: 9/27/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program Attendance Full Day

Notes

BP @ 8:38 am 182/68 mm Hg

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

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

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

Affect and activity tolerance has significantly improved./MP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

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

Spinal Stabilization: 26 minutes seated, standing

dmill

Minutes: 29:44 MPH: 1.7 Distance: 0.75

Balance Training

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

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
1 Hand Carry - R	7	1.5

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	6		4 steps
Kneeling Tall		16	

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

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

Name: Lettie Spencer

MRN: 12615

Tx Day: 25

Date: 9/27/2013

DOB:

Age At Visit:

Sex: F

Mamta Patel, P.T.



Mamta Patel, P.T.



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lette Spencer

Chart No: 12615

Days Tx: 25

Date: 9-27-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 25

Date: 9-27-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

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

Electronically Signed by:

T. Kern Carlton, III, MD

THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

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

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

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

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

Electronically Signed by:

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

WBO:dsh



Daily Progress Note

Name: Lettie Spencer
Chart No: 12615
Days Tx: 26
Date: 9-30-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 28

Date: 9-30-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

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

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettie Spencer MRN: 12616 Tx Day: 27 Date: 10/1/2013
 DOB: Age At Visit: Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance 8 - 11:15

Notes

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

BP @ 8:38 am 136/70 mm Hg

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

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

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 3 exercises completed

Treadmill

utes: 32 MPH: 2.3 Distance:

Physical Therapy - Goal: Improve Functional Status

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

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

Daily Progress Note



Name: Lettie Spencer

MRN: 12815

Tx Day: 26

Date: 9/30/2013

DOB:

Age At Visit:

Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

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

BP @ 132/72 mm Hg

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

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

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

Physical Therapy - Goal: Improve Physical Condition

Ability / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 10 exercises completed.

Spinal Stabilization: 25 min. supine, standing

Treadmill

Minutes: 17:47 MPH: Distance: .45

Balance Training

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

Standing

Minutes: 18 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

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

Push 12.

Circuit

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

Behavior: Occasional verbal complaints of pain.

Name: Lettie Spencer

MRN: 12615

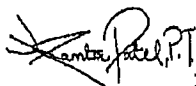
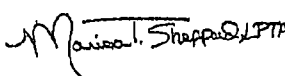
Tx Day: 26

Date: 9/30/2013

DOB:

Age At Visit:

Sex: F

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



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Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 27

Date: 10-1-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☐ Full Day ☐ Absent
☒ Half Day ☐ Other

PSYCHOLOGY

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

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.

Daily Progress Note



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

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

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

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

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 8 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill

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

Minutes: 10 MPH: .5 Distance:

Balance Training

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

Standing

Minutes: 20 Notes:

Minutes: 30 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

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

Pain Behavior: Occasional verbal complaints of pain.

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

Name: Lettie Spencer

MRN: 12615

Tx Day: 28

Date: 10/2/2018

OB:

Age At Visit:

Sex: F

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



THE REHAB CENTER
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FUNCTIONAL STATUS REPORT

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

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

ASSESSMENT:

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

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

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

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

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

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

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

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

Functional Status Report
Page 2 of 2

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

RECOMMENDATIONS:

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

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

PLAN;

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

Professionally,

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

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

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



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 28

Date: 10-2-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

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

Electronically Signed by:

Darcy Alexander, Ph.D.

Daily Progress Note



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

Type of Program: Comprehensive Rehabilitation Program Attendance Full Day

Notes

TUG Test: 4:37 seconds

BP @ 9:27 am 124/88 mm Hg

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

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

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

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

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

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

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

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

Spinal Stabilization: 25 min. supine, standing

Treadmill

Minutes: 21 MPH: 0.5-2.3 Distance: .33

Minutes: 10:31 MPH: .8 Distance:

Balance Training

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

Physical Therapy - Goal: Improve Functional Status

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

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

Name: Lettie Spencer

MRN: 12615

Tx Day: 29

Date: 10/3/2013

VB:

Age At Visit:

Sex: F

Rayanne Hitzeman, P.T.



Rayanne Hitzeman, PT

Marisa T. Sheppard, LPTA



Marisa T. Sheppard, LPTA

THE REHAB CENTER

2610 East Seventh Street
Charlotte, NC 28204

DISCHARGE SUMMARY

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

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

Electronically Signed by:

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

TKC:dsb

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Daily Progress Note

Name: LITTLE Spencer

Chart No: 12615

Days Tx: 29

Date: 10-3-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

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

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

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

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

Sitting Tolerance:

Sat through session without any pain behavior exhibited.

Participation:

Patient interacted consistently and appropriately and integrated material.

Pain Behavior

No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

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

Darcy Alexander, Ph.D.



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Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 29

Date: 10-3-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

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

- ☒ Rounds
☐ Team Conference
☐ Patient Education

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

Electronically Signed by:

T. Kern Carlton, III, MD



PHYSICAL THERAPY OUTPATIENT

Client Name: LITTLE Spencer
Chart Number: 12615

Date: 10-14-2013

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

OBJECTIVE:

Strength:

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

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

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

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

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

Electronically Signed by:

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

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2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

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

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

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

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

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

Electronically Signed by:

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

WBO:dsh

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2610 East Seventh Street
Charlotte, NC 28204

REEVALUATION

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

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

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

PHYSICAL EXAM:

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

IMPRESSION:

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

PLAN:

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

Electronically Signed by:

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

TKC:dsb

THE REHAB CENTER

2610 East Seventh Street
Charlotte, NC 28204

REEVALUATION

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

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Electronically Signed by:

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

TKC:dsh

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ORIGINAL RECORD ON
APPEAL



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

www.crc rehab.com

January 21, 2014

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

Re: Lettie Spencer

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

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

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

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

Sincerely,

A handwritten signature in cursive script, appearing to read 'Tracy Hill', with a large flourish at the end.
Tracy Hill, P.T.

2392 Two Nitch Road, Columbia, SC 29204, 799-7007
1 Wellness Blvd., Suite 204, Irmo, SC 29063, 749-0808
1177 Sunset Boulevard, West Columbia, SC 29169, 794-8440
115 Blarney Drive, Suite 202 Columbia, SC 29223, 738-4845



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Page 000278



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

www.crcrehab.com

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

Re: Lettie Spencer

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

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

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

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

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

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

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

Sincerely,

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

Tracy Hill, P.T.

2382 Two Notch Road, Columbia, SC 29204, 799-7007
1 Wellness Blvd., Suite 204, Irmo, SC 29063, 749-0808
1177 Sunset Boulevard, West Columbia, SC 29169, 794-3440
115 Blarney Drive, Suite 202 Columbia, SC 29223, 796-4845



425-3 McNulty Road, PO Box 218, Blythewood, SC 29016, 728-0421

Page 000279



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

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

FUNCTIONAL ABILITIES EVALUATION



Client Information

Client Name: Ms. Lottie Spencer

Address:

Injury Date: June 22, 2011

Dominant Hand: Right Hand

SSN:

Date of Birth:

Gender: Female

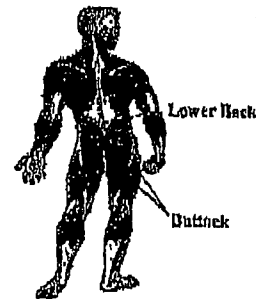
Height: 62 inches

Weight: 107 lbs

Start & Finish Date: Jan 21, 2014

Evaluator: Tracy Hill, PT

Areas of Complaint



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

Tracy Hill

Tracy Hill, PT
Physical Therapist

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



Name: Leffie Spencer

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

Strength **Lower Extremity Manual Muscle Test**

Jan 21, 2014 12:03:13 PM

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

Hip Flexion: Bilat 4/5
Extensor Hallucis Long: Bilat 5/5

Knee Extension: Bilat 4+/5
Eversion: Bilat 3/3

DorsiFlexion: Bilat 5/5

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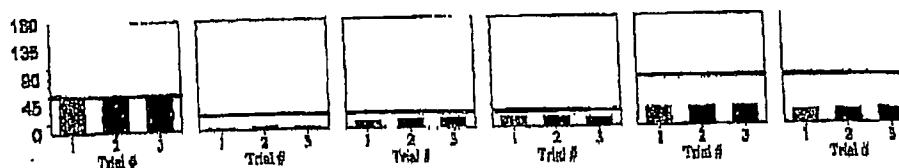
Mrs. Little Spencer



Range of Motion **Lumbar Range of Motion**

Jan 21, 2014 11:55:00 AM

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

Reference Information

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

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Ms. Letitia Spencer



Work Simulation - Dynamic Bending

Jan 21, 2014 12:16:56 PM

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

dynamic bending: 12 repetitions

PRE HR 66 POST
HR 84

Evaluator Comments

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

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Ms. Leslie Spencer



Work Simulation - Dynamic Rotation

Jan 21, 2014 12:20:23 PM

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

Dynamic rotation: 15 repetitions

PRE HR 64 POST
HR 80

Evaluator Comments

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

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ML Letitia Spencer



Work Simulation - Squatting

Jan 21, 2014 12:25:50 PM

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

squatting 2 minutes

PRE HA 64 PQST
HR 80

Evaluator Comments

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

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Ms. Leslie Spencer



Work Simulation - Kneeling

Jan 21, 2014 12:28:10 PM

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

Kneeling: 39 seconds

PRE HR 65 POST
HR 76

Evaluator Comments

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

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Ms. Lettie Spencer

Work Simulation - Dynamic Reaching

Jan 21, 2014 12:42:31 PM

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

Dynamic reaching: 3:49 minutes

PRR HR 72 POST
NR 89

Evaluator Comments

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

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Ma. Lettie Spencer



Work Simulation ▶ Stair Climbing

Jan 21, 2014 12:47:10 PM

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

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

Evaluator Comments

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

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Ms. Lettie Spencer

10

Work Simulation Floor to waist lift

Jan 21, 2014 12:56:05 PM

Floor to waist lifting results are as follows:

Floor to waist: 3 pounds

Physical demand level: limited sedentary

MAX HR 90

Evaluator Comments

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

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Ms. Letitia Spencer

11

Work Simulation 12 inch to waist lift

Jan 21, 2014 1:03:00 PM

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

12 inch to waist: 6 pounds

Physical demand level: limited sedentary

MAX HR 91

Evaluator Comments:

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

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Ms. Lettie Spencer



Work Simulation - Waist to shoulder lift

Jan 21, 2014 1:09:52 PM

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

Waist to shoulder: 5 pounds

Physical demand level: limited sedentary

MAX HR 92

Evaluator Comments

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

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Ms. Leticia Spencer



Work Simulation ➤ Shoulder to overhead lift

Jan 21, 2014 1:18:46 PM

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

Shoulder to overhead: 3 pounds

Physical demand level: limited sedentary

MAX HR 89

Evaluator Comments

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

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Ms. Lottie Spencer



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

Jan 21, 2014 12:22 PM

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

Dynamic 2-handed 7 pounds
carry:

Physical demand level: limited sedentary

MAX HR 92

Evaluator Comments

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

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Ma. Lettie Spencer



Work Simulation - Dynamic 1-handed carry

Jan 21, 2014 1:35:00 PM

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

Left-handed carry: 4 pounds

Right-handed carry: 4 pounds

MAX HR 93

Evaluator Comments

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

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Ms. Lottie Spencer



Work Simulation ➤ Dynamic Push/Pull

Jan 21, 2014 1:44:00 PM

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

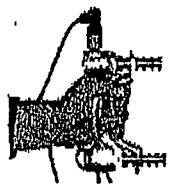
Push: 14.2 lb.A.

Pull: unable

MAX HR 93

Evaluator Comments

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

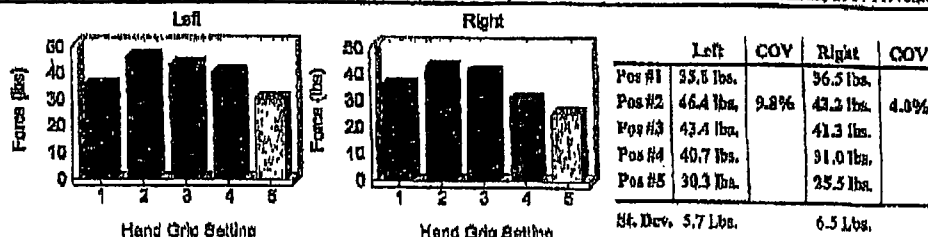
Hand Grip Strength

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

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

Modified Maximum Voluntary Effort (MMVE)

Jan 21, 2014 11:48:26 AM



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

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

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

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

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

¹¹ Elldredh D, Brudenbach W, Lisitor G, Hodges A. 1989. Detection of submaximal effort by use of the rapid exchange grip. J Hand Surgery 14A(4): 742-745.

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Ms. Lettie Spencer



The Waddell Signs



Jan 21, 2014

Please read:

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

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

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

- ☒ Negative
☐ Positive

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

- ☒ Negative
☐ Positive

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

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

- ☒ Negative
☐ Positive

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

- ☒ Negative
☐ Positive

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

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

- ☒ Negative
☐ Positive

4. Regional Disturbances - Divergence from accepted neuroanatomy

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

- ☒ Negative
☐ Positive

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

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

- ☒ Negative
☐ Positive

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

Scoring: Clinically insignificant.

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Ms. Leticia Spencer



Sitting tolerance

Jan 21, 2014

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

Evaluator Comments

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

Standing tolerance

Jan 21, 2014

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

Evaluator Comments

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

Cardiovascular Intake Jan 21, 2014

Resting Rate (b/min)	Systolic (mm Hg)	Diastolic (mm Hg)
58	140	72

Result	Slow Heart Rate	Borderline Hypertension	Normal Blood Pressure

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Ms. Leslie Spencer



Single Stage Pre-Testing Heart Disease Questions

Treadmill

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

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

Initial Heart Rate Initial Blood Pressure
58 BPM 140 / 72

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

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2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7607

Mr. Leslie Spencer



CURRICULUM VITAE
OF

TRACY L. HILL

PERSONAL INFORMATION

Home Address:

Date of Birth:

Place of Birth:

Columbia, South Carolina

EDUCATION

Undergraduate Coursework

Medical University of South Carolina
Allied Health Sciences
Charleston, South Carolina

June 1983 - May 1985
Degree - B.S. Physical Therapy

University Of South Carolina
Columbia, South Carolina

Sept. 1980 - May 1983

PHYSICAL THERAPY PRACTICE EXPERIENCE

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

May 1985 - Present

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

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

Fall 1990 - Fall 2000

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

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

PROFESSIONAL LICENCES:

Page 2 (Cont.)

S.C. Physical Therapy License # 984

CONTINUING EDUCATION - 2005 TO PRESENT

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

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

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

February 25, 2006 Maximizing Upper Extremity Neurological Dysfunction Utilizing
Neuro- Developmental Treatment (NDT)
Columbia, SC (4 contact hours)

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

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

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

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

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

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

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

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

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

Page 3 (Cont.)

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

Page 4 (Cont.)

May 18, 2012 The Shoulder Girdle to the Hand
(7.5 hours)

May 24, 2012 New Concepts in the Management
of Soft Tissue Dysfunction
(4 hours)

Blank

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

PROFESSIONAL PARK ON CLEVELAND

3 CLEVELAND COURT, SUITE C

GREENVILLE, SC 29607-2442

(864) 232-6216

FAX (864) 235-6369

PSYCHIATRIC EVALUATION

PATIENT NAME: Lettie Spencer

DATE OF BIRTH:

DATE OF DICTATION: 02/28/2014

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

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

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

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

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

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

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

02/28/2014

Lettie Spencer

DOB:

Page 2

CURRENT MEDICATIONS:

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

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

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

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

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

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

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

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

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02/28/2014

Lettie Spencer

DOB:

Page 3

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

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

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

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

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

Records sent by her attorney include records from Carolina Occupational Healthcare, Chester Regional Medical Center, Columbia Neurosurgical Associates, South Carolina Pain Associates, Select PT, Carolina Orthopedic Surgery Associates, PA, Springs Memorial Hospital, Sanjay Nandurkar, the Rehab Center (in Charlotte), and Tracy Hill Columbia Rehab Clinic, Inc. All of these records and summaries support the diagnosis of a chronic lumbar strain. There is also mention of disc impingement on her spinal cord. At Chester Regional Medical Center, there is an MRI that shows the L4-5 level hypertrophic facet change and ligamentum flavum thickening combined with a broad-based disc bulge to cause a component of inferior neural foramina narrowing bilaterally as well as a component of lateral recess narrowing – left greater than right. No central canal stenosis.

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

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02/28/2014

Lettie Spencer

DOB:

Page 4

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

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

DIAGNOSIS AND DISCUSSION:

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

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

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

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

02/28/2014

Lettie Spencer

DOB:

Page 5

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

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

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

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


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

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ORIGINAL RECORD ON
APPEAL

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

P.O. Box 97 • Franklin, NC 28744 • Office 704-877-4833 • Fax 866-547-8147
Lhollenbeck23@aol.com

Confidential – For Professional Use Only

RE: Lettie Spencer
Date of Injury: June 22, 2011
Date of Birth: 1
Date of Interview: February 25, 2014
Date of Report: March 8, 2014

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

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

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

RECORDS REVIEWED

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

MEDICAL HISTORY

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

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

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

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

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

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

Lifting

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

Carrying

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

Ms. Spencer was observed:

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

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

Ms. Spencer is diagnosed with the following:

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

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

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

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

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

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

CURRENT MEDICAL STATUS

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

CURRENTLY PRESCRIBED MEDICATIONS

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

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

PHYSICAL LIMITATIONS AND ABILITIES

She reports the following physical abilities and limitations:

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

CHIEF COMPLAINTS

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

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

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

EDUCATION

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

VOCATIONAL/EDUCATIONAL TESTING RESULTS

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

WORK HISTORY

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

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

VOCATIONAL STATUS

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

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

TRANSFERABLE SKILLS ANALYSIS

Ms. Spencer reported the following work history:

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

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

EMPLOYABILITY

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

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

LABOR MARKET SURVEY

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

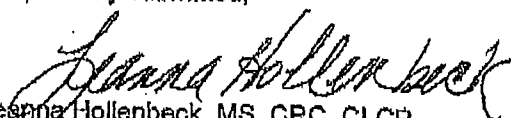
(SCESC) revealed no jobs for which Ms. Spencer would be able to qualify, given her lack of transferable skills and her functional limitations.

CONCLUSIONS

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

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

Respectfully submitted,


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

Enclosure: Ability Profile
Job Description: Licensed Practical Nurse

OCCUPATION LIST

DOT Code	DOT Title	Industry	SVP	Str	O*NET
079.374-014	Nurse, Licensed Practical	Medical Services	6	M	29-2051.00

ABILITY PROFILE

Name: Spencer, Lettie

SSN:

Case:

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

Hollenbeck
03/02/2014

Page 2

OCCUPATIONAL DESCRIPTION

079.374-014 Nurse, Licensed Practical

Provides prescribed medical treatment and personal care services to ill, injured, convalescent, and handicapped persons in such settings as hospitals, clinics, private homes, schools, sanitariums, and similar institutions. Takes and records patients' vital signs. Dresses wounds, gives enemas, douches, alcohol rubs, and massages. Applies compresses, ice bags, and hot water bottles. Observes patients and reports adverse reactions to medication or treatment to medical personnel in charge. Administers specified medication, orally or by subcutaneous or intramuscular injection, and notes time and amount on patients' charts. Assembles and uses such equipment as catheters, tracheotomy tubes, and oxygen suppliers. Collects samples, such as urine, blood, and sputum, from patients for testing and performs routine laboratory tests on samples. Sterilizes equipment and supplies, using germicides, sterilizer, or autoclave. Prepares or examines food trays for prescribed diet and feeds patients. Records food and fluid intake and output. Bathes, dresses, and assists patients in walking and turning. Cleans rooms, makes beds, and answers patients' calls. Washes and dresses bodies of deceased persons. Must pass state board examination and be licensed. May assist in delivery, care, and feeding of infants. May inventory and requisition supplies. May provide medical treatment and personal care to patients in private home settings and be designated Home Health Nurse, Licensed Practical (medical ser.).
DLU: 1987

ABILITY PROFILE

Name: Spencer, Lettie

SSN:

Case:

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

Hollenbeck
03/02/2014

Page 1

LEANNA HOLLENBECK, MS, CLCP, CRC

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CURRICULUM VITAE

EDUCATION

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

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

EMPLOYMENT

VOCATIONAL REHABILITATION & LIFE CARE PLANNING

1996-present

Hollenbeck & Associates, LLC

Fort Mill, SC/Franklin, NC

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

Contract Review Officer for SC Retirement System 2005-2012.

Contract Vocational Expert for Office of Hearings & Appeals since 1996.

1992-1996

VOCATIONAL REHABILITATION SPECIALIST

The Rehab Center, Inc.

Charlotte, NC

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

1990-1992

MARKETING DIRECTOR/VOCATIONAL SERVICES SUPERVISOR

Rebound, Inc.

Lancaster, SC

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

1988-1990

DIRECTOR

The Physical Restoration Center

Tampa, FL

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

1981-1988

MANAGER/REHABILITATION SPECIALIST

Intracorp

Tampa, FL

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

1974-1981

VOCATIONAL REHABILITATION COUNSELOR

Florida Office of Vocational Rehabilitation

Pensacola, FL

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

CERTIFICATES

Certified Life Care Planner (CLCP) #0245

Certified Rehabilitation Counselor (CRC) #17811

**PROFESSIONAL
MEMBERSHIPS**

International Association of Rehabilitation Professionals
International Academy of Life Care Planners