

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

SCWCC Number: 1003122

RECEIVED

APR 22 2014

SC Court of Appeals

Zeena Fletcher, Employee, Respondent,

v.

Dick's Sporting Goods, Employer, and Federal Insurance Co., Carrier, Appellants.

RECORD ON APPEAL

Andrew D. Smith
Andrew D. Smith, LLC
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Charleston, South Carolina 29412
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Attorney for Appellants

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Attorney for Respondent

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Carrier File #: 003619-001324-WC01
Carrier Code #:
Employer FEIN #:

Claimant's Name: Zecena L. Fletcher Employer's Name: Dick's Sporting Goods, Inc.
Address: 206 Lewis Road Address: 140 Fritz Drive
City: Williamston State: SC Zip: 29697 City: Anderson State: SC Zip: 29621
Home Phone: (864) 634-0965 Work Phone: () - Carrier: Federal Ins. Co./ Chubb Group of Ins. Companies
Preparer's Name: Andrew D. Smith Preparer's Phone #: (864) 963-0310

This form is only applicable to injuries by accident occurring on or after July 1, 2007 pursuant to Title 42-15-60 (A) as amended. The execution of this document is an agreement between the parties relating to a Workers' Compensation claim under §§42-1-160, 42-1-172 or 42-11-10.

Date of Injury or Illness: 03/13/2010

The above parties agree to pay and accept compensation based on the following facts:
Compensable ☒ Injury ☐ Illness ☐ Repetitive Trauma occurred on: 03/13/2010 (month/day/year).

The injury was to Lumbar spine and right knee body part(s) injured and also the injury affected Psyche other body part(s).
The authorized treating physician has released the Claimant from his care and has found maximum medical improvement on 1/14/2011 (month/day/year).
With an impairment rating of: 10% to the spine.

Average weekly wage: \$ 254.38 Compensation rate: \$ 169.60

By agreement of the parties, the following award has been referred to the Commission for approval:

- | | |
|--|--------------------|
| <u>7</u> Percentage loss of use to: <u>Right Lower Extremity</u> (body part(s) injured). | <u>13.65</u> weeks |
| <u>18</u> Percentage loss of use to: <u>Spine</u> (body part(s) affected). | <u>54</u> weeks |
| Percentage loss of use to: whole person | _____ weeks |
| Disfigurement to: _____ | _____ weeks |
| Wage Loss: \$ _____ amount | _____ weeks |
| Total and Permanent Disability: _____ | _____ weeks |
| Other: _____ | _____ weeks |

Estimated award (number of weeks times compensation rate) \$ 11,473.44
Estimated award is subject to verification by the Commission

Additionally, the Employer's Representative agrees to pay and the Claimant accepts the following medical care and treatment as recommended by the authorized treating physician pursuant to the attached physician's statement, Form 14B.

Additional medical ordered: ☒ Yes ☐ No
Attached 14B physician's statement dated: 10/14/2011 per Dr. Satterthwaite & 12/12/2011 per Dr. [illegible]

This agreement is binding on approval by the Commission. A claim for additional compensation based on a worsening of the Claimant's condition must be filed no later than one (1) year from the date of the last payment of compensation. Only medical care specifically filed herein will be paid under this agreement. If a dispute arises with regard to continued medical treatment, either party may request a hearing before the Commission pursuant to 42-15-60(B) 3 and (C).

Zecena L. Fletcher
Claimant's Signature

2/3/12
Date Agreement Signed

Employer's Representative

[Signature]
Attorney for Carrier

County Commissioner

Date agreement approved

RECEIVED

FEB 06 2012
Division of Claims
Claims Administrator
S.C. Workers' Compensation Commission

RECEIVED
SETTLEMENT
Email

FEB 08 2012

Division of Claims
BOWEN Comp. Comm.
Agreement for Permanent Disability/
Disfigurement Compensation

ORDER
of the
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
File Nos.: **1003122**

Zeena Fletcher,

Employee/Claimant,

vs.

Dick's Sporting Goods,

Employer, and

Federal Insurance Company,

Carrier/Defendants.

Hearing: Held in Spartanburg, South Carolina on September 5, 2012

Appearances: Kathryn Williams, Esq. of Kathryn Williams, P.A. for claimant

Andrew D. Smith, Esq. of Smith|Poe, P.A. for defendants

Purpose: To determine the issues on the Form 50

Decision & Order: T. Scott Beck, Commissioner

Filed: October 12, 2012

APA SUBMISSIONS
(as numbered and submitted by the parties)

By claimant:

#1	John R. Satterthwaite, M.D.	2/27/12-6/13/12	1-36
		7/25/12-8/8/12	1a-li
#2	C. David Tollison, Ph.D.	3/22/12-5/4/12	37-42
		7/30/12	37a-37c
#3	Upstate Physical Therapy	7/23/12	43-44
#19	Innervision MRI & Imaging	6/7/12	99-100
#20	Employment Separation Form	6/27/12	101

By defendants:

#4	Innervision MRI & Imaging	8/13/10	45-46
#5	Sports, Spine & Industrial PT	9/21/10	47-52
#6	Robert Moss, Ph.D.	11/8/10	53-55
#7	George R. Bruce, M.D.	12/1/10	56-60
#8	Anmed Health	2/17/12	61-75
		2/18/12	
#9	John R. Satterthwaite, M.D.	2/29/12-6/14/12	76-83
#10	Innervision MRI & Imaging	6/7/12	83a-83b
#11	SCWCC Form 14B/ Alan Posta, M.D.	10/1/10	84
#12	SCWCC Form 14B/ Mark Foster, M.D.	11/10/10	85
#13	SCWCC Form 14B/ C. David Tollison, Ph.D.	10/14/11	86
#14	SCWCC Form 14B/ C. David Tollison, Ph.D.	12/12/11	87
#15	SCWCC Form 16A	2/8/12	88
#17	Questionnaire/ John R. Satterthwaite, M.D.	5/24/12	89-91
#18	Deposition/ John R. Satterthwaite, M.D.	8/15/12	To be Supplemented

EXHIBITS

By claimant:

A. Deposition of John R. Satterthwaite, M.D., dated 8/15/12, consisting of 32 pages

STIPULATIONS

Counsel for all parties stipulated at the hearing to the following issues:

1. The purpose of the hearing is to determine issues set forth in the hearing notice, issues pled in the Form 50, and other issues timely brought before the Commissioner.
2. Notice of the hearing was timely and properly served upon all parties of interest.
3. Venue, set in Spartanburg County, is proper.
4. Claimant seeks additional benefits under the South Carolina Workers' Compensation Act based upon an admitted injury by accident she sustained on March 13, 2010 while she was working for employer-defendant, and therefore, the South Carolina Workers' Compensation Commission has jurisdiction of the case.
5. The Commission's file and the Hearing Commissioner's notes are a part of the record of this case, with the exception of any self-serving declarations or unstipulated medical reports.
6. Claimant's average weekly wage is \$254.38, for a corresponding compensation rate of \$169.60.

CLAIMANT'S BIOGRAPHICAL INFORMATION

Age: 53

Education: High School graduate

Work History: Claimant worked for employer-defendant as a Cashier then a Customer Service Specialist from September 2008 until June 27, 2012; she previously worked for Wal-Mart as a Cashier and Stocker.

STATEMENT OF THE CASE

Claimant seeks additional benefits for an admitted injury by accident she sustained on March 13, 2010 while working for employer-defendant causing injury to her right lower extremity and back. Defendants provided medical treatment, including medications, physical therapy, and injections. By subsequent Form 16A approved on February 8, 2012, the parties agreed claimant reached maximum medical improvement on October 14, 2011. Parties also agreed claimant sustained a 7% permanent partial disability of the righter lower extremity and an 18% permanent partial disability of the back with additional medical treatment ordered per Dr. Satterthwaite and Dr. Tollison.

Claimant now contends she suffered a change of condition for the worse to her back. Claimant asserts she is not at maximum medical improvement, seeks further medical care, and entitlement to temporary total disability benefits from February 27, 2012 to the present and continuing. Further, claimant requests an MRI of the right knee.

Defendants deny claimant's change of condition on two grounds. First, they contend claimant has not sustained a change of condition for the worse. Second, they contend the claimant suffered an intervening incident that broke the chain of causation.

Finally, defendants also deny claimant's entitlement to an MRI of the right knee as it is not specially delineated on the Forms 14B or 16A.

EVIDENCE OF THE CASE

Claimant was initially injured on March 13, 2010 when she slipped and fell injuring her right knee and back while performing her regular work duties for employer-defendant. Claimant testified that she did not have problems with employer-defendant prior to her injury and she enjoyed her job. After treating for her injury, claimant returned to work on light duty on August 2, 2010 and continued to work for employer-defendant. On February 8, 2012, the parties filed and Commission approved a Form 16A providing compensation for claimant's right lower extremity and back as well as additional medical treatment.

Claimant testified that she returned to work for employer-defendant following her March 13, 2010 injury by accident. Claimant worked from August 2, 2010 until February 27, 2012 under Dr. Satterthwaite's light duty restrictions all while managing continuous back pain and spasms with prescribed medications and injections. Claimant testified despite these light duty restrictions, she continued to need help with work duties because of her injuries.

Claimant testified her back condition has changed for the worse since the settlement of her claim. In February 2012, while shopping with her daughter, claimant developed flu symptoms and started to vomit. After feeling a muscle spasm and pop in her back, claimant was transported by ambulance to the hospital to receive fluids. The medical records show that claimant reported to the hospital on February 17, 2012, after

experiencing 12 episodes of vomiting over approximately 20 hours. She presented with complaints of chronic back pain and falling from a back spasm. Dr. Kaveti at Anmed Health diagnosed claimant with dehydration and admitted her for aggressive hydration with fluids on February 22, 2012.

On a previously scheduled February 27, 2012 follow up appointment, Dr. Satterthwaite noted that claimant suffered from a gastrointestinal virus earlier in February 2012 causing her to vomit. He wrote her out of work until March 14, 2012 due to increased problems with her back. He also recommended restarting physical therapy as her back spasms were worse; however, workers compensation did not approve the treatment. Claimant testified that her back continued to hurt and that she thought the pain was an extension of her March 13, 2010 injury because she previously suffered from back spasms before experiencing the dry heaving and vomiting. On March 18, 2012, Dr. Satterthwaite noted claimant's continued difficulty with standing, walking, and sitting for longer than 10 minutes as well as her inability to perform household chores due to decreased range of motion, decreased sensation, tingling in her leg, and increased back spasms. He continued to write claimant out of work until May 12, 2012.

On May 10, 2012, Dr. Satterthwaite opined in a statement that the claimant sustained a change of condition for the worse stemming from her March 13, 2010 injury by accident. He further opined that claimant's vomiting is a routine event and did not break the chain of causation relating to claimant's injury by accident. Because claimant's March 13, 2010 low back injury made her more susceptible to increased low back pain from routine events, Dr. Satterthwaite recommended an MRI of her back and physical

therapy to treat the causally-related change of condition. On May 14, 2012, he again wrote claimant out of work until June 13, 2012.

In a March 31, 2012 statement, Dr. Satterthwaite again opined that claimant's current back problems and need for more treatment resulted from a worsening of her March 13, 2010 injury by accident and that physical therapy and an MRI are necessary to maintain and improve claimant's functioning.

Dr. Satterthwaite continued to treat claimant noting on June 13, 2012 that claimant's chronic back pain worsened to the point where claimant requires the help of her husband to get out of bed. Dr. Satterthwaite also reviewed claimant's June 6, 2012 MRI and noted no acute changes when contrasted with her previous MRI of August 13, 2010. Therefore, Dr. Satterthwaite again opined that claimant had an exacerbation of symptoms from her original injury of March 13, 2010 and wrote her out of work until July 11, 2012. In an August 8, 2012 follow up appointment, Dr. Satterthwaite continued to note claimant's chronic back pain and wrote her out of work until October 8, 2012.

Dr. Satterthwaite's statements are further supported by his August 15, 2012 deposition where he stated that claimant's current condition is not the result of a new injury but a change of condition for the worse related to her March 13, 2010 work injury. Dr. Satterthwaite stated claimant's current course of treatment is a result of a natural progression or worsening of her prior condition due to her work injury and not the result of an intervening cause or break in the chain of causation. Additionally, Dr. Satterthwaite maintained his opinion that the claimant will always be prone to aggravations or exacerbations like routine vomiting because of her prior back injury. Dr. Satterthwaite also reaffirmed his previous written statements opining claimant's current

back problems and need for more treatment resulted from a worsening of her March 13, 2010 injury.

The medical records also show that claimant treated with Dr. Tollison for pain management. On March 22, 2012, Dr. Tollison noted that claimant's increased pain impaired her ability to sleep. Further, he noted that claimant wants and financially needs to work but is unable to do so because of her pain. On May 4, 2012, Dr. Tollison noted that claimant feels guilty about not being able to work.

Claimant's March 13, 2010 injury by accident also caused her right knee to require treatment. Claimant's right knee developed fluid under her kneecap that required draining. Claimant testified that her right knee continues to cause pain and worsen gradually. On June 6, 2012, Dr. Satterthwaite recommended an MRI and an orthopedist referral to address claimant's continuing problems with her right knee.

Employee records show employer-defendant terminated claimant on June 27, 2012 due to her inability to return to work.

FINDINGS OF FACT

1. By previous Form 16A agreement approved by the Commission on February 8, 2012, claimant sustained a compensable injury by accident on March 13, 2010, causing injury to her right lower extremity and back. This finding is based on the Commission's file.

2. By previous Form 16A agreement approved by the Commission on February 8, 2012, claimant's average weekly wage is \$254.38, for a corresponding compensation rate of \$169.60. This finding is based on the Commission's file.

3. Claimant filed a claim alleging change of condition for the worse on May 14, 2012. This finding is based on the Commission's file.

4. Since the Form 16A settlement on February 8, 2012, claimant experienced increased pain her back. This finding is based on all the evidence in the record, including but not limited to claimant's testimony and the medical records of Dr. Satterthwaite.

5. On February 17, 2012, claimant presented to Anmed Health complaining of dry heaving and vomiting. She also complained of increased low back pain and muscle spasms. This finding is based on the medical records of Anmed Health and Dr. Kaveti.

6. Since February 17, 2012, claimant has been diagnosed with increased low back pain and muscle spasms. This finding is based on the medical records and opinions of Dr. Satterthwaite.

7. Dr. Satterthwaite opined that claimant sustained a change of condition for the worse to her back since February 17, 2012. This finding is based on the medical records and opinions of Dr. Satterthwaite.

8. The greater weight of the evidence shows that claimant's current condition is a progression of and related to her original injuries sustained in her March 13, 2010 injury by accident and that she did not sustain an intervening injury. This finding is based on all the evidence on the record, including but not limited to claimant's testimony and the medical records of Dr. Satterthwaite.

9. Claimant has been unable to return to any work and has been temporarily totally disabled because of her continuing back pain and related limitations and restrictions since February 27, 2012. This finding is based on all the evidence on the

record, including but not limited to claimant's testimony and the medical records of Dr. Satterthwaite.

10. Claimant suffered a change of condition for the worse since the Form 16A agreement approved by the Commission on February 8, 2012, in that her compensable back injury worsened and caused her to experience additional problems and caused temporary total disability. This finding does not preclude a future finding that claimant has returned to baseline. This finding is based on all the evidence in the record, including but not limited to claimant's testimony and the medical records of Dr. Satterthwaite.

11. Claimant is entitled to causally related medical treatment because of her compensable injuries. This finding is based on all the evidence on the record, including but not limited to claimant's testimony and the medical records and opinions of Dr. Satterthwaite.

12. Claimant is not at maximum medical improvement from her injuries. This finding is based on all the evidence on the record, including but not limited to the medical records of Dr. Satterthwaite.

13. Claimant's request for an MRI to the right knee is denied as it was not contemplated in the prior settlement agreement. This finding is based on the all the evidence on the record, including but not limited to the Forms 16A and 14B.

RULINGS OF LAW

1. By previous Form 16A agreement approved by the Commission on February 8, 2012, claimant has sustained compensable injury by accident causing injury

to her back. See Singleton v. Young Lumber Co., 236 S.C. 454, 114 S.E.2d 837 (1960)(agreement approved by the Commission is binding on the parties).

2. By previous Form 16A agreement approved by the Commission on February 8, 2012 claimant's average weekly wage is \$254.38, for a corresponding compensation rate of \$169.60. See Singleton.

3. Under S.C. Code Ann. § 42-17-90, claimant timely and properly filed a claim alleging a change of condition for the worse since the previous Form 16A agreement approved by the Commission on February 8, 2012.

4. Under S.C. Code Ann. § 42-17-90, claimant experienced a change of condition for the worse since the Form 16A agreement approved by the Commission on February 8, 2012, in that her compensable back injury worsened and caused her to be unable to work.

5. Claimant has not reached maximum medical improvement from her injuries. See Dodge v. Bruccoli, Clark, Layman, Inc., 334 S.C. 574, 514 S.E.2d 593 (Ct.App.1999)(maximum medical improvement is a plateau at which no further medical care or treatment will lessen the degree of impairment).

6. Under S.C. Code Ann. § 42-15-60, claimant is entitled to and defendants are responsible for all causally related medical treatment and expenses from February 27, 2012 to the present and continuing.

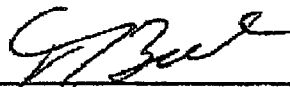
7. Under S.C. Code Ann. § 42-9-10, claimant is entitled to, and defendants are responsible for, temporary total disability benefits at the rate of \$169.60 per week from February 27, 2012 to the present and continuing until further Order of the Commission or agreement of the parties.

ORDER

It is ordered that defendants shall provide the following:

1. All causally related medical treatment and expenses from February 27, 2012 to the present and continuing.
2. Temporary total disability benefits at the rate of \$169.60 per week from February 27, 2012 to the present and continuing until further Order of the Commission or agreement of the parties. All payments shall be made to claimant through her attorney's office.

S.C. Workers' Compensation Commission



T. Scott Beck, Commissioner

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.

October 12, 2012

By: Amy Bracy, Administrative Assistant to Commissioner Beck

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

WCC FILE NO.: 1003122

Zeena L. Fletcher,	)	
	)	
Employee,	)	
Claimant,	)	
	)	
vs.	)	
	)	ORDER
Dick's Sporting Goods,	)	
	)	
Employer,	)	
	)	
and	)	
	)	
Gallagher Bassett Services/Federal Ins. Co.	)	
Chubb Group of Ins. Companies,	)	
	)	
Carrier,	)	
Defendants.	)	
_____	)	

This matter was scheduled for hearing before me on February 5, 2013. The Claimant and counsel for both parties were present at the hearing.

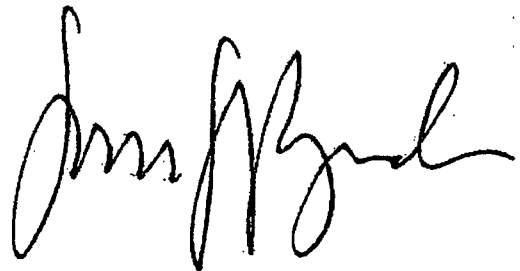
An extensive pre-hearing conference was held with counsel for both parties. The undersigned expressed concern that Claimant may want to obtain additional evidence in addition to the authorized treating physician's opinion that the Claimant has sustained a change of condition for the worse regarding her right knee. The undersigned discussed postponement in case Claimant's attorney wanted to obtain additional diagnostic evidence. At that point, defense counsel objected to the case being postponed. Claimant's counsel then withdrew the hearing request.

Defense counsel admitted during the pre-hearing conference that the reason he was insisting the Claimant withdraw the hearing request was so that he could raise a statute of limitations defense. The Form 16 in this case was approved by the Commission on February 8, 2012. This hearing was originally scheduled for January 18, 2013, and then reset January 29, 2013. Both hearings were rescheduled at the direction of the undersigned, and not at the request of the Claimant. The case was then reset for February 5, 2013.

Claimant was ready to proceed at all three hearings, and Defendants have been on notice of the change of condition claim for months as Claimant timely filed a Form 50 attaching medical documentation of the change in condition. Accordingly, all applicable time limits in S.C. Code Ann., §42-17-90 are tolled.

IT IS SO ORDERED.

March 12, 2013

A handwritten signature in black ink, appearing to read "Kristi Love", is written over the text "IT IS SO ORDERED." and the date "March 12, 2013".

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States mail addressed to any unrepresented party.

By Kristi Love on March 12, 2013

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

FILE NO.: 1003122

Zeena Fletcher, Employee-Claimant,

Respondent,

vs.

Dick's Sporting Goods, Employer, and **Federal Insurance Co.**, Carrier,

Appellants.

Appellate Panel Review Held in Columbia,
South Carolina on June 18, 2013, per notice timely
and properly served upon all parties of interest.

Appearances: Donald E. Kamb, Jr., Esq. of Kathryn Williams, P.A. of
Greenville, South Carolina for claimant

Andrew D. Smith, Esq. of Smith|Poe, P.A. of Simpsonville, South
Carolina for defendants

Purpose: Appellate Panel Review of issues set forth in defendants' Form 30
Request for Commission Review

Filed:

9-19-13

STATEMENT OF CASE

This claim came before Commissioner Susan S. Barden on February 5, 2013 in response to claimant's Form 50 hearing request alleging a change of condition with regard to the previously-determined compensable injury to her right knee. As stated in her March 12, 2013 Order, following an extensive pre-hearing conference with the attorneys for both parties, Commissioner Barden expressed concern that the authorized treating physician's uncontroverted opinion, stated to a reasonable degree of medical certainty, that "the Claimant has sustained a change of condition for the worse regarding her right knee condition stemming from her March 13, 2010 injury by accident," would not be sufficient to warrant a finding that the Claimant has sustained a change of condition for the worse to her right knee, and the Commissioner suggested that the case be postponed so that claimant's attorney could obtain additional evidence. However, defendants' attorney objected to the case being postponed, and in response, claimant's attorney withdrew the Form 50 hearing request.

As defendants' attorney admitted in this pre-hearing conference, the reason he objected to the postponement and was insisting that claimant instead withdraw the hearing request was so that he could raise a statute of limitations defense. The Commissioner issued her March 12, 2013 Order specifically finding that the Form 16 in this case was approved by the Commission on February 8, 2012, that the hearing was originally scheduled for January 18, 2013, that the hearing was reset on January 29, 2013 and then on February 5, 2013 at the Commissioner's direction, that claimant was ready to proceed at all three scheduled hearings, that defendants have been on notice of the change of condition claim for months as Claimant timely filed a Form 50 attaching medical

documentation of the change in condition, and that “[a]ccordingly, all applicable time limits in S.C. Code Ann., § 42-17-90 are tolled.”

Within the statutory period, defendants filed an Application for Review of this claim. On May 17, 2013, defendants filed an appellate brief contending “[t]he Single Commissioner erred in allowing the Claimant to withdraw their Form 50, Change of Condition for the worse, since by Order the statute of limitations cannot be tolled as set forth in S.C. Code Ann. § 42-17-90.” On June 12, 2013, claimant filed a respondent brief asserting that the Single Commissioner properly allowed claimant to withdraw her Form 50 request and that the applicable time limits in § 42-17-90 are tolled.

All proffered testimony and documentary evidence has been taken and delivered to the individual members of the Appellate Panel for their study and consideration.

EVIDENCE OF THE CASE

At the hearing before the Single Commissioner, the following summarized evidence was presented and discussion held:

This matter was scheduled for hearing on February 5, 2013 before Commissioner Barden. The Commissioner held an extensive pre-hearing conference with counsel for both parties. The Commissioner expressed concern that claimant may want to obtain additional evidence in addition to the authorized treating physician’s opinion that the claimant has sustained a change of condition for the worse regarding her right knee. The Commissioner discussed postponement in case claimant’s attorney wanted to obtain additional diagnostic evidence. At that point, defense counsel objected to the case being postponed. Claimant’s counsel then withdrew the hearing request.

Defense counsel admitted during the pre-hearing conference that the reason he was insisting the claimant withdraw the hearing request was so that he could raise a statute of limitations defense. The Form 16 was approved by the Commission on February 8, 2012. The hearing was originally scheduled for January 18, 2013, and then reset January 29, 2013. Both hearings were rescheduled at the direction of the Commissioner, and not at the request of the claimant. The case was then reset for February 5, 2013.

Claimant was ready to proceed at all three hearings, and defendants have been on notice of the change of condition claim for months as claimant timely filed a Form 50 attaching medical documentation of the change in condition. Accordingly, all applicable time limits in S.C. Code Ann. § 42-17-90 are tolled.

DECISION

Under S.C. Code Ann. § 42-17-50, an Appellate Panel is empowered to review the appealed award, weigh the evidence as presented at the initial hearing, and, if good grounds are shown therefore, make its own factual findings and legal conclusions consistent with or inconsistent with the Single Commissioner.

Based upon its review of all the evidence on the record in this case, the Panel hereby fully affirms the Order of the Single Commissioner. The Panel makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. By previous Form 16A agreement approved by the Commission on February 8, 2012, claimant sustained a compensable injury by accident on March 13, 2010 causing injury to her right lower extremity and back. This finding is based on information contained in the Commission's file.

2. This matter was scheduled for hearing before Commissioner Barden on February 5, 2013 on claimant's Form 50 claiming a change of condition for the worse with regard to her right lower extremity, and claimant and counsel for both parties were present at the hearing.

3. Commissioner Barden held an extensive pre-hearing conference with counsel for both parties, expressed concern that claimant may want to obtain additional evidence in addition to the authorized treating physician's opinion that claimant has sustained a change of condition for the worse regarding her right knee, and discussed postponement in case claimant's attorney wanted to obtain additional diagnostic evidence; however, at that point, defendants' attorney objected to the case being postponed, and claimant's attorney then withdrew the hearing request.

4. Defendants' attorney admitted during the pre-hearing conference that the reason he insisted claimant withdraw the hearing request was so that he could raise a statute of limitations defense.

5. The Commission approved the Form 16 in this case on February 8, 2012.

6. On or about November 20, 2012, claimant filed a Form 50 alleging she sustained a change of condition for the worse with regard to her right knee and attached supporting medical documentation.

7. A hearing was originally scheduled for January 18, 2013, and then reset to January 29, 2013. Both of these previously scheduled hearings were rescheduled at the direction of Commissioner Barden, and not at claimant's request.

8. Claimant was ready to proceed at all three scheduled hearings.

9. Defendants have been on notice of the change of condition claim for months, as claimant timely filed a Form 50 with attached medical documentation of the change in condition.

10. All applicable time limits in S.C. Code Ann., §42-17-90 were tolled, or satisfied, when claimant filed her Form 50 on or about November 20, 2012.

RULINGS OF LAW

1. Under S.C. Code Ann. § 42-17-50, the Commission's Appellate Panel is empowered to review the appealed award, weigh the evidence as presented at the initial hearing, and if good grounds are shown therefore, make its own findings of fact and conclusions of law consistent with or inconsistent with those of the Single Commissioner.

2. By previous Form 16A agreement approved by the Commission on February 8, 2012, claimant has sustained compensable injury by accident causing injury to her right knee. See Singleton v. Young Lumber Co., 236 S.C. 454, 114 S.E.2d 837 (1960)(agreement approved by the Commission is binding on the parties).

3. Under S.C. Code Ann. § 42-17-90, claimant timely and properly filed a claim alleging a change of condition for the worse.

4. All applicable time limits in S.C. Code Ann., §42-17-90 were tolled, or satisfied, when claimant filed her Form 50 on or about November 20, 2012.

5. An actual hearing on the alleged change of condition claim need not be held within the one year period referred to in S.C. Code Ann., §42-17-90. Allen v. Benson Outdoor Adver. Co., 236 S.C. 22, 112 S.E.2d 722 (1960)(so long as the change of condition claim is filed with the Commission within the one-year period, the actual hearing on the issue need not be heard during the one year).

6. Claimant's withdrawal of the hearing request in this matter does not withdraw the underlying claim. S.C. Code Reg. 67-609(A), (B)(2010)("[a] claimant may withdraw a Form 50 [hearing request] or Form 52 once as a matter of right with leave to renew" and the withdrawal "is without prejudice to the claimant's right to proceed with his or her claim.").

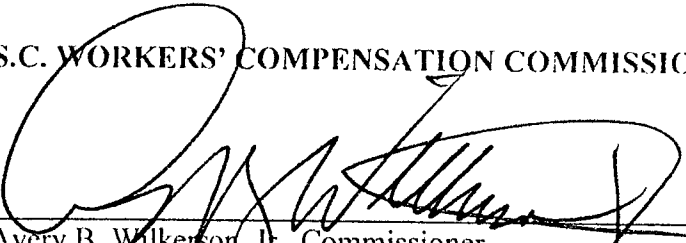
[Signature and Order page follows]

ORDER

IT IS, THEREFORE, ORDERED that the Order of the Single Commissioner is hereby affirmed in its entirety.

AND IT IS SO ORDERED.

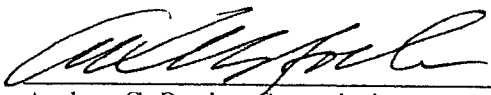
S.C. WORKERS' COMPENSATION COMMISSION


Avery B. Wilkerson, Jr., Commissioner

CONCUR:


T. Scott Beck, Commissioner

CONCUR:


Andrea C. Roche, Commissioner

Date: 9-19-13
Columbia, South Carolina

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States mail addressed to any unrepresented party.

By Valerie Deller on September 19, 2013



Carrier File #: **003619-001324-WC01**
Carrier Code #:
Employer FEIN #:

Claimant's Name: Zeena Fletcher SSN: 224 - 04 - 2218 Employer's Name: Dick's Sporting Goods, Inc.
Address: 206 Lewis Road Address: 140 Fritz Drive
City: Williamston State: SC Zip: 29697 City: Anderson State: SC Zip: 29621
Home Phone: (864) 634 - 0965 Work Phone: () - Insurance Carrier: Federal Insurance Group/Chubb
Preparer's Name: Andrew D. Smith Law Firm: Smith|Poe, P.A. Preparer's Phone #: (864) 963 - 0310

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☐ claimant ☒ employer (check one) Date of injury: 3/13/2010 (m/d/yyyy)

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

Whether the Single Commissioner erred in finding Dr. Satterthwaite opined the Claimant sustained a change of condition for the worse in regard to her back since February 17, 2012?

Whether the Single Commissioner erred in finding the greater weight of the evidence shows the Claimant's current condition is a progression of and related to her original injury by accident sustained on March 13, 2010 and that she did not sustain an intervening accident?

Whether the Single Commissioner erred in finding the Claimant is temporarily totally disabled because of a change of condition for the worse?

Whether the Single Commissioner erred in finding the Claimant is entitled to medical treatment in regard to the alleged change of condition for the worse?

Whether the Single Commissioner erred in failing to find the Claimant is at maximum medical improvement in regard to her initial injury of March 13, 2010?

Whether the Single Commissioner erred in failing to find there is a intervening accident cutting off the causal connection for any need of additional medical treatment and/or temporary disability benefits related to the March 13, 2010 injury?

Whether the Single Commissioner failed to find that Dr. Satterthwaite opined the Claimant did in fact sustain an aggravation of her pre-existing condition that is a new injury by accident?

Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

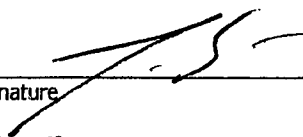
I certify that I have served this document pursuant to R.67-211 by delivering a copy to Kathryn Williams, Esquire, Kathryn Williams, P.A.

Name

P.O. Box 10693 Greenville, South Carolina 29603

the claimant appeals and is representing himself or herself, the Judicial Department will prepare the additional copies of this form and serve this form on the opposing party. R.67-701B. Otherwise, file the original and four copies of this form with the Judicial Department. The appeal must be postmarked no later than 14 days from the date of service of the Hearing Commissioner's decision. R.67-701 and R.67-205. Attach the filing fee to this form. Attach a Form 32 if you are unable to pay the filing fee. Refer to R.67-701 through R.67-711 for additional information.

on the 24th day of October, 2012 by ☒ first class ☐ personal service ☐ certified mail


Preparer's Signature

attorney-at-law

Title

10/24/2012

Date

Check this box if you are not represented by an attorney. ☐

**BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
WCC FILE NO: 1003122**

Dick's Sporting Goods,)
)
Employer, and)
)
Federal Insurance Company,)
)
Defendants/Appellants,)
)
v.)
)
Zeena Fletcher)
Employee/Respondent)
)
_____)

APPELLANTS' BRIEF

Statement of the Case

This matter came before the Single Commissioner pursuant to the Claimant's Form 50, alleging a change of condition for the worse to her right lower extremity and spine, as a result of her injury on March 13, 2010. The Claimant alleged she was not at maximum medical improvement and sought additional medical treatment and care as well as temporary total disability benefits from February 27, 2012 and continuing. Also, the Claimant specifically requested a MRI of the right knee as a result of a change of condition.

The Defendants denied the Claimant sustained a change of condition for the worse due to her spine. Rather, the Defendants argued the Claimant clearly sustained an intervening accident that broke the causal connection from her initial work-related injury, on March 13, 2010. The Defendants also deny the Claimant sustained a change of

condition for the worse to her right lower extremity; therefore, she was not entitled to any additional treatment not specified on Forms 14B or 16A.

Initially, this matter was scheduled to be heard before Commissioner Barden on December 22, 2011 at 9:30 am in Greenville, SC. Prior to the hearing, the Parties agreed to enter into a Form 16 settlement. Whereby, the Claimant received 7% permanent loss of use to her right lower extremity and 18% permanent loss of use to her spine. Per the Form 14B of Dr. Satterthwaite, dated October 14, 2011, the Claimant sustained 10% impairment to her spine and was unable to bend, twist, stoop or squat continuously but was able to walk and stand as tolerated and carry upwards of (25-30) twenty-five to thirty pounds. It was further indicated the Claimant would need medications, injections and intermittent physical therapy in the future. Dr. Tollison submitted a Form 14B, dated December 12, 2011, indicating the Claimant had a 5% impairment to the psyche and would need treatment for her adjustment disorder associated with pain and lifestyle change related to her on-the-job injury. He recommended psychological treatment (5-6) five to six times per year. Of note, Dr. Posta submitted a Form 14B, on October 1, 2010, indicating the Claimant had a 4% impairment to the right lower extremity and was unable to kneel, bend or crawl. He specified the Claimant was not in need of any future medical treatment or care. Dr. Foster, a board certified orthopaedic spine specialist, submitted a Form 14B, on November 10, 2010, indicating the Claimant had a 0% percent impairment and was able to return to work without restriction.

As stated previously, the Claimant filed a Form 50, alleging a change of condition to her spine and right lower extremity. A hearing was held in Spartanburg, South

Carolina on September 5, 2012. The Single Commissioner held as follows: 1) Claimant suffered a change of condition to her spine, but this finding does not preclude a later finding that the Claimant has returned to baseline status; 2) Claimant is entitled to causally related medical care; 3) Claimant is entitled to temporary total disability benefits from February 27, 2012 and continuing; 4) Claimant is not at maximum medical improvement; and 5) Claimant's request for an MRI to the right knee is denied as that was not contemplated in the prior settlement agreement. From the Single Commissioner's Order, dated October 12, 2012, the Defendants appealed.

Statement of Facts

On March 13, 2010, the Claimant slipped and fell at work. Per the Claimant's Form 50, she alleged injuring her right knee, left knee, right elbow, back, head, and requested treatment for psychological overlay. Following the incident, the Claimant was seen at AnMed, where x-rays were conducted of her right knee, cervical spine and lumbar spine.

The Claimant reported injuring her right knee and informed the physician that she did not strike her head or pass out. She was provided with Vicodin and an ACE bandage for her right knee. She was also provided with physical therapy at Upstate Physical Therapy. The Claimant continued to complain of pain in her right knee, so she was referred to Dr. Clemow at Blue Ridge Orthopedics. An MRI was conducted on May 10, 2010 that did not reveal a PCL or meniscal tear, although the visual acuity of the ACL was suspect. The Claimant was referred for a second opinion with Dr. Posta on July 21, 2010.

Dr. Posta recommended an MRI of the right knee be re-conducted to rule out the possibility of a torn ACL. The subsequent MRI revealed osteoarthritic changes, and no tears of the ACL were present. Dr. Posta indicated the Claimant has a (4%) four percent permanent impairment to the right lower extremity and should not be performing kneeling, bending or crawling. He also did indicate on the Form 14B that the Claimant was not in need of any further medical treatment or care.

The Claimant was also seen by Dr. Foster for her lower back complaints. Dr. Foster reviewed the x-rays of the Claimant's lumbar spine as well as the MRI that was conducted, which he opined demonstrated degenerative disc disease at L2-the sacrum, and the MRI was negative for any acute injuries. Dr. Foster referred the Claimant to Sports Spine Industrial, where a Functional Capacity Evaluation was conducted. The Claimant's job demand summary was reviewed, and her position was placed in the light-duty category. The Functional Capacity Evaluation indicated the Claimant could perform sedentary to light-duty.

The Defendants did refer the Claimant to Dr. Satterthwaite, based on recommendations by Dr. Posta, following a questionnaire submitted by the Claimant. The Claimant was referred to Dr. Satterthwaite on February 17, 2011. At that time, the Claimant was complaining of constant pain, which she would rate as a "6" in her lumbar spine and her right knee that becomes aggravated by bending, twisting, lifting, carrying, standing, stooping or crawling. Dr. Satterthwaite placed the Claimant on Ultram for the pain/spasms she was experiencing in the lumbar spine. He also indicated the Claimant should begin physical therapy, due to her de-conditioning, and facet injections should be

conducted at L3-L4, L4-L5 and L5-S1, a possible need to repeat the injection into the Claimant's right knee and referred the Claimant to Dr. Tollison for possible situational depression. The Claimant underwent the facet injection on March 9, 2011 at L3-L4, L4-L5 and L5-S1. The Claimant has also undergone physical therapy on March 14, 2011, March 16, 2011, March 21, 2011, March 28, 2011, March 31, 2011, April 4, 2011, April 7, 2011 and April 15, 2011.

On March 28, 2011, the Claimant reported having improvement in her back pain following the injections and the physical therapy. It was noted the Claimant continues to work full-duty at her regular employ. Dr. Satterthwaite, due to the success of the facet injections, was planning to perform a medial branch injection, possibly to be followed by a radiofrequency rhizotomy. The Claimant returned to Dr. Satterthwaite's office on April 25, 2011. She indicated the Ultram was upsetting her stomach, so she was switched to Lortab. It was also recommended the Claimant undergo medial branch blocks at L3-L4 through L5-S1. The Claimant was seen by Dr. Satterthwaite on May 27, 2011. She indicated improvement in her lower back pain following the injections. In fact, since the injections, she has had decreased pain, increased range of motion, improved sleeping patterns and self-reported improved quality of life. The Claimant was scheduled to return in (2) two months. The Claimant's medications were refilled, and she was instructed to continue physical therapy. On September 22, 2011, Dr. Satterthwaite placed the Claimant at maximum medical improvement.

The Claimant was seen by Dr. Tollison on March 16, 2011 and was diagnosed with situational depression. Dr. Tollison prescribed Pristiq. Dr. Tollison's note of April

4, 2011 indicates the Claimant is feeling "much better" and noted that her family members as well as her co-workers have noticed a difference in her attitude. The Claimant was scheduled to follow-up in one month's time.

The Claimant was seen by Dr. Tollison on May 17, 2011. The Claimant noted she did receive benefit from the bi-lateral L3, L4, L5 and S1 medial nerve facet blocks. The Claimant was still being prescribed Pristiq that was helping her mood. Dr. Tollison noted she was cognitively intact. Dr. Tollison noted at the July 29, 2011 appointment that the Claimant was continuing to do well on Prestiq and was to follow up in (6) six weeks. On November 28, 2011, Dr. Tollison placed the Claimant at maximum medical improvement.

As stated previously, the Parties entered into a Form 16A settlement on February 8, 2012. During the hearing held on September 5, 2012, the Claimant testified she is currently (53) fifty-three years old, has a twelfth grade education and has worked for Dick's Sporting Goods for (4) four years. She admittedly had an injury to her lower back and right knee on March 13, 2010.

The Claimant returned to work on a permanent basis on August 14, 2010. She continued to work at Dick's Sporting Goods, under Dr. Satterthwaite's work restrictions, from August of 2010 until February of 2011. Upon returning to work, the Claimant indicated she was physically able to perform all functions of her position with some exception. The Claimant alleged she was incapable of bending below the waist to stock merchandise, lift more than (15-20) fifteen to twenty pounds, would experience pain upon lifting objects more than (10-15) ten to fifteen pounds, and experienced lower back pain

upon sweeping. Otherwise, the Claimant indicated she was physically able to perform all aspects of her position, and she intended on continuing to work, until her episode in February of 2012.

On a Wednesday, in February of 2012, the Claimant was admittedly off work and was shopping with her daughter. She started feeling sick and vomited on a retail counter. She remained home on bed rest for (4) four days before going to the hospital. She admittedly was experiencing numerous episodes of vomiting and dry heaving before her hospitalization. On the day she called EMS, February 17, 2012, she reported vomiting on at least 12 episodes over approximately (20) twenty hour period. She was hospitalized until February 21, 2012. On February 27, 2012, the Claimant reported to Dr. Satterthwaite, "vomited so hard felt a pop in her back. . . .Some immediate leg numbness Now with significant spasms and back pain. . . . Off of work this week due to spasms." Also, Dr. Satterthwaite's noted, on June 13, 2012, that the Claimant "is having an exacerbation of her symptoms from the original injury."

At the hearing, the Claimant admittedly was having "really bad episodes of dry heaving." While she was having a dry heaving episode on February 17, 2012, she admittedly felt a "pop" in her back. She testified it was the "worst" pop in her back she had ever experienced. The Claimant also testified that she thought she was having a heart attack, so she called EMS. The Claimant admitted the vomiting exacerbated her preexisting back pain. Significantly, the Claimant stated she was having constant back pain prior to the vomiting episode, although her back is currently worse following the

vomiting episodes than it was previously. She further testified that her back condition has continued to remain worse following her hospitalization.

ISSUES

- I. **Did the Single Commissioner erred in failing to find the Claimant's extreme episodes of vomiting, in which she felt a 'pop' in her back, was not a intervening cause sufficient to break the chain of causation?**

LAW/ANALYSIS

- I. **The Single Commissioner erred in failing to find that the Claimant's extreme episodes of vomiting, in which she felt a 'pop' in her back was not a intervening cause sufficient to break the chain of causation.**

A claimant has the burden of proving facts sufficient to allow recovery under the Workers' Compensation Act. Hall v. Desert Aire, Inc., 376 S.C. 388 (S.C. App. 2007). The burden lies with the claimant to demonstrate causation by a preponderance of the evidence. South Carolina Second Injury Fund v. Liberty Mut. Ins. Co., 353 S.C. 117 (S.C.App. 2003). The Claimant has the burden of proving facts that will bring the injury within the workers' compensation law. Bartley v. Allendale County School Dist., 381 S.C. 262 (S.C. App. 2009). Obviously, the Appellate Panel of the Workers' Compensation Commission is the ultimate fact finder and is not bound by the Single Commissioner's findings of fact. Crisp v. Southco, Inc., 390 S.C. 340 (Crt. App. 2010). The Court held in Whitfield v. Daniel Constr. Co., 226 S.C. 37 (1954) that every natural consequence which flows from a compensable injury, unless the result of an independent intervening cause sufficient to break the chain of causation, is compensable.

Here, the Claimant has failed to meet her burden of proof that would allow her recovery under the Workers' Compensation Act. The Claimant sustained an independent intervening cause sufficient to break the chain of causation, and the Claimant's need for the additional medical treatment is not a natural consequence from her on-the-job injury.

In Sanders v. Wal-Mart Stores, Inc., 379 S.C. 554 (Crt. App. 2008), The Claimant suffered an injury to her knee while descending from a ladder while working at Wal-Mart. The Employer admitted the injuries and provided medical treatment. The Claimant was released to maximum medical improvement on February 15, 2001. At the time of her release, the Claimant had returned to work, although she was to avoid stooping, kneeling and squatting.

In September of 2002, the Claimant fell down stairs at her home, injuring the same knee. The Claimant alleged the fall at home was a natural consequence from her on-the-job injury. The Employer denied the fall at her home was a natural consequence from her on-the-job injury and argued it was an intervening act unrelated to her previous work-related injury and was therefore not compensable.

The Single Commissioner found the Claimant's knee injuries causally related to the original injury of June 14, 2000. The Employer appealed the findings to the Full Commission. The Full Commission found the injuries were not causally related to the initial injury. The Claimant appealed, and the Circuit Court overturned the Full Commission. The Employer then appealed to the Court of Appeals.

The Court of Appeals noted the Full Commission found there was not sufficient evidence that the Claimant's knee condition caused her to fall at home, and she had returned to work, with restrictions. Therefore, the Court of Appeals held the Circuit Court erred in reversing the Full Commission and reversed the Circuit Court's Order.

In Arnold v. Benjamin Booth Company, 257 S.C. 337 (1971), the Court held disability resulting from an aggravation of a preexisting condition or disease by an injury arising out of and in the course of employment is compensable as an injury under S.C. Code Ann. Section 42-1-160. Obviously, the same is true. If a Claimant sustains an aggravation of a preexisting condition outside of his/her employment it is considered a new injury and can be sufficient to break the causal connection between the original injury. Thus, it would not be deemed as a natural consequent or flow from the original injury, if this occurs, and the Claimant should be barred from additional compensation from the Act.

In this matter, the Claimant returned to work on a permanent basis on August 14, 2010. She continued to work at Dick's Sporting Goods, under Dr. Satterthwaite's work restrictions, from August of 2010 until February of 2012. She had been placed at maximum medical improvement by her treating physicians by February 17, 2012. The Claimant indicated she was physically able to perform all aspects of her position, with some exceptions, until February 17, 2012. She testified that she intended on continuing to work at Dick's Sporting Goods, until her episode in February of 2012.

Again, the Claimant testified on a Wednesday, in February of 2012, she was off work and was shopping with her daughter. Throughout the day she started feeling sick

and actually eventually vomited on a retail counter. She then remained off work, and she was on bed rest for (4) four days. After lying in bed for (4) four days, her symptoms did not alleviate and actually became worse.

She admittedly was experiencing numerous episodes of vomiting and dry heaving before her hospitalization. On the day she called EMS, February 17, 2012, she reported vomiting on at least 12 episodes over approximately a 20 hour period. She was hospitalized until February 21, 2012.

On February 27, 2012, the Claimant reported to Dr. Satterthwaite, "vomited so hard felt a pop in her back. . . . Some immediate leg numbness Now with significant spasms and back pain. . . . Off of work this week due to spasms." Also, Dr. Satterthwaite's noted, on June 13, 2012, that the Claimant "is having an exacerbation of her symptoms from the original injury."

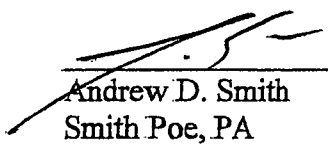
At the hearing, the Claimant admitted while she was having a dry heaving episode on February 17, 2012, she felt a "pop" in her back. She testified it was the "worst" pop in her back she had ever experienced. Significantly, the Claimant admitted the vomiting exacerbated her preexisting back pain. Although she stated she was having constant back pain prior to the vomiting episode, following her hospitalization, due to the vomiting episodes, her back is currently worse.

Clearly, the Claimant sustained an intervening cause due to the vomiting episodes that is unrelated to her on-the-job accident, and it cannot reasonably be expected to flow as a natural consequence of her original injury. By the Claimant's own testimony, she

experienced a permanent exacerbation of her preexisting condition, as a result of the vomiting episodes, that has made her condition worse.

CONCLUSION

For this and the other forgoing reasons, the Appellant respectfully requests the Single Commissioners' Decision and Order, dated October 12, 2012, be hereby overturned, and the Full Commission rule consistent with the evidence at hand.



Andrew D. Smith
Smith Poe, PA
634 B Fairview Road, Suite 2
Simpsonville, South Carolina 29680
(864) 963-0310
Facsimile (864) 228-7845

This 3rd day of January 2013
Simpsonville, South Carolina

1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675



Carrier File #: **003619-001324-WC01**

Carrier Code #: _____

Employer FEIN #: _____

Claimant's Name: Zeena Fletcher SSN: 224 - 04 - 2218 Employer's Name: Dick's Sporting Goods, Inc.
Address: 206 Lewis Road Address: 140 Fritz Drive
City: Williamston State: SC Zip: 29697 City: Anderson State: SC Zip: 29621
Home Phone: (864) 634 - 0965 Work Phone: () - Insurance Carrier: Federal Insurance Group/Chubb
Preparer's Name: Andrew D. Smith Law Firm: Smith|Poe, P.A. Preparer's Phone #: (864) 963 - 0310

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☐ claimant ☒ employer (check one) Date of injury: 3/13/2010 (m/d/yyyy)

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

Whether the Single Commisisoner can, by Order, extend the time limits as set forth by S.C. Code Ann. Section 42-17-90?

Whether the Single Commissioner erred in failing to find that in the event the Claimant withdrew her Form 50 that the claim would be barred by S.C. Code Ann. Section 42-17-90?

Whether the Claimant has failed to prove she sustained a change of condition for the worse within one year of the last date of payment of compensation to the Claimant?

Whether the Single Commissioner erred in failing to find in accordance with S.C. Code Ann. Section 42-17-90 that "the review must not be made after (12) twelve months from the date of the last payment of compensation pursuant to an award provided by this title."

SCWCC

MAR 18 2013

JUDICIAL

Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

I certify that I have served this document pursuant to R.67-211 by delivering a copy to Kathryn Williams, Esquire, Kathryn Williams, P.A.

Name

P.O. Box 10693 Greenville, South Carolina 29603

Address

on the 13th day of March, 2013 by ☒ first class mail ☐ personal service ☐ certified mail.

SCWCC

MAR 18 2013

JUDICIAL

If the claimant appeals and is representing himself or herself, the Judicial Department will prepare the additional copies of this form and serve this form on the opposing party. R.67-701B. Otherwise, file the original and four copies of this form with the Judicial Department. The appeal must be postmarked no later than 14 days from the date of service of the Hearing Commissioner's decision. R.67-701 and R.67-205. Attach the filing fee to this form. Attach a Form 32 if you are unable to pay the filing fee. Refer to R.67-701 through R.67-711 for additional information.

Preparer's Signature

Title

Date

Check this box if you are not represented by an attorney. ☐

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION

WCC Number: 1003122

Zeena Fletcher, Employee.....Respondent,

Dick's Sporting Goods, Employer,

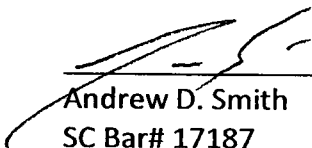
and

Federal Insurance Co., Carrier.....Appellants.

NOTICE OF APPEAL

Pursuant to S.C. Code Ann. § 42-17-60, Dick's Sporting Goods, and Federal Insurance Co., appeals the Order of the Appellate Panel of the S.C. Workers' Compensation Commission, Filed on September 19, 2013. Appellant received written notice of the entry of the original Order on September 19, 2013.

September 24, 2013



Andrew D. Smith
SC Bar# 17187
Andrew D. Smith, LLC
147 Wappoo Creek Dr. STE 104
Charleston, SC 29412
(843) 737-4619

Other Counsel of Record:

Kathryn Williams, Esquire
Kathryn Williams, P.A.
619 N. Main St., P.O Box 10693
Greenville, SC 29603

Zeena Fletcher vs. Dick's Sporting Goods
WCC File No.: 1003122

As S.C. Code Ann. § 42-17-60 provides that the "[n]otice of appeal must state the grounds of the appeal or the alleged errors of law," the following is provided as an attachment to the Notice of Appeal:

1. The Commission erred in allowing a Claimant to withdraw their Form 50, Change of Condition for the worse, then by Order toll the statute of limitations as set forth in S.C. Code Ann. §42-17-90, which allows the Claimant to file for review outside the (12) twelve month period as set forth in the statute.
2. The Commission erred in failing to find, in accordance with S.C. code Ann. §42-17-90, that the" review [request for a hearing] must not be made after (12) months from the date of the last payment of compensation pursuant to an award provided by this title."
3. The Commission erred in affirming a Decision and Order that allowed the Single Commissioner to extend the time limits as set forth by S.C. Code Ann. §42-17-90.
4. The Commission erred in finding that even though the Claimant withdrew her Form 50, at the hearing, that her claim was not barred by S.C. Code Ann. §42-17-90.

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION

WCC Number: 1003122

Zeena Fletcher, Employee.....Respondent,

Dick's Sporting Goods, Employer,

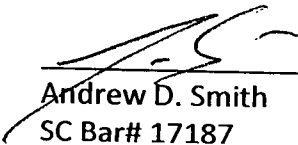
and

Federal Insurance Co., Carrier.....Appellants.

PROOF OF SERVICE

I certify that I have served the Notice of Appeal on the Respondent by depositing a copy of the document in the United States mail, first class postage prepaid, on September 24, 2013, to Zenna Fletcher's counsel of record Kathryn Williams, Esquire, 619 N. Main St. P. O. Box 10693, Greenville, SC 29603, (864) 235-6254.

September 24, 2013



Andrew D. Smith

SC Bar# 17187

Andrew D. Smith, LLC

147 Wappoo Creek Dr. STE 104

Charleston, SC 29412

(843) 737-4619

STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC No. 1003122

Zeena L. Fletcher,)
Employee,)
v.)
Dick's Sporting Goods,)
Employer,)
and)
Federal Ins. Co./Chubb Group of)
Ins. Cos.)
Carrier/Defendants.)
-----)

COPY

FULL COMMISSION HEARING

Tuesday, June 18, 2013
10:57 a.m. - 11:11 a.m.

The Full Commission Hearing was heard before Commissioners T. Scott Beck, Andrea Pope Roche and Avery Wilkerson at the Workers' Compensation Commission, 1333 Main Street, Suite 500, Columbia, South Carolina, on the 18th day of June 2013, before Andrea R. Taylor, Court Reporter and Notary Public in and for the State of South Carolina.

APPEARANCES

Donald E. Kamb, Jr., Esquire
 KATHRYN WILLIAMS, PA
 Post Office Box 10693
 Greenville, South Carolina 29603
 Attorney for the Claimant

Andrew D. Smith, Esquire
 ANDREW D. SMITH, LLC
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 Charleston, South Carolina 29412
 Attorney for the Defendant

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EXHIBITS

(There were no exhibits marked during this hearing.)

STIPULATIONS

It is stipulated and agreed that this hearing is being taken pursuant to the Administrative Procedures Act and the South Carolina Rules of Civil Procedure.

1 **COURT REPORTER:** Today is June 18th, 2013. This is
2 South Carolina Workers' Compensation Case
3 Number 1003122. This is the case of Zeena L.
4 Fletcher, Claimant, vs. Dick's Sporting Goods,
5 Employer, and Federal Insurance Company/Chubb
6 Groups of Insurance Companies, Carrier. The
7 Appellant is the defendant represented by
8 Andrew Smith. The Respondent is represented by
9 Donald E. Kamb., Jr. Each side is allowed ten
10 minutes for oral argument and the Appellant
11 three minutes in reply. You are requested to
12 argue the grounds of exception and stay within
13 the record.

14 **THE CHAIR:** Mr. Smith.

15 **MR. SMITH:** May it please the Commission. The date
16 of the accident was on March 13, 2010. It was
17 a slip and fall at Dick's. This matter first
18 came before Commissioner Barden back on
19 December 22nd, 2011. We elected to settle on
20 a Form 16. The Form 19 was signed on February
21 21st, 2012. Thereafter, a Form 50 was filed
22 for a change in condition in regard to an
23 alleged injury on February 27th, 2012. We then
24 went before Your Honor, Commissioner Beck and
25 their alleged change in condition was due to a

1 four-day hospitalization. It was the
2 defendant's argument that that was an
3 intervening accident. She had told Dr.
4 Sathwaid she'd felt a pop in her back. From
5 that, ruling Commissioner Beck found that she
6 had had a change of condition to her spine.
7 There was not in change in condition to the
8 right lower extremity. She was not granted the
9 MRI. The defendants did appeal that matter.
10 While the matter was pending before the
11 Commission, the claimant's attorney refiled a
12 Form 50 for a change of condition. Then that
13 again came before Commissioner Barden. That
14 hearing was held on February 5th, 2013.
15 There's an extensive pre-hearing conference.
16 During that conference, essentially
17 Commissioner Barden -- I'm not speaking outside
18 the record; it's in the order -- felt that
19 there wasn't enough diagnostic evidence to
20 support claimant's claim. And at that point,
21 she withdrew her Form 50 and also requested
22 that Commissioner Barden put in there that it
23 would toll the statute of limitations under 42-
24 17-90. The defendants clearly argued, even in
25 the order, that that was not permissible. You

1 cannot toll the statute of limitations under
2 42-17-90. Commissioner Barden had retained
3 jurisdiction, completely different story, or
4 had she refiled, the claimant on February 21st,
5 before February 21st, because the hearing
6 notice was February 5th, she refiled a Form 50,
7 she would have been fine, or if Commissioner
8 Barden said go get some more diagnostic
9 evidence and come back to us, I think that
10 would have been fine. But here in Commissioner
11 Barden's order on March 12th, 2013,
12 specifically states that the claimant withdrew
13 her hearing request and she was allowed to
14 refile, and it says the statute of limitations
15 is tolled. And I do not believe the single
16 Commissioner has the power to toll the statute
17 of limitations under 42-17-90 or under 42-15-
18 40. You simply cannot toll that statute. The
19 claimants will argue that under Regulation 67-
20 609 that they're allowed to refile at any time
21 and that constitutes filing. I agree with that
22 argument, they can refile at any time, but they
23 still have to refile within the statute of
24 limitations. So if you have one year statute
25 of limitations for a change in condition,

1 they'd have to refile within that year. That
2 provision was not meant to obscure the statute
3 of limitations in 42-15-40 or 42-17-90. The
4 regulation certainly wasn't meant to go against
5 the legislature and extend the statute of
6 limitations saying okay, if you filed one
7 claim, you're allowed to go as long as you want
8 and refile. I mean, clearly that's been the
9 precedent of the court. I mean, essentially
10 with 42-15-40, it's about a year after the last
11 date of payment of compensation and you better
12 refile. And under change in condition statute,
13 you have a year to file. And right now, we are
14 in four months past a year for a change in
15 condition for the worst, a year and four months
16 and there is yet to been a Form 50 refiled.
17 And this would be the third Form 50 refiled.
18 And the defendants are in pendency because
19 we're still waiting on a Form 50. Now, if
20 Commissioner Barden's order was allowed to stay
21 in place, they could refile their change of
22 condition at any time in the future. It puts
23 no limitations on it, the statute's tolled. So
24 that regulation was not meant to. There's a
25 red herring the claimant's trying to throw out

1 there about the case of Allen vs. I think it's
2 Benson or Denson Sporting Goods. Obviously the
3 hearing doesn't have to take place within the
4 one year change of condition for the worse, but
5 the Form 50 needs to be filed within that year.
6 And if there's exceptional reasons, if there
7 was some kind of reliance issue, if there was
8 an estoppel issue, it would be different.
9 There isn't any. She did not have enough
10 evidence to go forward. She should have
11 refiled her Form 50. You can't toll the
12 statute of limitations under this provision
13 just by the regulations. They're allowed to
14 withdraw, but they must refile in accordance
15 with the statute of limitations. Thank you,
16 Commissioners.

17 **THE CHAIR:** Mr. Kamb.

18 **MR. KAMB:** Commissioners, the 50 that was required
19 to be filed in this case to toll the statute
20 was filed on November 20th, 2012. It's the
21 only one that needed to be filed. That was a
22 claim 50, or actually, that was a hearing 50
23 for change of condition to the knee ---

24 **COMMISSIONER ROCHE:** So, Mr. Kamb, all a claimant
25 has to do is within one year file the motion

1 for -- file a 50 alleging a change in
2 condition, they can turn around the next day
3 and withdraw that 50 and then ten years later
4 come back and get their change in condition?

5 **MR. KAMB:** Not at all, and I think there's a
6 distinction there. Number one, Allen is not
7 a red herring. Allen is directly on point. It
8 says that all you have to do is file the
9 application for change of condition and it does
10 not have to be held within that year. I think
11 that's ---

12 **COMMISSIONER ROCHE:** That has nothing to do with
13 what we're talking about.

14 **MR. KAMB:** But I think it does, because that states
15 that you file the 50, the claim, which we did,
16 the hearing request on that claim is a separate
17 thing. That's what was withdrawn at the
18 hearing before Commissioner Barden, and the
19 regulation specifically ---

20 **COMMISSIONER ROCHE:** Well, answer my question again
21 that I asked you then. So you're saying that
22 a claimant can file a 50 alleging a change of
23 condition, file the claim, not request a
24 hearing, or request a hearing and then withdraw
25 the request for a hearing and then come back at

1 any time, 10, 15, 20 years down the road to get
2 their change in condition?

3 **MR. KAMB:** No, I don't think that they 10, 15, 20
4 years down the road, obviously laches ---

5 **COMMISSIONER ROCHE:** Three, three years.

6 **MR. KAMB:** --- that sort of things are there.

7 **COMMISSIONER ROCHE:** Three years down the road.

8 **MR. KAMB:** And I -- three years, I don't know, that
9 would be a question for the Commission as to
10 whether that's too long, but we're not dealing
11 with that here, okay? We were ready for a
12 hearing ---

13 **COMMISSIONER ROCHE:** How do we know we're not
14 dealing, you haven't even refiled your 50 yet,
15 according to Mr. Smith. Is that true, y'all
16 haven't refiled the 50?

17 **MR. KAMB:** We have not refiled a hearing ---

18 **COMMISSIONER ROCHE:** Request.

19 **MR. KAMB:** --- 50 yet. But under the Commission's
20 regulations, we don't have to. The claim has
21 been tolled. Commissioner Barden's order was
22 simply recognizing that the statute of
23 limitations had already been tolled by the
24 filing of the Claim 50 ---

25 **COMMISSIONER ROCHE:** And this is a little different

1 because it's -- I think this is a
2 jurisdictional issue and not necessarily a
3 statute of limitations issue.

4 **MR. KAMB:** Well, the Commission's rules clearly
5 state that the Commission still has
6 jurisdiction to hear the issue. It's without
7 prejudice the claimant's right to proceed with
8 the claim. I mean it can't be more clear than
9 that I don't think. Yes, we could get into a
10 situation where if it went too long the
11 defendants could argue laches or something of
12 that nature and the Commission may determine
13 that things went too long. But it hasn't been
14 all that long, and we couldn't -- even if we
15 had filed a hearing request 50 on this, we
16 wouldn't be here now because we'd be waiting on
17 this appeal to be resolved. So, you know, it's
18 not a significant amount of time that's passed
19 here. We were ready to go at the hearing.
20 Commissioner Barden felt like we needed
21 additional information and that's the sort of
22 thing that, you know, we tend to listen to when
23 we're in those inform- -- in those pre-hearing
24 conference. If the Commissioner gives you that
25 sort of direction, you feel like you've got to

1 go and get some more information. That takes
2 some time to do. So under the Commission's
3 rules, 40-67-609(B) says the hearing request
4 can be withdrawn. It does not withdraw the
5 claim because it's without prejudice the
6 claimant's right to proceed with the claim. So
7 yes, we could -- that could go too long. We
8 could wait too long to get that filed, but I
9 don't think we're here yet at that point yet.
10 It's only been a couple of months and we
11 couldn't have done anything different, nothing
12 different would have happened because we're
13 here on this appeal. And maybe that brings up
14 the idea that maybe this whole thing is
15 interlocutory at the point -- at this point.
16 I don't know. Maybe it needs to be ---

17 **COMMISSIONER ROCHE:** Yeah, I tend to agree with you
18 that it might have been the time to raise this
19 was when y'all tried to refile and claim then
20 that the statute had -- that we no longer had
21 jurisdiction.

22 **MR. KAMB:** But then you know ---

23 **COMMISSIONER ROCHE:** It's not really a statute of
24 limitations it's a ---

25 **MR. KAMB:** Well, the one year thing. And I don't

1 think -- the Commission's rules specifically
2 made clear that, you know, it's without
3 prejudice a claimant's right to proceed with
4 the claim. Yes, that can go too long. Ten
5 years would clearly be too wrong -- too long,
6 I'm sorry. But we're not in that situation
7 now. It's only been a couple of months and
8 nothing different could have happened in this
9 situation because we're here waiting on this
10 appeal. So I think that the defendant's
11 argument is completely without merit when you
12 look at the statutes, the cases interpreting
13 that statute and the Commission's regulations
14 on the issue.

15 **THE CHAIR:** Thank you, sir. Anything further, Mr.
16 Smith?

17 **MR. SMITH:** Just a few things. Obviously I wouldn't
18 be here if this was completely without merit.
19 And Allen obviously is a red herring. In that
20 case, the Form 50 was filed within the one year
21 change of condition for the worse. They argue
22 that only a little time has transpired. If you
23 have a one year change of condition and they're
24 four months out, that's almost halfway to
25 doubling the statute of limitations. So again,

1 we still don't have a Form 50 filed.
2 Regulation 609 again is also a red herring.
3 It's not meant to prolong the statute of
4 limitations. It allows claimants to refile
5 within the statute of limitations. So that
6 would just be saying anybody that withdrew
7 their Form 50 could refile it. And they say
8 that's -- you know, this matter was pending
9 appeal, so this matter was pending appeal so
10 they haven't had time to refile the Form 50 or
11 it wouldn't be appropriate. The claimant did
12 the same thing to me when I appealed Your
13 Honor's ruling, she then turned around and
14 filed a change of condition for the right leg
15 again after you found the right leg wasn't a
16 change in condition. What stopped her there?
17 So I had an appeal going up on a change in
18 condition and I was going to a hearing on a
19 change in condition. And what the claimant
20 argued at that point in time is there was
21 nothing barring them from filing a new change
22 in condition, but yet they come here today and
23 say that since I filed this appeal, that's
24 prevented them from filing a Form 50. It
25 didn't prevent them from filing ---

1 **THE CHAIR:** Two different body parts though.

2 **MR. SMITH:** Well, they had alleged on the original
3 Form 50 spine ---

4 **THE CHAIR:** Well, the hearing they had in front of
5 me, and I recall this case now, was the back
6 that I'd found compensable.

7 **MR. SMITH:** Correct, and she was requesting an MRI
8 for the right lower extremity ---

9 **THE CHAIR:** Right.

10 **MR. SMITH:** --- and that wasn't mentioned on her
11 Form 16. On the Form 50 she alleged change in
12 condition, right lower extremity was mentioned.
13 And obviously since it wasn't mentioned in the
14 Form 16, she would have to be requesting a
15 change in condition for the worse or the
16 defendants obviously would have no obligation
17 to provide additional medical treatment or
18 care. So when she appealed that matter up --
19 so I appealed that matter. Then she refiled
20 just on the right lower extremity and tried to
21 argue that it wasn't -- she wasn't trying to
22 claim change in condition previously. I argued
23 that matter is still pending appeal. Now they
24 argue that they didn't file a Form 50 because
25 this matter is pending appeal when, in turn,

1 they did the same thing previously. So they're
2 kind of -- that's a double-edge sword. They're
3 kind of in between. And there -- certainly the
4 statute of limitations is in place for the
5 employer defendant. It doesn't matter and the
6 court has said over -- no matter how notorious
7 the claim is, the statute of limitations is an
8 absolute bar. Allowing the statute of
9 limitations to be tolled per an order of the
10 Commission simply can't be done, and we're in
11 that position right now.

12 **COMMISSIONER ROCHE:** I mean didn't the Commissioner
13 have the power just to go ahead with the
14 hearing and leave the record open to receive
15 more evidence?

16 **MR. SMITH:** Absolutely. And if that would have
17 happened we would not be here today, and I
18 completely believe just go ahead and take
19 whoever you needs deposition, go get additional
20 IME, retain jurisdiction of the file. I would
21 not have any problem with that. I think that
22 would have been completely appropriate. But to
23 put us in a position where our hands are tied
24 not knowing when they're going to refile a Form
25 50, and they're almost halfway above the one

1 year statute of limitations, four months
2 outside of that puts us in a bind. How are we
3 to defend a case when we don't know it's going
4 to come back up again? Are we just supposed to
5 keep it on the shelf waiting for them to
6 refile? Thank you, Commissioners.

7 **THE CHAIR:** Thank you. That will conclude this
8 proceeding. Thank y'all very much.

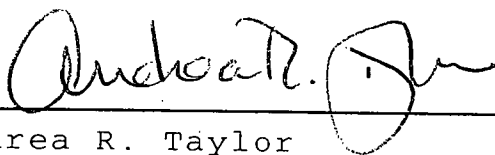
9 (There being nothing further, the hearing was
10 concluded at 11:11 a.m.)
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CERTIFICATE

This is to certify that the within hearing consisting of sixteen (16) pages, is a true and correct transcript of the testimony given by said witnesses after being duly sworn; said hearing was reported by the method of Stenomask with Backup.

I further certify that I am neither employed by nor related to any of the parties in this matter or their counsel; nor do I have any interest, financial or otherwise, in the outcome of same.

IN WITNESS WHEREOF I have hereunto set my hand and seal on November 5, 2013.



Andrea R. Taylor
Court Reporter

Notary Public for South Carolina
My Commission Expires: April 27, 2014

Carolinas Center for Advanced Mgmt of Pain - Greenville Office
220 Roper Mountain Road Ext Greenville, SC 29615
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March 14, 2012
Page 1
Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

02/27/2012 - Office Visit: Follow-Up Pain

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Back pain

History of Present Illness: GI virus and dehydration earlier this month. Vomited so hard she felt a pop in her back. Some immediate leg numbness, which has resolved. Awaiting authorization for a repeat ESI. Admitted to the hospital from the vomiting. Now with significant spasms and back pain. Has not had Zanaflex, as the hospital did not give it back to her. At times it is so bad it is hard to move.

Off of work this week due to spasms.

Comp not paying for Daypro or Pepcid.

Off of oral meds and now on insulin for her diabetes, as sugars were very unstable during her hospitalization.

Location Of Pain: Back

Description Of Pain: Sharp, Aching

Pain Rating: 7

Activity: Decreased

Did Injection Help? Yes

Is the patient taking any new medications? Yes

New Meds:

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Does the patient have any new medical or surgical problems? No

New Problems:

DIABETES MELLITUS (ICD-250.00)

Is the patient experiencing increased sadness, anxiety, or family problems? No

Past, Family, and Social History

Past History: Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS

Surgery: C-section, breast biopsy, diaphragmatic hernia repair.

Family History (Reviewed - No Changes Since Last Visit): Migraines, cancer, back problems

Social History (Reviewed - No Changes Since Last Visit): Married with 3 children

High school graduate

Customer Service Specialist at Dick's Sporting Goods where she was injured 3/13/10. Worker's Comp.

Continues to work full-time, regular duty. Attorney: Kathryn Williams

Denies tobacco

Occasional alcohol

Review of Systems

General: fatigue, headaches

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or

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discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema**Respiratory:** Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing**Gastrointestinal:** reflux**Genitourinary:** Denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain**Musculoskeletal:** back pain, joint pain**Skin:** denies rash, itching, dryness, suspicious lesions**Neurologic:** denies transient paralysis, weakness, paresthesias, seizures, syncope, tremors, vertigo**Psychiatric:** depression**Endocrine:** denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change**Hematologic/Lymphatic:** denies abnormal bruising, bleeding, enlarged lymph nodes**Allergic/Immunologic:** denies urticaria, hay fever, persistent infections, HIV exposure**Vital Signs**

Ht 184.8 in. Wt 190 lbs. BMI: 3.93 P: 77 Rhythm: regular R: 16 BP: 153/87

Physical Exam**General****General appearance:** well developed, well nourished, no acute distress**Communication ability:** communicates by voice, normal quality**Gait and station:** Assistive Device**Comment:** Cane**Psychiatric****Mental Status:** AAO x3**Judgement/Insight:** Intact**Mood/Affect:** Appropriate**Recent/Remote Memory:** Normal**Thoracolumbar****ROM:** Decreased in all directions**Patrick's Test:** Negative**Straight Leg Raise:** Negative**Palpation:** Tender**Paravertebral****Comments:** spasm**Manual Muscle Testing****RUE:** 5/5**RLE:** 5/5**LUE:** 5/5**LLE:** 5/5**Muscle Stretch Reflex****RUE:** 2+**RLE:** 2+**LUE:** 2+

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March 14, 2012

Page 3

Chart Document

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LLE: 2+

Sensory Intact to light touch/pin prick, Negative allodynia/hyperpathia

Neuro No Atrophy or Clonus

Sympathetic Function: Normal

Tinnel's: Negative

Assessment**Status of Existing Problems:**

Assessed SPINAL STENOSIS - LUMBAR as unchanged - John Satterthwaite MD

Assessed Z-JOINT SYNDROME as unchanged - John Satterthwaite MD

Assessed LOW BACK PAIN as deteriorated - John Satterthwaite MD

Assessed KNEE PAIN, RIGHT as unchanged - John Satterthwaite MD

Assessed MYOFASCIAL PAIN SYNDROME as deteriorated - John Satterthwaite MD

Assessed DISPLACED DISC - LUMBAR W/O MYELOPATHY as unchanged - John Satterthwaite MD

New Problems:

DIABETES MELLITUS (ICD-250.00)

Plan

Restart PT, as her spasm is worse.

Refill Zanaflex for bid.

Schedule repeat ESI when authorization received.

Out of work for 2 weeks.

Return for follow up in a month

New Prescriptions/Refills:

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid #60 x 0, 02/27/2012, John Satterthwaite MD

Current Medication List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 3/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 3/day

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

New Orders:

Expanded [99213]

Return for Epidural Steroid Injection [XXXXX]

Physical Therapy Referral [XXXXX]

Return for follow-up 1 month [xxxxx]

Prescriptions:

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March 14, 2012
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Chart Document

MRS ZEENA L FLETCHER

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ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid #60 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 02/27/2012

Method used: Print then Give to Patient

RxID: 1645953813506550

Electronically signed by John Satterthwaite MD on 02/27/2012 at 3:43 PM

Eugene Mironer, MD
John C. Haasis, MD
Phillip C. LaTourette, MD
Edward A. Lewis, MD
John R. Satterthwaite, MD
Renju T. Joseph, MD
Patricia R. Grant, MD
Kelby Hutcheson, MD
David Tollison, PhD
Donald W. Hinnant, PhD



CAROLINAS CENTER
FOR ADVANCED MANAGEMENT OF PAIN
www.carolinapain.com

Work Excuse

Date: 2/27/12

Zeene Fletcher

is under the care of

Y. Eugene Mironer, MD
~~John R. Satterthwaite, MD~~
Phillip C. LaTourette, MD
John C. Haasis, MD
J. Kelby Hutcheson, MD
Renju T. Joseph, MD
C. David Tollison, PhD

Siri Craft, FNP
Monica Speak, FNP
Kacie Tartaro, FNPC
Mary Cohen, FNPC
Mary Cohen, FNPC

And the following applies:

☒ Patient was/is unable to work until 3/14/12

☐ Patient is unable to work until seen on _____

☐ Patient is restricted to limited duty for/until _____

☐ Patient is able to return to work with the following restrictions: _____

☐ Other _____

Signed _____

6 Roper Mountain Road
Spartanburg, SC 29605
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10 Bolling Springs Road
Spartanburg, SC 29303
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2220 Street
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Phone: 828-586-7550
Fax: 828-586-1376

2200 Street
Spartanburg, NC 28801
Phone: 828-232-1955
Fax: 828-232-0329

Spring Street
Wood, SC 29646
Phone: 864-725-4095
Fax: 864-725-5082

Spring Street
Spartanburg, NC 28739
Phone: 828-233-0060
Fax: 828-233-0063

Medians Park Drive
Spartanburg, SC 29325
Phone: 864-583-2053
Fax: 864-583-0396

Don Lane
Columbia, SC 29169
Phone: 803-791-7175
Fax: 803-401-6099

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March 14, 2012

Page 1
Chart Document**MRS ZEENA L FLETCHER**

Female DOB: 11/17/1959

39709

03/14/2012 - Office Visit: Follow-Up Pain**Provider: John Satterthwaite MD****Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office**

Follow-Up Visit**Chief Complaint:** Back pain**History of Present Illness:** Ongoing low back pain with intermittent spasms.

Muscle relaxant helping.

Has not started PT as we have not heard from Worker's Comp.

Has not had ESI as we have not gotten authorization.

~~Was put out of work until today, with the thinking that in 2 weeks we should have done the PT and ESI.~~

Still unable to work due to the delay.

Back pain, spasms, some leg pain. Increased with standing, walking, bending, lifting.

Pain meds less effective.

Location Of Pain: Low back and both legs R>L**Description Of Pain:** Burning.**Activity:** Decreased**Did Medications Help?** Not Sure**Did Injection Help?** Yes**Is the patient taking any new medications?** No**Does the patient have any new medical or surgical problems?** No**New Problems:**

LUMBAR RADICULOPATHY (ICD-724.4)

Is the patient experiencing increased sadness, anxiety, or family problems? No**Data Reviewed:** Med Records**Past, Family, and Social History****Past History:** Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration**Surgery:** C-section, breast biopsy, diaphragmatic hernia repair.**Family History (Reviewed - No Changes Since Last Visit):** Migraines, cancer, back problems**Social History (Reviewed - No Changes Since Last Visit):** Married with 3 children

High school graduate

Customer Service Specialist at Dick's Sporting Goods where she was injured 3/13/10. Worker's Comp.

Continues to work full-time, regular duty. Attorney: Kathryn Williams

Denies tobacco.

Occasional alcohol

Review of Systems**General:** fatigue, headaches**Eyes:** denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia**Ear/Nose/Throat:** denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia**Cardiovascular:** Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

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March 14, 2012
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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing.

Gastrointestinal: reflux.

Genitourinary: Denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency.

amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain

Musculoskeletal: back pain, joint pain

Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: denies transient paralysis, weakness, paresthesias, seizures, syncope, tremors, vertigo

Psychiatric: depression

Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 184.8 in. Wt: 196 lbs. BMI: 4.05 P: 79 Rhythm: regular R: 18 BP: 155/84

Assessment

Status of Existing Problems:

Assessed SPINAL STENOSIS - LUMBAR as unchanged - John Satterthwaite MD

Assessed Z-JOINT SYNDROME as unchanged - John Satterthwaite MD

Assessed LOW BACK PAIN as deteriorated - John Satterthwaite MD

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - John Satterthwaite MD

Assessed DISPLACED DISC - LUMBAR W/O MYELOPATHY as unchanged - John Satterthwaite MD

New Problems:

LUMBAR RADICULOPATHY (ICD-724.4)

Plan

Renew efforts for ESI and PT.

Out of work 1 month until Comp approves us to proceed.

Has medications

Try and get ESI and PT done soon.

Prior to completing the note, I have been informed that PT has been denied.

Still unable to get any response regarding the injection.

Will just have to wait and see. In the meantime, she is unable to work.

Current Medication List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 3/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 3/day

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

New Orders:

Return for Epidural Steroid Injection [XXXXX]

Focused [99212]

Physical Therapy Referral [XXXXX]

Risk Factors

Tobacco use: never

Passive smoke exposure: yes

Alcohol use: no

Drug use: other

Comments: Denies

HIV high risk behavior: no

Caffeine use (drinks/day): 4

Exercise (times/week): 0

Seatbelt use: 100 %

Sun exposure: occasionally

Electronically signed by John Satterthwaite MD on 03/14/2012 at 2:52 PM



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 Patricia R. Grant, MD
 Kelby Hutcheson, MD
 David Tollison, PhD
 Donald W. Hinnant, PhD

Work Excuse

Date: 3-14-12

Leena Hatcher is under the care of

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15 Physicians Park Drive
 Marion, SC 29525
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 Fax: 864-583-0350

15 Union Lane
 West Columbia, SC 29169
 Phone: 803-791-7175

And the following applies:

____ Patient was/is unable to work _____

/ Patient is unable to work until seen on 4-12-12

____ Patient is restricted to limited duty for/until _____

____ Patient is able to return to work with the following restrictions:

Other _____

Signed

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May 8, 2012

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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

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04/04/2012 - Office Procedure: Epidural Steroid Injection**Provider: John Satterthwaite MD****Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office**

Epidural Steroid Injection**Indications:**

Left L5-S1 disc protrusion

Previous ESI with 80% pain reduction for 6-7 weeks

Increased back and leg pain following an episode of severe vomiting

Repeat injection

Procedure:

After informed consent was obtained, the patient was placed in the prone position and the back was prepped with Betadine and draped in the usual sterile fashion. Fluoroscopy was used to localize the appropriate interspace. Local anesthesia was administered using a 27 gauge needle and 1% Lidocaine. Using an 18 gauge Touhy needle and loss of resistance technique, the epidural space was entered at the L5-S1 interspace. No blood or CSF was noted returning from the needle. Following negative aspiration, 40mg Triamcinolone in 3cc normal saline with 1cc of .25% Bupivacaine was injected into the space. The needle was removed and the puncture wound was dressed.

Observations

- The patient was monitored for an appropriate length of time after the procedure and then discharged home, in good condition, with a driver.

- The patient was instructed to refrain from driving for 12 hours and to contact the office immediately if any of the following were noted: new or different pain in the back, loss of bladder or bowel control, new pain, numbness or weakness of the legs, redness or drainage from the needle insertion site.

- No sedation was given.

- The patient tolerated the procedure well.

The following complications were noted:

None

Additional Comments: Follow up next week as scheduled**Orders**

o-arm [CPT-77003]

Single Lumbar / Caudal [62311]

Triamcinolone 10mg [J3301]

Return for Follow-Up [XXXXX]

Updated Medication List

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 3/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 3/day

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bld

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

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DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food
PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset
PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson
NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD
IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD
PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD
LUMIGAN 0.01 % SOLN (BIMATOPROST) other md
LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Electronically signed by John Satterthwaite MD on 04/04/2012 at 12:32 PM

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May 8, 2012

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

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04/12/2012 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit**Chief Complaint:** Chronic back and extremity pain**History of Present Illness:** Patient is S/P L5/S1 with no relief as yet and it has been 1 week since injection.

Patient states she can not stand, sit, walk for longer than 10 minutes.

She is unable to do her laundry, vacuum, sweep, mop, lift, push or pull.

She has been basically doing only what was necessary at home.

Using ice and heat. Has had to ration out her medications as they have not been approved since February by W/C

Location Of Pain: Low back and both legs R>L**Description Of Pain:** Sharp, Aching, Burning**Pain Rating:** 7**Activity:** Increased**Did Medications Help?** Yes**Is the patient taking any new medications?** No**Does the patient have any new medical or surgical problems?** No**Is the patient experiencing increased sadness, anxiety, or family problems?** No**Data Reviewed:** Old Charts**Past, Family, and Social History****Past History (Reviewed - No Changes Since Last Visit):** Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration**Surgery:** C-section, breast biopsy, diaphragmatic hernia repair.**Social History (Reviewed - No Changes Since Last Visit):** Married with 3 children

High school graduate

Customer Service Specialist at Dick's Sporting Goods where she was injured 3/13/10. Worker's Comp.

Continues to work full-time, regular duty. Attorney: Kathryn Williams

Denies tobacco

Occasional alcohol

Review of Systems**General:** fatigue, headaches**Eyes:** denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia**Ear/Nose/Throat:** denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia**Cardiovascular:** Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema**Respiratory:** Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing**Gastrointestinal:** reflux**Genitourinary:** Denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain**Musculoskeletal:** back pain, joint pain

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May 8, 2012
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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

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Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: denies transient paralysis, weakness, paresthesias, seizures, syncope, tremors, vertigo

Psychiatric: depression

Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 61.5 in. Wt: 196.8 lbs. BMI: 36.72 P: 83 Rhythm: regular BP: 145/85

Physical Exam

General

General appearance: well developed, well nourished, no acute distress

Communication ability: communicates by voice, normal quality

Gait and station: antalgic

Comment: lower back and leg pain

Psychiatric

Mental Status: AAO x3

Judgement/Insight: Intact

Mood/Affect: Appropriate

Recent/Remote Memory: Normal

Thoracolumbar

ROM: Decreased in all directions

Palpation: Tender

Midline, Facets, SI, Paravertebral, Gluts

Comments: Bilateral L4-5, L5-S1

Spasm: Into thoracic paravertebral area.

Muscle Stretch Reflex

Sensory: Decreased sensation to light touch, Negative allodynia/hyperpathia

Comments: tingling paresthesia down both legs to knee L>R

Neuro: No Atrophy or Clonus

Sympathetic Function: Normal

Assessment

Status of Existing Problems:

Assessed LUMBAR RADICULOPATHY as deteriorated - MONICA P SPEAK NP

Assessed DIABETES MELLITUS as unchanged - MONICA P SPEAK NP

Assessed SPINAL STENOSIS - LUMBAR as unchanged - MONICA P SPEAK NP

Assessed Z-JOINT SYNDROME as deteriorated - MONICA P SPEAK NP

Assessed LOW BACK PAIN as deteriorated - MONICA P SPEAK NP

Assessed KNEE PAIN, RIGHT as unchanged - MONICA P SPEAK NP

Assessed MYOFASCIAL PAIN SYNDROME as deteriorated - MONICA P SPEAK NP

Assessed DISPLACED DISC - LUMBAR W/O MYELOPATHY as unchanged - MONICA P SPEAK NP

Comments:

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

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Plan

Status getting benefit from present medications for chronic pain

Reviewed subjective and objective findings with Dr. Satterthwaite to see what options or changes if any he may wish to make to our present treatment plan

After reviewing the findings today the following plan of care was developed with Dr. Satterthwaite:

- 1) refill all medications.
 - 2) Since patient has not received any relief from her LESI and she has had increased pain in her lower back with radiation we will need to get a repeat L-MRI to see if we have any new pathology that is causing her new radiating pain.
 - 3) She will need to remain off work until seen back and we have to MRI results.
- Patient may call and move appointment forward if there is a need to be seen earlier.

Other: OFF WORK UNTIL SEEN BACK BY US.

New Prescriptions/Refills:

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson #30 x 0, 04/12/2012, MONICA P SPEAK NP
PRILOSEC 40 MG CPDR (OMEPRAZOLE) 1 daily to take with Daypro to prevent GI upset #30 Each x 0, 04/12/2012, MONICA P SPEAK NP
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food #60 x 0, 04/12/2012, MONICA P SPEAK NP
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid #150 x 0, 04/12/2012, MONICA P SPEAK NP
ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid #60 x 0, 04/12/2012, MONICA P SPEAK NP
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 3/day. #90 x 0, 04/12/2012, MONICA P SPEAK NP

Current Medication List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 3/day.
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 3/day
ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food
PRILOSEC 40 MG CPDR (OMEPRAZOLE) 1 daily to take with Daypro to prevent GI upset
PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson
NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD
IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD
PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD
LUMIGAN 0.01 % SOLN (BIMATOPROST) other md
LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

New Orders:

Expanded [99213]

MRI, lumbar spine, w/o contrast [CPT-72148]

Return for follow-up 1 month [xxxxx]

Prescriptions:

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 04/12/2012

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May 8, 2012
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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

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Method used: Print then Give to Patient

RxID: 1649848753806820

PRILOSEC 40 MG CPDR (OMEPRAZOLE) 1 daily to take with Daypro to prevent GI upset #30 Each x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 04/12/2012

Method used: Print then Give to Patient

RxID: 1649848751356820

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 04/12/2012

Method used: Print then Give to Patient

RxID: 1649848749006820

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid #150 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 04/12/2012

Method used: Print then Give to Patient

RxID: 1649848746556820

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 04/12/2012

Method used: Print then Give to Patient

RxID: 1649848744156820

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 3/day. #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 04/12/2012

Method used: Print then Give to Patient

RxID: 1649848719956820

Risk Factors:

Tobacco use: never smoker

Drug use: no

HIV high-risk behavior: no

Alcohol use: yes

Has patient -

Felt need to cut down: no

Been annoyed by complaints: no

Felt guilty about drinking: no

Needed eye opener in the morning: no

Counseled to quit/cut down alcohol use: yes

Exercise: no

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May 8, 2012
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MRS ZEENA L FLETCHER
Female DOB: 11/17/1959

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Electronically signed by MONICA P SPEAK NP on 04/12/2012 at 4:43 PM

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 Phillip C. LaTourette, MD
 Edward A. Lewis, MD
 John R. Satterthwaite, MD
 Renju T. Joseph, MD
 Patricia R. Grant, MD
 J. Kelby Hutcheson, MD
 C. David Tollison, PhD
 Donald W. Hirsant, PhD



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Work Excuse

Date: 4-12-12

Zeena Fletcher

is under the care of

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 John C. Haasis, MD
 J. Kelby Hutcheson, MD
 Renju T. Joseph, MD
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 Fax: 864-583-0250

431 Hulton Lane
 West Columbia, SC 29189
 Phone: 803-791-7173

And the following applies:

____ Patient was/is unable to work _____

☒ Patient is unable to work until seen on 5-12-12

____ Patient is restricted to limited duty for/until _____

____ Patient is able to return to work with the following restrictions:

____ Other _____

Signed

Sh. Speak, FNP

STATEMENT OF

JOHN R. SATTERTHWAITE, M.D.

Re: Zeena L. Fletcher
Social Security No.: xxx-xx-2218
Date of Birth: 11/17/59
Date of Accident: 3/13/10

Based on my review of the medical records and notes related to this patient, it is my opinion to a reasonable degree of medical certainty that

 Ms. Fletcher has sustained a change of condition for the worse regarding the low back condition stemming from her March 13, 2010 injury by accident.

— or —

 Ms. Fletcher has not sustained a change of condition for the worse regarding the low back condition stemming from her March 13, 2010 injury by accident.

John R. Satterthwaite, M.D.

5/10/12
Date

STATEMENT OF
JOHN R. SATTERTHWAITE, M.D.

Re: **Zeena L. Fletcher**
Social Security No.: xxx-xx-2218
Date of Birth: 11/17/59
Date of Accident: 3/13/10

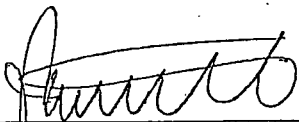
Based on my review of the medical records and notes related to this patient, it is my opinion to a reasonable degree of medical certainty that

✓

It is more likely than not that Ms. Fletcher's current low back problems are a continuation of the low back injuries sustained in her work accident on March 13, 2010.

— or —

It is more likely than not that Ms. Fletcher's current low back problems are not a continuation of the low back injuries sustained in her work accident on March 13, 2010.


John R. Satterthwaite, M.D.

5/10/12
Date

STATEMENT OF
JOHN R. SATTERTHWAITE, M.D.

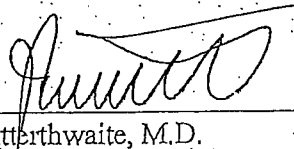
Re: Zeena L. Fletcher
Social Security No.: xxx-xx-2218
Date of Birth: 11/17/59
Date of Accident: 3/13/10

Based on my review of the medical records and notes related to this patient, it is my opinion to a reasonable degree of medical certainty that

✓
Ms. Fletcher's increased back pain following her GI virus and related vomiting in early February 2012 was a routine event and does not represent a break in the chain of causation linking her low back problems to her work accident on March 13, 2010.

— or —

Ms. Fletcher's increased back pain following her GI virus and related vomiting in early February 2012 was not a routine event and does represent a break in the chain of causation linking her low back problems to her work accident on March 13, 2010.


John R. Satterthwaite, M.D.

5/10/12
Date

STATEMENT OF
JOHN R. SATTERTHWAITE, M.D.

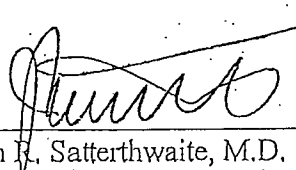
Re: **Zeena L. Fletcher**
Social Security No.: xxx-xx-2218
Date of Birth: 11/17/59
Date of Accident: 3/13/10

Based on my review of the medical records and notes related to this patient, it is my opinion to a reasonable degree of medical certainty that

_____ It is more likely than not that Ms. Fletcher's work-related low back injuries on March 13, 2010 made her more susceptible to increased low back pain from routine events, such as what occurred following her recent GI virus and related vomiting.

— or —

_____ It is more likely than not that Ms. Fletcher's work-related low back injuries on March 13, 2010 did not make made her more susceptible to increased low back pain from routine events, such as what occurred following her recent GI virus and related vomiting.



John R. Satterthwaite, M.D.

5/10/12

Date

STATEMENT OF
JOHN R. SATTERTHWAITE, M.D.

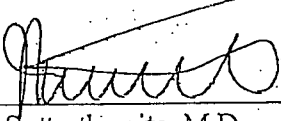
Re: **Zeena L. Fletcher**
Social Security No.: xxx-xx-2218
Date of Birth: 11/17/59
Date of Accident: 3/13/10

Based on my review of the medical records and notes related to this patient, it is my opinion to a reasonable degree of medical certainty that

✓ It is more likely than not that Ms. Fletcher's current low back problems and her need for physical therapy and an MRI are causally-related to her work accident on March 13, 2010.

- or -

 It is more likely than not that Ms. Fletcher's current low back problems and her need for physical therapy and an MRI are not causally-related to her work accident on March 13, 2010.


John R. Satterthwaite, M.D.

5/10/10
Date

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July 3, 2012
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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

05/14/2012 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Chronic back and extremity pain.

History of Present Illness: Patient returns today with complaint of ongoing and increased lower back pain and increased right knee pain.

We requested approval for an L-MRI for patient and have made several phone calls to W/C without any success in getting an answer to our request.

We have now contacted the patient asking her to see what she can do on her part to expedite this request for the MRI.

The patient's pain has deteriorated and her knee pain wakes her up at night.

She is not able to work full time period at this point as she had a shower for her expectant daughter and mopped the floor and was down on her back for several hrs after that activity.

Her physical therapy has not been approved either so at the moment our hands are tied for any therapeutic help we may want to start on this patient as we can not get anything approved.

We are only able to prescribe pain medication and keep her out of work for the present.

Location Of Pain: lower back and right knee pain.

Description Of Pain: Sharp, Burning

Activity: Decreased

Did Medications Help? Yes

Is the patient taking any new medications? No

New Meds:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Data Reviewed: Old Charts

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration

Surgery: C-section, breast biopsy, diaphragmatic hernia repair.

Social History (Reviewed - No Changes Since Last Visit): Married with 3 children

High school graduate

Customer Service Specialist at Dick's Sporting Goods where she was injured 3/13/10. Worker's Comp.

Continues to work full-time, regular duty. Attorney: Kathryn Williams

Denies tobacco

Occasional alcohol

Vital Signs

Ht: 61.5 in. Wt: 214.6 lbs. BMI: 40.04 P: 86 Rhythm: regular BP: 165/82

Physical Exam

Carolinas Center for Advanced Mgmt of Pain - Greenville Office
220 Roper Mountain Road Ext Greenville, SC 29615
(864) 295-6399 Fax: (864) 295-2337

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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

General

General appearance: obese

Communication ability: communicates by voice, normal quality

Gait and station: Normal

Psychiatric

Mental Status: AAO x3

Judgement/Insight: Intact

Mood/Affect: Appropriate

Recent/Remote Memory: Normal

Thoracolumbar

ROM: Decreased in all directions

Palpation: Tender

Midline, Facets, Paravertebral

Comments: bilateral L5-S1 radiates up to L1-T12

Muscle Stretch Reflex

Sensory Intact to light touch/pin prick, Negative allodynia/hyperpathia

Neuro No Atrophy or Clonus

Sympathetic Function: Normal

Assessment

Status of Existing Problems:

Assessed LUMBAR RADICULOPATHY as deteriorated - MONICA P SPEAK NP

Assessed SPINAL STENOSIS - LUMBAR as unchanged - MONICA P SPEAK NP

Assessed Z-JOINT SYNDROME as deteriorated - MONICA P SPEAK NP

Assessed LOW BACK PAIN as deteriorated - MONICA P SPEAK NP

Assessed UNSPECIFIED DISORDER OF SYNOVIUM TENDON&BURSA as unchanged - MONICA P SPEAK NP

Assessed KNEE PAIN, RIGHT as unchanged - MONICA P SPEAK NP

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - MONICA P SPEAK NP

Assessed DISPLACED DISC - LUMBAR W/O MYELOPATHY as unchanged - MONICA P SPEAK NP

Plan

Pain has increased.

Increase in lower back spasm

Reviewed subjective and objective findings with Dr. Satterthwaite to see what options or changes if any he may wish to make to our present treatment plan

Increase Percocet to 4/day.

Increase Zanaflex to tid.

Continue other medications as before.

Med pick up next month

Patient may call and move appointment forward if there is a need to be seen earlier.

Patient is to be off work until see by our office in 1 month.

New Prescriptions/Refills:

PRISTIQ 50 MG XR24H-TAB (DESYENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson #30 x 0,
05/14/2012, MONICA P SPEAK NP

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset #30 Each x 0,
05/14/2012, MONICA P SPEAK NP
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food #60 x 0, 05/14/2012, MONICA P SPEAK NP
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid #150 x 0, 05/14/2012,
MONICA P SPEAK NP
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.
#120 x 0, 05/14/2012, MONICA P SPEAK NP
ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid #90 x 1, 05/14/2012, MONICA P SPEAK NP

Current Medication List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 3/day
ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food
PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset
PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson
NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD
IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD
PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD
LUMIGAN 0.01 % SOLN (BIMATOPROST) other md
LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

New Orders:

Expanded [99213]

Return for Med Pickup [XXXXXX]

Prescriptions:

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 05/14/2012

Method used: Print then Give to Patient

RxID: 1652628755906560

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset #30 Each x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 05/14/2012

Method used: Print then Give to Patient

RxID: 1652628740156560

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 05/14/2012

Method used: Print then Give to Patient

RxID: 1652628740056560

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid #150 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 05/14/2012

Method used: Print then Give to Patient

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

RxID: 1652628739856560
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.
#120 x 0

Entered by: MONICA P SPEAK NP
Authorized by: John Satterthwaite MD
Electronically signed by: MONICA P SPEAK NP on 05/14/2012
Method used: Print then Give to Patient
RxID: 1652628732306560

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid #90 x 1

Entered by: MONICA P SPEAK NP
Authorized by: John Satterthwaite MD
Electronically signed by: MONICA P SPEAK NP on 05/14/2012
Method used: Print then Give to Patient
RxID: 1652628248306560

Risk Factors:

Tobacco use: never smoker
Passive smoke exposure: yes
Drug use: no
HIV high-risk behavior: no
Caffeine use: 4 drinks per day
Alcohol use: yes
Type: wine cooler on special occasion
Drinks per day: <1
Has patient -
Felt need to cut down: no
Been annoyed by complaints: no
Felt guilty about drinking: no
Needed eye opener in the morning: no
Counseled to quit/cut down alcohol use: no
Exercise: no
Seatbelt use: 100 %
Sun Exposure: occasionally

Electronically signed by MONICA P SPEAK NP on 05/14/2012 at 3:49 PM

Eugene Mironer, MD
 John C. Haasis, MD
 Phillip C. LaTourette, MD
 Edward A. Lewis, MD
 John R. Satterthwaite, MD
 Renju T. Joseph, MD
 Patricia R. Grant, MD
 Kelly Hutcherson, MD
 C. David Tollison, PhD
 Donald W. Pinnant, PhD



CAROLINAS CENTER
 FOR ADVANCED MANAGEMENT OF PAIN
 www.carolinapain.com

Work Excuse

Date: 5/14/12

Zaena Fletcher is under the care of

Y. Eugene Mironer, MD
John R. Satterthwaite, MD
 Phillip C. LaTourette, MD
 John C. Haasis, MD
 J. Kelby Hutcherson, MD
 Renju T. Joseph, MD
 C. David Tollison, PhD

Siri Craft, FNP
Monica Speck, FNP
 Kacie Tartaro, FNPC
 Mary Cohen, FNPC
 Mary Cohen, FNPC

125 Fodor Mountain Road Ext.
 Greenville, SC 29635
 Phone: 864-295-6559
 Fax: 864-295-1337

1390 Boiling Springs Road
 Suite 2700
 Spartanburg, SC 29326
 Phone: 864-582-0053
 Fax: 864-582-0390

45 Pretau Street
 Easley, SC 29643
 Phone: 864-586-7950
 Fax: 864-586-4376

69 McDowell Street
 Asheville, NC 28801
 Phone: 828-253-1355
 Fax: 828-253-0725

1335 Spring Street
 Greenwood, SC 29646
 Phone: 864-735-4695
 Fax: 864-735-5063

390 Fleming Street
 Hendersonville, NC 28739
 Phone: 828-233-0060
 Fax: 828-233-0069

113 Physicians Park Drive
 Thomas, SC 29685
 Phone: 864-583-0053
 Fax: 864-583-0390

421 Hutton Lane
 West Columbia, SC 29169

And the following applies:

____ Patient was/is unable to work _____

☒ Patient is unable to work until seen on 6-13-12

____ Patient is restricted to limited duty for/until _____

____ Patient is able to return to work with the following restrictions:

Other _____

Signed Monica Speck FNP BC

Smith | Poe, PA

Attorneys and Counselors at Law

FAXED
5-31-12

634 B Fairview Road, Suite #2
Simpsonville, South Carolina 29680

330 East Coffee Street
Greenville, South Carolina 29601

Telephone: (864) 963-0310
Facsimile: (864) 228-7845

May 24, 2012

Dr. John R. Satterthwaite
Carolinas Center for Advanced Management of Pain
220 Roper Mountain Ext.
Greenville, SC, 29605

Re: Zecna L. Fletcher v. Dick's Sporting Goods
SCWCC: 1003122
Claim No.: 003619-001324-WC01
Our File No.: 7000-01
Date of Accident: 03/13/2010

Dear Dr. Satterthwaite:

As you are aware, by prior conversation, I represent the Employer/Carrier in regard to the above-referenced matter. I am currently in receipt of a questionnaire that was forwarded to your attention by the Claimant's attorney, and it appears to have been signed by you on May 10, 2012. I have attached a copy of the same. Clearly, you indicate, more likely than not, that the Claimant's current lower back problems and her need for physical therapy are causally related to her on-the-job accident of March 13, 2010.

With this being said, I am curious to your opinion on the following:

1. Is it your opinion, within a reasonable degree of medical certainty, (more likely than not), that the Claimant's current lower back symptoms and need for additional medical treatment including but not limited to physical therapy, an updated MRI are a natural progression or worsening of her on-the-job accident of March 13, 2010?

Yes ☒

No ☐

If "No," please explain:

2. Is it your opinion, within a reasonable degree of medical certainty, (more likely than not), that the Claimant's current lower back symptoms necessitate additional therapy and an updated MRI are necessary to maintain the Claimant's level of function as a result of her level of function as a result of her on-the-job injury of March 13, 2010?

Yes ☒No ☐

If "No," please explain:

Required to improve current functional

3. Is it your opinion, within a reasonable degree of medical certainty, (more likely than not), that the Claimant's current lower back symptoms necessitating the need for additional medical treatment including but not limited to physical therapy and an updated MRI are a result of a new injury or a physical change of condition for the worse?

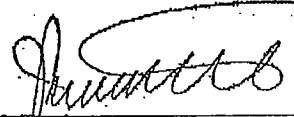
Yes ☐No ☒

If "Yes," please explain:

UNABLE TO DETERMINE WITHOUT TESTS

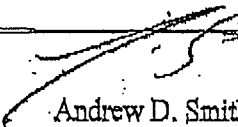
Date

5/31/12


Dr. John Satterthwaite

Should you have any questions or suggestions, please do not hesitate to contact me.

Very truly yours,



Andrew D. Smith

ADS/dkp
Enclosures

Cc: Glendora Bastion, Gallagher Bassett Services (*via email*)
Marla McClary, Dick's Sporting Goods (*via email*)

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

06/13/2012 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit**Chief Complaint:** Chronic back and extremity pain.**History of Present Illness:** Patient returns with ongoing complaints of chronic pain

States pain is worse and her husband had to help her out of bed on Sunday because she could not get out on her own.

Last daypro refill was not approved so patient had to ration out what she had left from a previous refill.

States she is also having memory problems as well.

States the Percocet makes her very sleepy so if she takes 4 per day she sleeps a lot. Then if she takes it and does anything she can only do something for about 2 hrs.

She continues to have muscle spasms.

Taking zanaflex tid for spasm.

Medicine containers brought in, filled 5/15/12 *MAY FILL ON* 6/14/12 & 7/14/12

Explained to patient that from time to time an injection may not give a patient as much pain reduction due to external variables, such as stress, weather, activity level etc.

Location Of Pain: lower back and right knee pain.**Description Of Pain:** Sharp, Aching, Burning**Pain Rating:** 7**Activity:** Stayed The Same**Did Medications Help?** No**Is the patient taking any new medications?** No**New Meds:**

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day

Does the patient have any new medical or surgical problems? No**Is the patient experiencing increased sadness, anxiety, or family problems?** No**Data Reviewed:** Old Charts, MRI**Comments:** L-MRI shows no acute changes from previous MRI.**Past, Family, and Social History****Past History (Reviewed - No Changes Since Last Visit):** Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration**Surgery:** C-section, breast biopsy, diaphragmatic hernia repair.**Social History (Reviewed - No Changes Since Last Visit):** Married with 3 children

High school graduate

Customer Service Specialist at Dick's Sporting Goods where she was injured 3/13/10. Worker's Comp.

Continues to work full-time, regular duty. Attorney: Kathryn Williams

Denies tobacco

Occasional alcohol

Review of Systems**General:** fatigue, headaches**Eyes:** denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

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Female DOB: 11/17/1959

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Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia
Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema
Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing
Gastrointestinal: reflux
Genitourinary: Denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain
Musculoskeletal: back pain, joint pain
Skin: denies rash, itching, dryness, suspicious lesions
Neurologic: denies transient paralysis, weakness, paresthesias, seizures, syncope, tremors, vertigo
Psychiatric: depression
Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change
Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes
Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht 61.5 in. Wt 211 lbs. BMI: 39.36 P: 74 Rhythm: regular BP: 173/102

Physical Exam**General**

General appearance: well developed, well nourished, no acute distress
Communication ability: communicates by voice, normal quality
Gait and station: Assistive Device
Comment: cane

Psychiatric

Mental Status: AAO x3
Judgement/Insight: Intact
Mood/Affect: Appropriate
Recent/Remote Memory: Normal

Extremities

Pedal pulses: pulses 2+, symmetric
Periph. circulation: no cyanosis, clubbing, edema, or varicosities

Thoracolumbar

ROM: decreased rotation/extension
Comments: flexion
Palpation: Tender
Midline, Facets
Comments: Bilateral L4-S1, L5-S1

Muscle Stretch Reflex

Sensory: Decreased sensation to light touch, Negative allodynia/hyperpathia
Comments: burning paresthesia at L4-S1 lumbar area
Neuro: No Atrophy or Clonus
Sympathetic Function: Normal

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 Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

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Assessment

Status of Existing Problems:

Assessed LUMBAR RADICULOPATHY as unchanged - MONICA P SPEAK NP
 Assessed SPINAL STENOSIS - LUMBAR as unchanged - MONICA P SPEAK NP
 Assessed Z-JOINT SYNDROME as unchanged - MONICA P SPEAK NP
 Assessed LOW BACK PAIN as unchanged - MONICA P SPEAK NP
 Assessed KNEE PAIN, RIGHT as deteriorated - MONICA P SPEAK NP
 Assessed MYOFASCIAL PAIN SYNDROME as unchanged - MONICA P SPEAK NP
 Assessed DISPLACED DISC - LUMBAR W/O MYELOPATHY as unchanged - MONICA P SPEAK NP
 Assessed GLAUCOMA BILATERAL as unchanged - MONICA P SPEAK NP
 Comments: NOTE: L-MRI: No acute changes noted from previous MRI : Therefore patient having exacerbation of original injury.

Plan

Reviewed subjective and objective findings with Dr. Satterthwaite to see what options or changes if any he may wish to make to our present treatment plan

L-MRI shows no acute changes from previous MRI therefore patient is having an exacerbation of her symptoms from the original injury.

We will continue with the same medication and ask the patient to take the percocet 4/day as needed and possibly hold ONE Zanaflex for the somnolence.

Pt acknowledges understanding of instructions.

She is advised to speak with her Lawyer about the fact that her Daypro was not approved last month.

We will try for approval for a repeat LESI L5-S1 as patient is having tingling in the posterior right thigh and lateral aspect of left leg.

Patient also continues to ask about the right knee pain she has had since the original injury and what can be done about it.

We could try to get some films of the knee or an MRI and then referral to an orthopedist if W/C will approve. She has great difficulty going up and down stairs, right knee is tender to touch. I have asked patient to mention all of this to her lawyer so that we might expedite any requests we may make for her knee pain.

She now tells me she fell again last night.

Refill meds

MAY FILL ON 6/13/12 & 7/13/12

follow up 2 months

Patient is to try 1&1/2 Zanaflex at hs and hold the afternoon dose to see if she has less somnolence.

New Prescriptions/Refills:

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson #30 x 1,

06/13/2012, MONICA P SPEAK NP

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset #30 x 1,

06/13/2012, MONICA P SPEAK NP

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food #60 x 1, 06/13/2012, MONICA P SPEAK NP

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid #150 x 0, 06/13/2012, MONICA P SPEAK NP

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid #90 x 1, 06/13/2012, MONICA P SPEAK NP

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day #120 x 0, 06/13/2012, MONICA P SPEAK NP

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

#120 x 0, 06/13/2012, MONICA P SPEAK NP

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Female DOB: 11/17/1959

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Current Medication List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day
ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knees bid
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food
PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset
PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson
NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD
IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD
PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD
LUMIGAN 0.01 % SOLN (BIMATOPROST) other md
LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

New Orders:

Expanded [99213]

Return for Epidural Steroid Injection [XXXXXX]

Return for follow-up 2 months [XXXXX]

Prescriptions:

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson #30 x 1

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 06/13/2012

Method used: Print then Give to Patient

RxID: 1655197580956530

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset #30 x 1

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 06/13/2012

Method used: Print then Give to Patient

RxID: 1655197580256530

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food #60 x 1

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 06/13/2012

Method used: Print then Give to Patient

RxID: 1655197550456530

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid #150 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 06/13/2012

Method used: Print then Give to Patient

RxID: 1655197535156530

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid #90 x 1

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 06/13/2012

Method used: Print then Give to Patient

RxID: 1655197534906530

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day #120 x

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Female DOB: 11/17/1959

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0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 06/13/2012

Method used: Print then Give to Patient

Note to Pharmacy: MAY FILL ON 7/13/12

RxID: 1655197527506530

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

#120 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 06/13/2012

Method used: Print then Give to Patient

Note to Pharmacy: MAY FILL ON 6/13/12

RxID: 1655197495556530

Risk Factors:

Tobacco use: never smoker

Passive smoke exposure: yes

Drug use: no

HIV high-risk behavior: no

Caffeine use: 4 drinks per day

Alcohol use: yes

Type: wine cooler on special occasions

Drinks per day: <1

Has patient --

Felt need to cut down: no

Been annoyed by complaints: no

Felt guilty about drinking: no

Needed eye opener in the morning: no

Counseled to quit/cut down alcohol use: no

Exercise: no

Seatbelt use: 100 %

Sun Exposure: occasionally

Electronically signed by MONICA P SPEAK NP on 06/13/2012 at 9:16 AM

Eugene Mironer, MD
John C. Haasis, MD
Phillip C. LaTourette, MD
Edward A. Lewis, MD
John R. Satterthwaite, MD
Ranjit T. Joseph, MD
Patricia R. Grant, MD
Kelby Hutcheson, MD

C. David Tollison, PhD
Donald W. Pinnart, PhD



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Work Excuse

Date: 6-13-12

Teena Fletcher

is under the care of

Y. Eugene Mironer, MD
John R. Satterthwaite, MD
Phillip C. LaTourette, MD
John C. Haasis, MD
J. Kelby Hutcheson, MD
Ranjit T. Joseph, MD
C. David Tollison, PhD

Siri Craft, FNP
Monica Speak, FNP
Kacie Tartaro, FNPC
Mary Cohen, FNPC
Mary Cohen, FNPC

And the following applies:

____ Patient was/is unable to work _____

☒ Patient is unable to work until seen on: 7-11-12

____ Patient is restricted to limited duty for/until _____

____ Patient is able to return to work with the following restrictions:

Other _____

Signed

Ms. Speak FNP BC

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Fax: 803-583-0055

401 Union Lane
Columbia, SC 29906
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August 10, 2012

Page 1

Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 634-0965

07/25/2012 - Office Procedure: Epidural Steroid Injection

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Epidural Steroid Injection**Indications:**

Left L5-S1 disc protrusion

Previous ESI with less pain reduction

Increased back and leg pain which has persisted

MRI shows ongoing disc disease with S1 root compromise on the left. No acute change from previous study.

Repeat injection

Says she has heard about SCS and is asking about that.

Procedure:

After informed consent was obtained, the patient was placed in the prone position and the back was prepped with Betadine and draped in the usual sterile fashion. Fluoroscopy was used to localize the appropriate interspace. Local anesthesia was administered using a 27 gauge needle and 1% Lidocaine. Using an 18 gauge Touhy needle and loss of resistance technique, the epidural space was entered at the L5-S1 interspace. No blood or CSF was noted returning from the needle. Following negative aspiration, 40mg Triamcinolone in 4cc normal saline with 1cc of .25% Bupivacaine was injected into the space. The needle was removed and the puncture wound was dressed.

Observations

- The patient was monitored for an appropriate length of time after the procedure and then discharged home, in good condition, with a driver.

- The patient was instructed to refrain from driving for 12 hours and to contact the office immediately if any of the following were noted: new or different pain in the back, loss of bladder or bowel control, new pain, numbness or weakness of the legs, redness or drainage from the needle insertion site.

- No sedation was given.

- The patient tolerated the procedure well.

The following complications were noted:

None

Orders

c-arm [CPT-77003]

Single Lumbar / Caudal [62311]

Triamcinolone 10mg [J3301]

Return for Follow-Up: [XXXXXX]

Updated Medication List

CYMBALTA 60 MG 1 qd

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

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Home: (864) 634-0965

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food
PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset
PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd (discontinued)
NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD
IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD
PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD
LUMIGAN 0.01 % SOLN (BIMATOPROST) other md
LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Vital Signs

Ht: 61.5 in. Wt: 212 lbs. BMI: 39.55 T: 97.1 deg F. T site: oral P: 104 Rhythm: regular R: 18 BP: 180/98

Risk Factors:

Tobacco use: never smoker
Passive smoke exposure: yes
Drug use: None
HIV high-risk behavior: no
Caffeine use: 4 drinks per day
Alcohol use: yes
Type: wine cooler on special occasions
Drinks per day: <1
Has patient -
Felt need to cut down: no
Been annoyed by complaints: no
Felt guilty about drinking: no
Needed eye opener in the morning: no
Counseled to quit/cut down alcohol use: no
Exercise: no
Seatbelt use: 100 %
Sun Exposure: occasionally

Electronically signed by John Satterthwaite MD on 07/25/2012 at 11:29 AM



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C. David Tollison, PhD
Donald W. Kinnear, PhD

Work Excuse

Date: 7-25-12

Leena Heter is under the care of

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15 Physicians Park Drive
Greenville, SC 29607
Phone: 864-587-0023
Fax: 864-587-0023

15 Leno Lane
Columbia, SC 29204
Phone: 803-701-7777

And the following applies:

____ Patient was/is unable to work _____

☒ Patient is unable to work until seen on 8-8-12

____ Patient is restricted to limited duty for/until _____

____ Patient is able to return to work with the following restrictions:

Signed

[Signature]

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August 10, 2012
Page 1
Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 634-0965

08/08/2012 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Chronic back and extremity pain.

History of Present Illness: Patient is S/P LESI done 7/25/12 with excellent pain reduction in her lower back.

-states she was able to increase her activity, is sleeping better, and has better lumbar function, with improved quality of life.

She has been able to do some housework.

She is still having posterior right knee pain.

Forgot her medication containers, and does need refills.

Location Of Pain: lower back and right knee pain.

Description Of Pain: Sharp, Aching, Burning

Pain Rating: 6

Activity: Stayed The Same

Did Medications Help? Yes

Did Injection Help? Yes

Percent: 50

Is the patient taking any new medications? No

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Data Reviewed: Old Charts

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration

Surgery: C-section, breast biopsy, diaphragmatic hernia repair.

Family History (Reviewed - No Changes Since Last Visit): Migraines, cancer, back problems

Social History (Reviewed - No Changes Since Last Visit): Married with 3 children

High school graduate

Customer Service Specialist at Dick's Sporting Goods where she was injured 3/13/10. Worker's Comp.

Continues to work full-time, regular duty. Attorney: Kathryn Williams

Denies tobacco

Occasional alcohol

Review of Systems

General: fatigue, headaches

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

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MRS ZEENA L FLETCHER

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Gastrointestinal: reflux**Genitourinary:** Denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain**Musculoskeletal:** back pain, joint pain**Skin:** denies rash, itching, dryness, suspicious lesions**Neurologic:** denies transient paralysis, weakness, paresthesias, seizures, syncope, tremors, vertigo**Psychiatric:** depression**Endocrine:** denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change**Hematologic/Lymphatic:** denies abnormal bruising, bleeding, enlarged lymph nodes**Allergic/Immunologic:** denies urticaria, hay fever, persistent infections, HIV exposure**Vital Signs**

Ht: 61.5 in.

Physical Exam**General****General appearance:** well developed, well nourished, no acute distress**Communication ability:** communicates by voice, normal quality**Gait and station:** antalgic**Comment:** knee pain**Psychiatric****Mental Status:** AAO x3**Judgement/Insight:** Intact**Mood/Affect:** Appropriate**Recent/Remote Memory:** Normal**Thoracolumbar****ROM:** decreased flexion**Muscle Stretch Reflex****Sensory Negative allodynia/hyperpathia****Neuro No Atrophy or Clonus****Sympathetic Function:** Normal**Assessment****Status of Existing Problems:**

Assessed LUMBAR RADICULOPATHY as unchanged - MONICA P SPEAK NP

Assessed SPINAL STENOSIS - LUMBAR as unchanged - MONICA P SPEAK NP

Assessed Z-JOINT SYNDROME as unchanged - MONICA P SPEAK NP

Assessed LOW BACK PAIN as unchanged - MONICA P SPEAK NP

Assessed UNSPECIFIED DISORDER OF SYNOVIUM TENDON&BURSA as unchanged - MONICA P SPEAK NP

Assessed KNEE PAIN, RIGHT as unchanged - MONICA P SPEAK NP

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - MONICA P SPEAK NP

Assessed DISPLACED DISC - LUMBAR W/O MYELOPATHY as unchanged - MONICA P SPEAK NP

Plan

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August 10, 2012

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 634-0965

Reviewed subjective and objective findings with Dr. Satterthwaite to see what options or changes if any he may wish to make to our present treatment plan

States getting benefit from present medications for chronic pain.

Per Dr. Satterthwaite we will continue same plan of care.

Refill meds

MAY FILL ON 8/12/12 & 9/11/12

Work excuse needed. 8/8/12 until return visit.

Continue physical therapy.

See orthopedic MD for posterior cyst on right knee.

New Prescriptions/Refills:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day #120 x 0, 08/08/2012, MONICA P SPEAK NP, Reprinted

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid #150 x 1, 08/08/2012, MONICA P SPEAK NP

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day #120 x 0, 08/08/2012, MONICA P SPEAK NP

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

#120 x 0, 08/08/2012, MONICA P SPEAK NP

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset #30[capsule] x 1, 08/08/2012, MONICA P SPEAK NP

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food #60[tablet] x 1, 08/08/2012, MONICA P SPEAK NP

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid #90[tablet] x 1, 08/08/2012, MONICA P SPEAK NP

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily #30[capsule] x 1, 08/08/2012, MONICA P SPEAK NP

Current Medication List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

New Orders:

Focused [99212]

Return for follow-up 2 months [xxxxx]

Prescriptions:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day #120 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 08/08/2012.

Carolinas Center for Advanced Mgmt of Pain - Greenville Office

August 10, 2012

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Chart Document

MRS ZEENA L FLETCHER

Home: (864) 634-0965

Female DOB: 11/17/1959

39709

Method used: Reprint

Note to Pharmacy: DO NOT FILL BEFORE 9/11/12

RxID: 1660053471456370

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid #150 x 1

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 08/08/2012

Method used: Print then Give to Patient

RxID: 1660053170756370

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day #120 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 08/08/2012

Method used: Print then Give to Patient

Note to Pharmacy: DO NOT FILL BEFORE 7/11/12

RxID: 1660053113956370

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day. #120 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 08/08/2012

Method used: Print then Give to Patient

Note to Pharmacy: DO NOT FILL BEFORE 8/12/12

RxID: 1660053112406370

Handout requested.

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset #30[capsule] x 1

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 08/08/2012

Method used: Electronically to

WALMART* (retail)

3812 LIBERTY HWY

ANDERSON, SC 29621

Ph: (864) 231-6071

Fax: (864) 231-6073

RxID: 1660052932156370

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food #60[tablet] x 1

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Electronically signed by: MONICA P SPEAK NP on 08/08/2012

Method used: Electronically to

WALMART* (retail)

3812 LIBERTY HWY

ANDERSON, SC 29621

Ph: (864) 231-6071

Fax: (864) 231-6073

RxID: 1660052930706370

Handout requested.

ZANAPLEX 4 MG TABS (TIZANIDINE HCL) 1 tid #90[tablet] x 1

Entered by: MONICA P SPEAK NP

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August 10, 2012

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 634-0965

Authorized by: John Satterthwaite MD
Electronically signed by: MONICA P SPEAK NP on 08/08/2012
Method used: Electronically to
WALMART* (retail)
3812 LIBERTY HWY
ANDERSON, SC 29621
Ph: (864) 231-6071
Fax: (864) 231-6073

RxID: 1660052929156370

Handout requested.

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily #30[capsule] x 1

Entered by: MONICA P SPEAK NP
Authorized by: John Satterthwaite MD
Electronically signed by: MONICA P SPEAK NP on 08/08/2012
Method used: Electronically to
WALMART* (retail)
3812 LIBERTY HWY
ANDERSON, SC 29621
Ph: (864) 231-6071
Fax: (864) 231-6073

RxID: 1660052899056370

Handout requested.

Risk Factors:

Tobacco use: never smoker
Passive smoke exposure: yes
Drug use: no
HIV high-risk behavior: no
Caffeine use: 4 drinks per day
Alcohol use: yes
Type: wine cooler on special occasions
Drinks per day: <1
Has patient --
Felt need to cut down: no
Been annoyed by complaints: no
Felt guilty about drinking: no
Needed eye opener in the morning: no
Counseled to quit/cut down alcohol use: no
Exercise: no
Seatbelt use: 100 %
Sun Exposure: occasionally

Electronically signed by MONICA P SPEAK NP on 08/08/2012 at 4:51 PM

Eugene Mironer, MD
 John C. Haasis, MD
 Phillip C. LaTourette, MD
 Edward A. Lewis, MD
 John R. Satterthwaite, MD
 Renju T. Joseph, MD
 Patricia R. Grant, MD
 J. Kelby Hutcheson, MD
 C. David Tollison, PhD
 Donald W. Minner, PhD



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Work Excuse

Date: 8-8-12

Leona Hatcher is under the care of

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Siri Craft, FNP

John R. Satterthwaite, MD

Monica Speak, FNP

Phillip C. LaTourette, MD

Kacie Tartaro, FNPC

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100 Harting Street
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 Fax: 828-233-0052

35 Physicians Plaza Circle
 Columbia, SC 29203
 Phone: 803-733-2055 x1
 Fax: 803-733-2101

4500 Main Drive
 West Columbia, SC 29169
 Phone: 803-733-2101

And the following applies:

____ Patient was/is unable to work _____

☒ Patient is unable to work until seen on 10-8-12

____ Patient is restricted to limited duty for/until _____

____ Patient is able to return to work with the following restrictions:

____ Other _____

Signed Monica Speak FNP-BC

Carolinas Center for Advanced Mgmt of Pain - Greenville Office

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October 29, 2012

Page 1

Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 437-5697

10/08/2012 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit**Chief Complaint:** Chronic back and extremity pain**History of Present Illness:** Patient returns with ongoing complaints of chronic pain in lower back and right knee.

States her pain has increased in her knee and also states that she is not getting as much benefit from her pain medication.

Having scattered unpredictable burning sensations in lower back lasting up to 7 seconds.

Apparently no set pattern or movement that can be related to the pain.

Has asked about Neurontin for her pain.

We could try her on some of the Neurontin to see if this will help her pain.

Otherwise We would like to see what the Orthopedist has to say about her knee.

We have not heard from our approval requests for the Ortho referral.

Location Of Pain: lower back and right knee.**Description Of Pain:** Sharp, Burning**Pain Rating:** 8**Activity:** Decreased**Did Medications Help?** No**Is the patient taking any new medications?** No**New Meds:**

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po hs

Does the patient have any new medical or surgical problems? No**Is the patient experiencing increased sadness, anxiety, or family problems?** No**Data Reviewed:** Old Charts**Past, Family, and Social History****Past History (Reviewed - No Changes Since Last Visit):** Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration**Surgery:** C-section, breast biopsy, diaphragmatic hernia repair.**Family History (Reviewed - No Changes Since Last Visit):** Migraines, cancer, back problems**Social History (Reviewed - No Changes Since Last Visit):** Married with 3 children

High school graduate

Customer Service-Specialist at Dick's Sporting Goods where she was injured 3/13/10. Worker's Comp.

Continues to work full-time, regular duty. Attorney: Kathryn Williams

Denies tobacco

Occasional alcohol

Review of Systems**General:** fatigue, headaches**Eyes:** denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia**Ear/Nose/Throat:** denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

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October 29, 2012

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Chart Document

MRS ZEENA L FLETCHER

Home: (864) 437-5697

Female DOB: 11/17/1959

39709

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

Gastrointestinal: reflux

Genitourinary: Denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain

Musculoskeletal: back pain, joint pain

Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: denies transient paralysis, weakness, paresthesias, seizures, syncope, tremors, vertigo

Psychiatric: depression

Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 61.5 in. Wt: 217.2 lbs. BMI: 40.52 P: 102 Rhythm: regular BP: 109/69

Physical Exam

General

General appearance: obese

Communication ability: communicates by voice, normal quality

Gait and station: antalgic

Comment: right knee

Psychiatric

Mental Status: AAO x3

Judgement/Insight: Intact

Mood/Affect: Appropriate

Recent/Remote Memory: Normal

Thoracolumbar

ROM: decreased flexion

Palpation: Tender

Midline

Comments: L5-S1

Muscle Stretch Reflex

Sensory Intact to light touch/pin prick, Negative allodynia/hyperpathia

Neuro No Atrophy or Clonus

Sympathetic Function: Normal

Assessment

Status of Existing Problems:

Assessed LUMBAR RADICULOPATHY as unchanged - MONICA P SPEAK NP - Signed

Assessed SPINAL STENOSIS - LUMBAR as unchanged - MONICA P SPEAK NP - Signed

Assessed Z-JOINT SYNDROME as unchanged - MONICA P SPEAK NP - Signed

Assessed LOW BACK PAIN as unchanged - MONICA P SPEAK NP - Signed

Carolinas Center for Advanced Mgmt of Pain - Greenville Office

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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 437-5697

Plan

Reviewed subjective and objective findings with Dr. Satterthwaite to see what options or changes if any he may wish to make to our present treatment plan

States medications not working as well as it used to.

We will try Neurontin 300 1 hs

Side effects of new meds and/or increase in present meds were explained to patient and patient instructed to call if having any problems with the new medication

Patient may call and move appointment forward if there is a need to be seen earlier.

New Prescriptions/Refills:

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po hs #30 x 1, 10/08/2012, MONICA P SPEAK NP

Current Medication List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po hs

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

New Orders:

Expanded [99213]

Return for follow-up 2 months [xxxxx]

Prescriptions:

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po hs #30 x 1

Entered and Authorized by: MONICA P SPEAK NP

Electronically signed by: MONICA P SPEAK NP on 10/08/2012

Method used: Print then Give to Patient

RxID: 1665326106806570

Electronically signed by MONICA P SPEAK NP on 10/08/2012 at 5:08 PM

10/08/2012 - Append: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

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Home: (864) 437-5697

Did not do billing charge for Urine test for therapeutic drug monitoring. Will add now. M.Speak FNP-BC

Electronically signed by MONICA P SPEAK NP on 10/10/2012 at 12:30 PM

Eugene Mironer, MD
 John C. Haasis, MD
 Phillip C. LaTourette, MD
 Edward E. Lewis, MD
 John R. Satterthwaite, MD
 Renju T. Joseph, MD
 Patricia R. Grant, MD
 Kelby Hutcheson, MD
 C. David Tollison, PhD
 Donald W. Hinnant, PhD



CAROLINAS CENTER
 FOR ADVANCED MANAGEMENT OF PAIN
www.carolinapain.com

Work Excuse

Date: 10-8-12

Leena Fletcher is under the care of

Y. Eugene Mironer, MD
 John R. Satterthwaite, MD
 Phillip C. LaTourette, MD
 John C. Haasis, MD
 J. Kelby Hutcheson, MD
 Renju T. Joseph, MD
 C. David Tollison, PhD

Siri Craft, FNP

Monica Speake, FNP

Kacie Tartaro, FNPC

Mary Cohen, FNPC

Mary Cohen, FNPC

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 Fax: 864-582-4350

40 Peachtree Street
 Winston-Salem, NC 27103
 Phone: 336-582-7550
 Fax: 336-582-4176

59 McDowell Street
 Asheville, NC 28801
 Phone: 828-253-1233
 Fax: 828-253-0320

1135 Soaring Street
 Spartanburg, SC 29583
 Phone: 864-733-4086
 Fax: 864-733-5082

110 Fletting Street
 Andersonville, NC 28703
 Phone: 828-333-0062
 Fax: 828-333-0062

15 Physicians Park Drive
 Columbia, SC 29205
 Phone: 803-387-0053
 Fax: 803-387-0350

101 Union Lane
 West Columbia, SC 29169
 Phone: 803-791-1111

And the following applies:

☐ Patient was/is unable to work _____

☒ Patient is unable to work until seen on 12-6-12

☐ Patient is restricted to limited duty for/until _____

☐ Patient is able to return to work with the following restrictions:

☐ Other _____

Signed He. meca Speake FNPC

STATEMENT OF

JOHN R. SATTERTHWAITE, M.D.

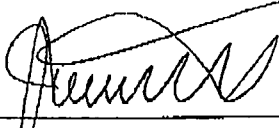
Re: **Zeena L. Fletcher**
Social Security No.: xxx-xx-2218
Date of Birth: 11/17/59
Date of Accident: 3/13/10

Based on my review of the medical records and notes related to this patient, it is my opinion to a reasonable degree of medical certainty that

☒ Ms. Fletcher has sustained a change of condition for the worse regarding the right knee condition stemming from her March 13, 2010 injury by accident.

— or —

☐ Ms. Fletcher has not sustained a change of condition for the worse regarding the right knee condition stemming from her March 13, 2010 injury by accident.



John R. Satterthwaite, M.D.

10/18/12

Date

Carolinas Center for Advanced Mgmt of Pain - Greenville Office

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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 437-5697

11/19/2012 - Office Visit: Follow-Up Pain**Provider: John Satterthwaite MD****Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office****Follow-Up Visit****Chief Complaint:** Back pain**History of Present Illness:** Insurance denying Cymbalta. Ongoing interference with her care. Has been getting improvement in her mood with Cymbalta.

Pain in the back has significantly increased since she has not had an injection in 5 months.

Had been receiving them every two month with good reduction in pain for 5-7 weeks. Has been able to reduce medications 50% with injections.

Having trouble walking without back and leg pain.

Spasms better with medications.

Facet arthropathy and stenosis at L3-L4.

Location Of Pain: Back and bilateral thighs**Description Of Pain:** Aching, Burning**Pain Rating:** 7**Activity:** Decreased**Did Medications Help?** Yes**Did Injection Help?** Yes**Is the patient taking any new medications?** No**Does the patient have any new medical or surgical problems?** No**Is the patient experiencing increased sadness, anxiety, or family problems?** No**Data Reviewed:** MRI**Past, Family, and Social History****Past History (Reviewed - No Changes Since Last Visit):** Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration**Surgery:** C-section, breast biopsy, diaphragmatic hernia repair.**Family History (Reviewed - No Changes Since Last Visit):** Migraines, cancer, back problems**Social History (Reviewed - No Changes Since Last Visit):** Married with 3 children

High school graduate

Customer Service Specialist at Dick's Sporting Goods where she was injured 3/13/10. Worker's Comp.

Continues to work full-time, regular duty. Attorney: Kathryn Williams

Denies tobacco

Occasional alcohol

Review of Systems**General:** fatigue, headaches**Eyes:** denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia**Ear/Nose/Throat:** denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia**Cardiovascular:** Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema**Respiratory:** Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing**Gastrointestinal:** reflux

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MRS ZEENA L FLETCHER

Home: (864) 437-5897

Female DOB: 11/17/1959

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Genitourinary: Denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain

Musculoskeletal: back pain, joint pain

Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: See HPI

Psychiatric: depression

Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: **62.5** In. Wt: **221.2** lbs. BMI: 39.96 T: **97.3** deg F. T site: oral P: **95** Rhythm: regular R: **16** BP: **160/96**

Plan

Getting benefit from medications and injections when given every 2 months.

Able to reduce pain medications 50% with ESI

Able to be more active.

Unable to get any consistent benefit since the injections are not being approved in a timely manner.

Would do much better, physically, if we could continue injections every 2 months.

Would do better mentally if medications would be approved in a timely fashion.

Needs samples of Cymbalta, since that is not being approved.

Needs authorization for repeat ESI since it has been 5 months.

Continue current treatment

Follow up with the Nurse Practitioner, as she is capable of evaluating her need for medications and injections.

Medications for November being filled today, so she does not need a prescription for 1 month.

Follow up in 1 month

Try to get ESI approved

New Prescriptions/Refills:

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily #14 x 0, 11/19/2012, John Satterthwaite MD

Current Medication List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po hs

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRILOSEC 40 MG CPDR (OMEPRAZOLE) 1 daily to take with Daypro to prevent GI upset

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

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Home: (864) 437-5697

New Orders:

Expanded [99213]

Return for follow-up 1 month [xxxxx]

Return for Epidural Steroid Injection [XXXXXX]

Prescriptions:

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily #14 x 0

Entered and Authorized by: John Satterthwaite MD

Electronically signed by: John Satterthwaite MD on 11/19/2012

Method used: Samples Given

RxID: 1668950626256480

Risk Factors:

Tobacco use: never smoker

Passive smoke exposure: yes

Drug use: None

HIV high-risk behavior: no

Caffeine use: 4 drinks per day

Alcohol use: yes

Type: wine cooler on special occasions

Drinks per day: <1

Has patient --

Felt need to cut down: no

Been annoyed by complaints: no

Felt guilty about drinking: no

Needed eye opener in the morning: no

Counseled to quit/cut down alcohol use: no

Exercise: no

Seatbelt use: 100 %

Sun Exposure: occasionally

Electronically signed by John Satterthwaite MD on 11/19/2012 at 5:14 PM

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MRS ZEENA L FLETCHER

Home: (864) 437-5697

Female DOB: 11/17/1959

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11/28/2012 - Office Procedure: Epidural Steroid Injection**Provider: John Satterthwaite MD****Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office****Epidural Steroid Injection****Indications:**

Left L5-S1 disc protrusion
Previous ESI with >50% pain reduction
Increased back and leg pain
MRI shows S1 root compromise on the left.
Repeat injection

Procedure:

After informed consent was obtained, the patient was placed in the prone position and the back was prepped with Betadine and draped in the usual sterile fashion. Fluoroscopy was used to localize the appropriate interspace. Local anesthesia was administered using a 27 gauge needle and 1% Lidocaine. Using an 18 gauge Touhy needle and loss of resistance technique, the epidural space was entered at the L5-S1 interspace. No blood or CSF was noted returning from the needle. Following negative aspiration, 40mg Triamcinolone in 4cc normal saline with 1cc of .25% Bupivacaine was injected into the space. The needle was removed and the puncture wound was dressed.

Observations

- The patient was monitored for an appropriate length of time after the procedure and then discharged home, in good condition, with a driver.
- The patient was instructed to refrain from driving for 12 hours and to contact the office immediately if any of the following were noted: new or different pain in the back, loss of bladder or bowel control, new pain, numbness or weakness of the legs, redness or drainage from the needle insertion site.
- No sedation was given.
- The patient tolerated the procedure well.

The following complications were noted:

None

Orders

c-arm [CPT-77003]
Single Lumbar / Caudal [62311]
Triamcinolone 10mg [J3301]
Return for Follow-Up [XXXXX]

Updated Medication List

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po hs
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid
CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily

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Home: (864) 437-5697

Female DOB: 11/17/1959

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ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food
PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset
NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD
IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD
PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD
LUMIGAN 0.01 % SOLN (BIMATOPROST) other md
LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Vital Signs

Ht: 62 in. Wt: 222.6 lbs. BMI: 40.86 T: 97.8 deg F. T site: oral P: 116 Rhythm: regular R: 16 BP: 185/101

Risk Factors:

Tobacco use: never smoker
Passive smoke exposure: yes
Drug use: None
HIV high-risk behavior: no
Caffeine use: 4 drinks per day
Alcohol use: yes
Type: wine cooler on special occasions
Drinks per day: <1
Has patient -
Felt need to cut down: no
Been annoyed by complaints: no
Felt guilty about drinking: no
Needed eye opener in the morning: no
Counseled to quit/cut down alcohol use: no
Exercise: no
Seatbelt use: 100 %
Sun Exposure: occasionally

Electronically signed by John Satterthwaite MD on 11/28/2012 at 3:34 PM

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

03/22/2012 - Office Visit: Follow-Up

Provider: C David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Psychology Follow-Up

Personal/Social History

Age: 52 Years Old

Date of Birth: 11/17/1959

Marital Status: Married

Years: married x1 since 1979

County of Residence: Anderson County

Substance Use/Abuse - Alcohol: None

Substance Use/Abuse - Tobacco: None

Substance Use/Abuse - Drugs: other

Education/Vocational History

Last Grade Completed: graduated high school

Work Status: Full-Time

Disabled: Dick's Sporting Goods, currently working

Appearance and Self care

Grooming: Neat/Clean

Gait: Normal

Motor Activity: Unremarkable

Sensorium

Level of Consciousness: Alert

Attention: Normal

Orientation: Person, Place, Time, Situation

Memory: Good

Interpersonal Behavior

Demeanor: Cooperative, Pleasant, Friendly, Polite

Affect and Mood

Affect: Appropriate, Reactive, Blunted

Mood: Dysphoric, Anxious

Language and Thought Process:

Speech: Fluent, Soft

Thought Content: Appropriate to mood/circumstance

Organization: Logical

Preoccupations: None

Hallucinations: None

Medical History:

Current Physical Complaints: Depression associated with pain intensity, duration, and lifestyle

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Female DOB: 11/17/1959

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alteration. No prior contact with mental health professionals prior to initial evaluation with Dr. Tollison on 3-16-11.

Past Medical History: Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration

Surgery: C-section, breast biopsy, diaphragmatic hernia repair.

Current Medications:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 3/day.
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h pm pain max 3/day
ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food
PRILISEQ 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset
PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson
NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD
IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD
PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD
LUMIGAN 0.01 % SOLN (BIMATOPROST) other md
LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Previous Psychological Assessment:

Initially evaluated by Dr. Tollison on referral from Dr. Satterthwaite on 3-16-11. Depression associated with pain intensity, duration, and lifestyle alteration. P-3 on 3-16-11 with Depression 12th, Somatization 19th, Anxiety Average Range. Psychological MMI as of 9-6-11.

Current Problem List:

LUMBAR RADICULOPATHY (ICD-724.4)
DIABETES MELLITUS (ICD-250.00)
LONG TERM/CURRENT USE MEDICATION (ICD-V58.69)
SPINAL STENOSIS - LUMBAR (ICD-724.02)
Z-JOINT SYNDROME (ICD-724.8)
LOW BACK PAIN (ICD-724.2)
UNSPECIFIED DISORDER OF SYNOVIUM TENDON&BURSA (ICD-727.9)
KNEE PAIN, RIGHT (ICD-719.46)
MYOFASCIAL PAIN SYNDROME (ICD-729.1)
DISPLACED DISC - LUMBAR W/O MYELOPATHY (ICD-722.10)
ADJUSTMENT DISORDER/MIXED (ICD-309.28)
DEPRESSION (ICD-311)
GLAUCOMA BILATERAL (ICD-365.9)

Treatment Plan: Reduce influence of psychological symptoms on pain intensity, duration, and lifestyle alteration, increase physical activity, continue working and levels of productivity. Psychological MMI as of 9-6-11.

Next Appointment: one month

Assessment

She continues with some medical problems related to hospitalization 6 weeks or so ago and her blood glucose levels remain unsteady. She frustrated that WC is not authorizing physical therapy or injections as agreed so her attorney is re-opening case. She remains out of work, one month, and she questions being

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able to return "if I keep feeling like I do now because of back spasms." She feels she would benefit from injection and physical therapy. Psychologically, she is symptomatic but stable and she is rehearsing cognitive restructuring techniques. She working with Dr. Satterthwaite is treating pain. Sleep is impaired secondary to recently increased pain. She having financial problems and needs and wants to work but pain is a barrier at present and she finds all this unsettling, frustrated, and unwanted. Cognitively intact and compliant with treatment. Denies suicidal and homicidal ideation. She wants to return to work.

Axis I - ADJUSTMENT DISORDER/MIXED (ICD-309.28)

Axis II - deferred

Plan

Continue current treatment plan and notify me of any significant change in condition. Urged to rehearse daily cognitive coping skills with restructuring of perceptions in combination with behavioral redirection and distraction techniques for therapeutic benefit. Follow up with Dr. Satterthwaite as scheduled. Telephone with need and return appointment appointment in one month, sooner if need.

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Return for follow-up 1 month [xxxxx]

Updated Med List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 3/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 3/day

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRIOSEC 40 MG CPDR (OMEPRAZOLE) 1 daily to take with Daypro to prevent GI upset

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Electronically signed by C David Tollison PhD on 03/22/2012 at 11:11 AM

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

05/04/2012 - Office Visit: Follow-Up

Provider: C David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Psychology Follow-Up

Personal/Social History

Age: 52 Years Old

Date of Birth: 11/17/1959

Marital Status: Married

Years: married x1 since 1979

County of Residence: Anderson County

Substance Use/Abuse - Alcohol: None

Comments: yes

Substance Use/Abuse - Tobacco: None

Substance Use/Abuse - Drugs: None

Education/Vocational History

Last Grade Completed: graduated high school

Work Status: Full-Time

Disabled: Dick's Sporting Goods, currently working

Appearance and Self care

Grooming: Neat/Clean

Gait: Normal

Motor Activity: Unremarkable

Sensorium

Level of Consciousness: Alert

Attention: Normal

Orientation: Person, Place, Time, Situation

Memory: Good

Interpersonal Behavior

Demeanor: Cooperative, Pleasant, Friendly, Polite

Affect and Mood

Affect: Appropriate, Reactive, Blunted

Mood: Dysphoric, Anxious

Language and Thought Process:

Speech: Fluent, Soft

Thought Content: Appropriate to mood/circumstance

Organization: Logical

Preoccupations: None

Hallucinations: None

Medical History:

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Female DOB: 11/17/1959

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Current Physical Complaints: Depression associated with pain intensity, duration, and lifestyle alteration. No prior contact with mental health professionals prior to initial evaluation with Dr. Tollison on 3-16-11.

Past Medical History: Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration

Surgery: C-section, breast biopsy, diaphragmatic hernia repair.

Current Medications:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 3/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 3/day.

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRILLOSEC 40 MG CPDR (OMEPRAZOLE) 1 daily to take with Daypro to prevent GI upset

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Previous Psychological Assessment:

Initially evaluated by Dr. Tollison on referral from Dr. Satterthwaite on 3-16-11. Depression associated with pain intensity, duration, and lifestyle alteration. P-3 on 3-16-11 with Depression 12th, Somatization 19th, Anxiety Average Range. Psychological MMI as of 9-6-11.

Current Problem List:

LUMBAR RADICULOPATHY (ICD-724.4)

DIABETES MELLITUS (ICD-250.00)

SPINAL STENOSIS - LUMBAR (ICD-724.02)

Z-JOINT SYNDROME (ICD-724.8)

LOW BACK PAIN (ICD-724.2)

UNSPECIFIED DISORDER OF SYNOVIUM TENDON&BURSA (ICD-727.9)

KNEE PAIN, RIGHT (ICD-719.46)

MYOFASCIAL PAIN SYNDROME (ICD-729.1)

DISPLACED DISC - LUMBAR W/O MYELOPATHY (ICD-722.10)

ADJUSTMENT DISORDER/MIXED (ICD-309.28)

DEPRESSION (ICD-311)

GLAUCOMA BILATERAL (ICD-365.9)

LONG TERM/CURRENT USE MEDICATION (ICD-V58.69)

Treatment Plan: Reduce influence of psychological symptoms on pain intensity, duration, and lifestyle alteration, increase physical activity, continue working and levels of productivity. Psychological MMI as of 9-6-11.

Next Appointment: one month

Assessment

She remains out of work and reports that if she doesn't return to work by May 9 then she will lose her job and she is struggling with this because "sometimes I think I can go back and then I will do something that

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

puts me down and I realize I can't" but she feels guilty about not working and this fuels her affective distress. She worries about finances. She reports improvement in glucose levels and is working with her physicians. Cognitively intact and compliant with treatment. Denies suicidal and homicidal ideation.

Axis I - ADJUSTMENT DISORDER/MIXED (ICD-309.28)

Axis II - no diagnosis

Plan

Continue current treatment plan and notify me of any significant change in condition. Get out more and use distraction techniques and keep mentally occupied to avoid excessive rumination. Develop an action plan. Focus on thoughts, feelings, and behavior. Telephone with need and return appointment in one month.

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Return for follow-up 1 month [xxxxx]

Updated Med List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 3/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 3/day

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 bid

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd per Dr. Hutcheson

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Electronically signed by C David Tollison PhD on 05/04/2012 at 2:14 PM

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August 10, 2012

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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 634-0965

07/30/2012 - Office Visit: Follow-Up

Provider: C David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Psychology Follow-Up**Personal/Social History**

Age: 52 Years Old

Date of Birth: 11/17/1959

Marital Status: Married

Years: married x1 since 1979

County of Residence: Anderson County

Substance Use/Abuse - Alcohol: None

Comments: yes

Substance Use/Abuse - Tobacco: None

Substance Use/Abuse - Drugs: None

Education/Vocational History

Last Grade Completed: graduated high school

Work Status: Full-Time

Disabled: Dick's Sporting Goods, currently working

Appearance and Self care

Grooming: Neat/Clean

Gait: Normal

Motor Activity: Unremarkable

Sensorium

Level of Consciousness: Alert

Attention: Normal

Orientation: Person, Place, Time, Situation

Memory: Good

Interpersonal Behavior

Demeanor: Cooperative, Pleasant, Friendly, Polite

Affect and Mood

Affect: Appropriate, Reactive, Blunted

Mood: Dysphoric, Anxious

Language and Thought Process:

Speech: Fluent, Soft

Thought Content: Appropriate to mood/circumstance

Organization: Logical

Preoccupations: None

Hallucinations: None

Medical History:

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August 10, 2012

Page 2
Chart Document**MRS ZEENA L FLETCHER**

Female DOB: 11/17/1959

39709

Home: (864) 634-0965

Current Physical Complaints: Depression associated with pain intensity, duration, and lifestyle alteration. No prior contact with mental health professionals prior to initial evaluation with Dr. Tollison on 3-16-11.

Past Medical History: Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration

Surgery: C-section, breast biopsy, diaphragmatic hernia repair.

Current Medications:

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day
ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food
PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset
PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd (discontinued)
NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD
IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD
PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD
LUMIGAN 0.01 % SOLN (BIMATOPROST) other MD
LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Previous Psychological Assessment:

Initially evaluated by Dr. Tollison on referral from Dr. Satterthwaite on 3-16-11. Depression associated with pain intensity, duration, and lifestyle alteration. P-3 on 3-16-11 with Depression 12th, Somatization 19th, Anxiety Average Range. Psychological MMI as of 9-6-11.

Current Problem List:

LUMBAR RADICULOPATHY (ICD-724.4)
SPINAL STENOSIS - LUMBAR (ICD-724.02)
Z-JOINT SYNDROME (ICD-724.8)
LOW BACK PAIN (ICD-724.2)
UNSPECIFIED DISORDER OF SYNOVIUM TENDON&BURSA (ICD-727.9)
KNEE PAIN, RIGHT (ICD-719.46)
MYOFASCIAL PAIN SYNDROME (ICD-729.1)
DISPLACED DISC - LUMBAR W/O MYELOPATHY (ICD-722.10)
ADJUSTMENT DISORDER/MIXED (ICD-309.28)
DEPRESSION (ICD-311)
GLAUCOMA BILATERAL (ICD-365.9)
LONG TERM/CURRENT USE MEDICATION (ICD-V58.69)
DIABETES MELLITUS (ICD-250.00)

Treatment Plan: Reduce influence of psychological symptoms on pain intensity, duration, and lifestyle alteration, Increase physical activity, continue working and levels of productivity. Psychological MMI as of 9-6-11.

Next Appointment: one month

Assessment

Last visit Dr. Satterthwaite changed her Pristiq to Cymbalta and she is reporting some fatigue but, overall,

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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 634-0965

she is doing a little better psychologically. She is rehearsing cognitive restructuring techniques instructed "and it helps." Cognitively intact and compliant with treatment. Denies suicidal and homicidal ideation. Focus on thoughts, feelings, and behavior.

Axis I - ADJUSTMENT DISORDER/MIXED (ICD-309.28)**Axis II - deferred****Plan**

Continue current treatment plan and notify me of any significant change in condition. Urged to rehearse daily cognitive coping skills with restructuring of perceptions in combination with behavioral redirection and distraction techniques for therapeutic benefit. Return one month

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Return for follow-up 1 month [xxxxx]

Updated Med List:

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset

PRISTIQ 50 MG XR24H-TAB (DESVENLAFAXINE SUCCINATE) 1 qd (discontinued)

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Prescriptions:

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily #30 x 0

Entered by: C David Tollison PhD

Authorized by: John Satterthwaite MD

Electronically signed by: C David Tollison PhD on 07/30/2012

Method used: Handwritten

RxID: 1659272591806230

Electronically signed by C David Tollison PhD on 07/30/2012 at 1:07 PM

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October 29, 2012

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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 437-5697

09/18/2012 - Office Visit: Follow-Up

Provider: C David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Psychology Follow-Up**Personal\Social History**

Age: 52 Years Old

Date of Birth: 11/17/1959

Marital Status: Married

Years: married x1 since 1979

County of Residence: Anderson County

Substance Use/Abuse - Alcohol: None

Comments: yes

Substance Use/Abuse - Tobacco None

Substance Use/Abuse - Drugs no

Education\Vocational History

Last Grade Completed: graduated high school

Work Status: Full-Time

Disabled: Dick's Sporting Goods, currently working

Appearance and Self care

Grooming: Neat/Clean

Gait: Normal

Motor Activity: Unremarkable

Sensorium

Level of Consciousness: Alert

Attention: Normal

Orientation: Person, Place, Time, Situation

Memory: Good

Interpersonal Behavior

Demeanor: Cooperative, Pleasant, Friendly, Polite

Affect and Mood

Affect: Appropriate, Reactive, Blunted

Mood: Dysphoric, Anxious

Language and Thought Process:

Speech: Fluent, Soft

Thought Content: Appropriate to mood/circumstance

Organization: Logical

Preoccupations: None

Hallucinations: None

Medical History:

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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 437-5697

Current Physical Complaints: Depression associated with pain intensity, duration, and lifestyle alteration. No prior contact with mental health professionals prior to initial evaluation with Dr. Tollison on 3-16-11.

Past Medical History: Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration

Surgery: C-section, breast biopsy, diaphragmatic hernia repair.

Current Medications:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid
CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily
ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food
PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset
NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD
IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD
PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD
LUMIGAN 0.01 % SOLN (BIMATOPROST) other md
LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Previous Psychological Assessment:

Initially evaluated by Dr. Tollison on referral from Dr. Satterthwaite on 3-16-11. Depression associated with pain intensity, duration, and lifestyle alteration. P-3 on 3-16-11 with Depression 12th, Somatization 19th, Anxiety Average Range. Psychological MMI as of 9-6-11.

Current Problem List:

LUMBAR RADICULOPATHY (ICD-724.4)
SPINAL STENOSIS - LUMBAR (ICD-724.02)
Z-JOINT SYNDROME (ICD-724.8)
LOW BACK PAIN (ICD-724.2)
UNSPECIFIED DISORDER OF SYNOVIUM TENDON&BURSA (ICD-727.9)
KNEE PAIN, RIGHT (ICD-719.46)
MYOFASCIAL PAIN SYNDROME (ICD-729.1)
DISPLACED DISC - LUMBAR W/O MYELOPATHY (ICD-722.10)
ADJUSTMENT DISORDER/MIXED (ICD-309.28)
DEPRESSION (ICD-311)
GLAUCOMA BILATERAL (ICD-365.9)
LONG TERM/CURRENT USE MEDICATION (ICD-V58.69)
DIABETES MELLITUS (ICD-250.00)

Treatment Plan: Reduce influence of psychological symptoms on pain intensity, duration, and lifestyle alteration, increase physical activity, continue working and levels of productivity. Psychological MMI as of 9-6-11.

Next Appointment: 4-6 weeks

Assessment

Using straight cane, complaining of pain, had a tough weekend due to pain and she went with husband to Charlotte and she had to spend the majority of weekend in hotel room. Frustrated over intensity of pain

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 437-5697

and the duration of pain. She working with Dr. Satterthwaite on pain management. Denies suicidal thought. She having considerable financial stress.....husband's truck reposessed.....and this adds to her stress that, in turn, adds to her pain.

Axis I - ADJUSTMENT DISORDER/MIXED (ICD-309.28)**Axis II - deferred****Plan**

Continue current treatment plan and notify me of any significant change in condition. Urged to rehearse daily cognitive coping skills with restructuring of perceptions in combination with behavioral redirection and distraction techniques for therapeutic benefit. Follow up with Dr. Satterthwaite as scheduled, telephone with need and return appointment in 4-6 weeks, sooner if need.

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Updated Med List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Electronically signed by C David Tollison PhD on 09/18/2012 at 3:02 PM

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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 437-5697

10/26/2012 - Office Visit: Follow-Up

Provider: C David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Psychology Follow-Up**Personal/Social History**

Age: 52 Years Old

Date of Birth: 11/17/1959

Marital Status: Married

Years: married x1 since 1979

County of Residence: Anderson County

Substance Use/Abuse - Alcohol: None

Comments: yes

Substance Use/Abuse - Tobacco: None

Substance Use/Abuse - Drugs: None

Education/Vocational History

Last Grade Completed: graduated high school

Work Status: Full-Time

Disabled: Dick's Sporting Goods, currently working

Appearance and Self care

Grooming: Neat/Clean

Gait: Normal

Motor Activity: Unremarkable

Sensorium

Level of Consciousness: Alert

Attention: Normal

Orientation: Person, Place, Time, Situation

Memory: Good

Interpersonal Behavior

Demeanor: Cooperative, Pleasant, Friendly, Polite

Affect and Mood

Affect: Appropriate, Reactive, Blunted

Mood: Dysphoric, Anxious

Language and Thought Process:

Speech: Fluent, Soft

Thought Content: Appropriate to mood/circumstance

Organization: Logical

Preoccupations: None

Hallucinations: None

Medical History:

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October 29, 2012

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Chart Document

MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 437-5897

Current Physical Complaints: Depression associated with pain intensity, duration, and lifestyle alteration. No prior contact with mental health professionals prior to initial evaluation with Dr. Tollison on 3-16-11.

Past Medical History: Migraine headaches, hypertension, diabetes, depression, asthma, glaucoma OS, dehydration

Surgery: C-section, breast biopsy, diaphragmatic hernia repair.

Current Medications:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.
PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po hs
PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid
CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily
ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid
DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food
PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset
NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD
IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD
PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD
LUMIGAN 0.01 % SOLN (BIMATOPROST) other md
LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Previous Psychological Assessment:

Initially evaluated by Dr. Tollison on referral from Dr. Satterthwaite on 3-16-11. Depression associated with pain intensity, duration, and lifestyle alteration. P-3 on 3-16-11 with Depression 12th, Somatization 19th, Anxiety Average Range. Psychological MMI as of 9-6-11.

Current Problem List:

LUMBAR RADICULOPATHY (ICD-724.4)
SPINAL STENOSIS - LUMBAR (ICD-724.02)
Z-JOINT SYNDROME (ICD-724.8)
LOW BACK PAIN (ICD-724.2)
UNSPECIFIED DISORDER OF SYNOVIUM TENDON&BURSA (ICD-727.9)
KNEE PAIN, RIGHT (ICD-719.46)
MYOFASCIAL PAIN SYNDROME (ICD-729.1)
DISPLACED DISC - LUMBAR W/O MYELOPATHY (ICD-722.10)
ADJUSTMENT DISORDER/MIXED (ICD-309.28)
DEPRESSION (ICD-311)
GLAUCOMA BILATERAL (ICD-365.9)
LONG TERM/CURRENT USE MEDICATION (ICD-V58.69)
DIABETES MELLITUS (ICD-250.00)

Treatment Plan: Reduce influence of psychological symptoms on pain intensity, duration, and lifestyle alteration, increase physical activity, continue working and levels of productivity. Psychological MMI as of 9-6-11.

Next Appointment: 6 weeks

Assessment

"Sometimes I do a little better because of all the stuff you guys do for me but other days the pain and

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MRS ZEENA L FLETCHER

Female DOB: 11/17/1959

39709

Home: (864) 437-5697

worry is bad.....I was supposed to see you this past Monday but I could hardly get out of bed." She working with Dr. Satterthwaite on pain management. Cognitively intact and compliant with treatment. Denies suicidal and homicidal ideation. She is trying to get out of house a little more often. Financial stress, worried about losing house, husband's truck reposessed. She reports benefit from Cymbalta.

Axis I - ADJUSTMENT DISORDER/MIXED (ICD-309.28)**Axis II - deferred****Plan**

Continue current treatment plan and notify me of any significant change in condition. Get out more and use distraction techniques and keep mentally occupied to avoid excessive rumination. Develop an action plan. Focus on thoughts, feelings, and behavior. Follow up with her physicians as scheduled. Return appointment in 6 weeks.

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Updated Med List:

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 po q4-6h prn pain max 4/day.

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) 1 q4-6h prn pain max 4/day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po hs

PENNSAID 1.5 % SOLN (DICLOFENAC SODIUM) Apply 40 drops to the knee bid

CYMBALTA 60 MG CPEP (DULOXETINE HCL) 1 po daily

ZANAFLEX 4 MG TABS (TIZANIDINE HCL) 1 tid

DAYPRO 600 MG TABS (OXAPROZIN) 1 bid with food

PRILOSEC 40 MG CPDR (OMEPRazole) 1 daily to take with Daypro to prevent GI upset

NOVOLOG 100 UNIT/ML SOLN (INSULIN ASPART) other MD

IMITREX 50 MG TABS (SUMATRIPTAN SUCCINATE) other MD

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) other MD

LUMIGAN 0.01 % SOLN (BIMATOPROST) other md

LANTUS SOLOSTAR 100 UNIT/ML SOLN (INSULIN GLARGINE) other MD

Electronically signed by C David Tollison PhD on 10/26/2012 at 12:33 PM

STATEMENT OF**C. DAVID TOLLISON, PH.D.**

Re: Zeena L. Fletcher
Social Security No.: xxx-xx-2218
Date of Birth: 11/17/59
Date of Accident: 3/13/10

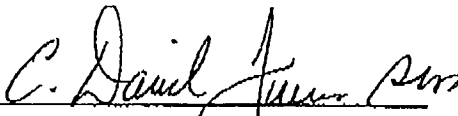
Based on my review of the medical records and notes related to this patient, it is my opinion to a reasonable degree of professional certainty that

✓

Ms. Fletcher has sustained a change of condition for the worse regarding the psychological problems stemming from her March 13, 2010 injury by accident.

— or —

Ms. Fletcher has not sustained a change of condition for the worse regarding the psychological problems stemming from her March 13, 2010 injury by accident.


C. David Tollison, Ph.D.

11-12-12
Date

STATEMENT OF

C. DAVID TOLLISON, PH.D.

Re: Zeena L. Fletcher
Social Security No.: xxx-xx-2218
Date of Birth: 11/17/59
Date of Accident: 3/13/10

Based on my review of the medical records and notes related to this patient, it is my opinion to a reasonable degree of professional certainty that

✓

Ms. Fletcher has been prescribed Cymbalta due to problems causally related to injuries sustained in her accident at work on March 13, 2010 and whether the recommendation Ms. Fletcher take Cymbalta is reasonable and necessary to effect a cure or give relief and to lessen the period of her disability stemming from the work-related injuries.

-- or --

Ms. Fletcher has not been prescribed Cymbalta due to problems causally related to injuries sustained in her accident at work on March 13, 2010 and the recommendation Ms. Fletcher take Cymbalta is not reasonable and necessary to effect a cure or give relief and to lessen the period of her disability stemming from the work-related injuries.

C. David Tollison, Ph.D.
C. David Tollison, Ph.D.

11-12-12
Date

Heonica Speck FNP-BC

11/12/12

Upstate Physical Therapy, PA
120 Mutual Drive
Anderson, SC 29621-1767
Phone: (864)261-3313
Fax: (864)261-3371

Physical Therapy Initial Examination

Patient Name: Fletcher, Zeena
Date of Birth: 11/17/1959
Referring Physician(s): Satterthwaite, John MD

Date of Initial Examination: 07/23/2012
Injury/Onset Date/Change of Status Date: Chronic
Diagnosis: 000.00: Unknown, 724.2: Lumbago, 724.02: Spinal stenosis, lumbar region, without neurogenic claudication, 729.1: Myalgia and myositis, unspecified
Treatment Diagnosis: 000.00: Unknown, 724.2: Lumbago, 781.2: Abnormality of gait

Visit No.: 1

Subjective

Treatment Side: N/A

History of Falls: No

History of Present Condition/Mechanism of Injury: PT HAD INJURY AT DICKS SPORTING GOODS AND HAD EXTENSIVE THERAPY WITH ME SEVERAL YEARS AGO. PT HAD REHAB IN GREENVILLE AND REPORTS THAT SHE HAD A BURN ON HER BACK FROM THE TENS UNIT. PT IS SCHEDULED FOR EPIDURAL THIS WEEK AND HAS BEEN GETTING MULTIPLE EPIDURALS FOR 18 MONTHS.

Current Level of Function: PT HAS BEEN TERMINATED DUE POOR WORK ATTENDANCE, REPORTS INABILITY TO BEND OVER AT WAIST, INABILITY TO DO STAIRS.

Prior Level of Function: Patient was independent in the following areas: ADLs, Self Care, Caregiving, Ambulation/Mobility, Community Integration/Access.

Primary Concern/Chief Complaint: CONSTANT PAIN IN MIDDLE, LOWER BACK THAT CAN GO UP TO THE MIDDLE OF THE BACK. PT C/O SOME TINGLING INTO EACH OF HER LEGS. PT C/O MUSCLE SPASMS IN HER BACK THAT CAN GO UP INTO HER CHEST. CONSTANT BURNING INTO R KNEE (PES ANSERINE BURSA).

Pain Scale: Worst: Best: Current:

Mental Status/Cognitive Function Appears Impaired? No

Current Medications With Dosages: Prescription (PRILOSEC, PERCOSET, NEUVALOG, LIPITOR, ZATAFLEX, DAYPRO)

Patient Goals: BE ABLE TO ENJOY SPENDING TIME WITH GRANDCHILDREN, RETURN TO WORK IF POSSIBLE.

Objective

Inspection

Patient Consent

Patient/Parent/Guardian Consent Yes

Observation

Comments PT AMBULY W/ MIN ANTALGIA AND SLOW GAIT SPEED

Range of Motion

Comments LIMITED TRUNK FLEXION TO 40 DEG IN STANDING

Strength

Comments CORE ABDOMINALS 2/5
QUADS 4/5 BILAT

Palpation

Comments PT TENDER TO PALPATION OF BILAT LUMBAR PARASPINALS

Assessment

Assessment/Diagnosis: PT PRESENTS W/ DECREASED FUNCTION AND SUBJECTIVE REPORTS OF PAIN FOLLOWING INJURY FROM SEVERAL YEARS BACK. PT HAS HAD SIGNIFICANT THERAPY AND PAIN MANAGEMENT AND I THEREFORE DO NOT EXPECT A GREAT PROGNOSIS FOR SIGNIFICANT IMPROVEMENT WITH OUR SESSIONS. HOWEVER, WE WILL PERFORM GENTLE FLEXIBILITY AND STRENGTHENING AS DIRECTED IN HOPE THAT PT'S PAIN CAN BE REDUCED AND HER FUNCTIONAL CAPACITY INCREASED.

Rehab Potential: Good

Contraindications to Therapy: None

Short Term Goals:

1: (9 VISITS) [0%] PT WILL REPORT VAS OF 6/10 OR LESS

Upstate Physical Therapy, PA
120 Mutual Drive
Anderson, SC 29621-1767
Phone: (864)261-3313
Fax: (864)261-3371

Physical Therapy
Initial
Examination

Patient Name: Fletcher, Zeena
Date of Birth: 11/17/1959
Document Date: 07/23/2012

Long Term Goals:

1: (18 VISITS) | 0% | PT WILL REPORT VAS OF 3/10 OR LESS

2: (18 VISITS) | 0% | PT WILL REPORT ABILITY TO STAND FOR 1 HOUR OR GREATER TO IMPROVE HER CAPACITY FOR RETURN TO WORK

Plan

Frequency: 3 times a week

Duration: 6 weeks

Plan: Begin Plan as Outlined

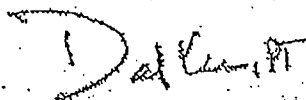
Treatment to be provided:

Procedures

Therapeutic Exercises (ROM, Strength), Therapeutic Activity (Work Specific)

Certification of Medical Necessity: It will be understood that the treatment plan mentioned above is certified medically necessary by the documenting therapist and referring physician mentioned in this report. Unless the physician indicates otherwise through written correspondence with our office, all further referrals will act as certification of medical necessity on the treatment plan indicated above.

Thank you for this referral. If you have questions regarding this plan of care, please contact me at (864)261-3313.



David Keese, PT
License #4453

Completed by David Keese, PT on July 23, 2012 at 8:31 pm

Elizabeth

From: Sebrina Jordan [SJordan@carolinaortho.net]

Sent: Thursday, January 17, 2013 11:30 AM

To: Elizabeth

Subject: RE: Zeena Fletcher

Elizabeth,

Dr. Posta reviewed our previous records as well as the records that were sent to us by Mr. Smith for Zeena Fletcher. Upon review, he states that he has nothing to offer the patient at this time. He recommends that she be evaluated by Dr. Ridgeway at Piedmont Orthopaedics for possible total knee arthroplasty.

Thanks,

Sebrina Jordan RT(R)

Carolina Orthopaedic Center

p- (864) 234-9900

f- (864) 234-9817



Sports Spine & Industrial

Physical Therapy and
Performance Training CenterFunctional Capacity Evaluation

Date of test: 9/21/2010 Test location: ☐ Greer ☒ Simpsonville
 Patient: Zeena Fletcher SS#: 224-04-2218 DOB: 11-17-59
 Physician: Dr Posta Diagnosis: Knee Pain/ LBP Date of injury:
 Employer: Dick's Sporting Goods Case manager: Lorie White Insurer: Genex
 Attorney: Work Status: ☐ Full ☒ Light/Restricted ☐ Medical Leave ☐ Terminated

Job's Physical Demand Level: ☐ S ☐ S-L ☒ L ☐ L-M ☐ M ☐ M-H ☐ H ☐ VH
 Tested Physical Demand Level: ☐ S ☒ S-L ☐ L ☐ L-M ☐ M ☐ M-H ☐ H ☐ VH
 Effort: ☐ Excellent ☒ Good ☐ Fair ☐ Poor ☐ Unable Inconsistent
 Body Mechanics: ☐ Excellent ☒ Good ☐ Acceptable ☐ Poor ☐ Frequent Reminders ☐ Unacceptable
 Attitude: ☒ Cooperative ☐ Uncooperative
 Current Complaints: Constant ache in lower back which increases with activity. Can't stand/walk for more than 30 minutes due to lower back and right knee pain. Get a sharp pain behind right knee cap with slight squatting or bending of knee. Hurts knee to squat, kneel, crawl. Knee pops getting up/dpwn from chairs. Hurts lower back to sweep, vacuum, or mob for more than 30 minutes. Not able to lift more than 15 lbs without severe pain.
 Major Limitations: Mrs Fletcher was found to be pleasant and cooperative during today's testing. Mrs Fletcher was willing to attempt all portions of today's test. Mrs Fletcher's maximum safe lifting capacity today is:
 Floor to waist - 15 lb
 Waist to shoulder - 17 lb.
 Shoulder to overhead - 10 lb.
 Maximum safe carry for 20 feet is - 15 lb
 Maximum safe push - 36 lb, pull - 30 lb.
 Mrs Fletcher is able to: sit constantly.
 Mrs Fletcher is able to: stand, walk, or forward bend frequently.
 Mrs Fletcher is able to: squat, kneel, work overhead with up to 2 lb, and climb stairs occasionally.
 Mrs Fletcher is not able to: crouch, crawl or climb ladders.
 Mrs Fletcher is found to have poor balance and may be at a high risk for falls.
 Mrs Fletcher was found to have given good consistant effort with today's testing.

Thank you for allowing SSI to evaluate your client. If I can be of further assistance, please do not hesitate to call. Greer phone: (864) 801-8706, Simpsonville phone: (864) 963-9229

Lance Owens, PT

Patient Name: Zeena Fletcher 9/21/10**MEDICAL HISTORY**

Injury Mechanism: 3/13/10 while working as front end manager (CSS) at Dick's Sporting Goods, Mrs Fletcher was going from the back of the store to the front carrying tils. She reports slipping on some signage on the floor causing her to fall onto right knee, then left elbow, then head. Was knocked out briefly. Had immediate pain and swelling in right knee. Sat with ice on knee but later could not stand or walk on that leg. Went to Eurgent Care for x-rays and sent home. Knee pain and swelling progressively got worse. Later was sent to Orthopedist and has had physical therapy for past several months. Tried to return to work but was not able to perform duties.		
Diagnostic Tests: ☒ X-Ray Early Arthritis ☒ MRI Not sure ☐ CT Scan ☐ NCV		
Medications: See attached list		
Past Medical History: Diabetes, Migraines, High BP		
Pain Scale Report:	Pre-Test	Post-Test
Current:	2-3/10	5-6/10
Best:	0/10	
Worst:	8/10	8/10 during lifting and crouching
Symptoms increase with: Walking, bending, lifting, standing		
Symptoms decrease with: Meds, sitting, ice		

JOB DESCRIPTION

Employer: Dick's Sporting Goods		
Occupation: Front End Manager (CSS)		
Physical Demand Level: ☐ S ☐ S-L ☐ L ☐ L-M ☐ M ☐ MH ☐ H ☐ VH		
Description of Job Duties: See attachment provided by Mrs Fletcher		
Explanation of Physical Demand Work Levels:		
Level	Weight Lifted	Frequency
Sedentary	10# or less	Infrequently
Sedentary - Light	15# 10# or less	Infrequently Frequently
Light	20# 10# or less	Infrequently Frequently
Light - Medium	35# 20# or less	Infrequently Frequently
Medium	50# 25# or less	Infrequently Frequently
Medium - Heavy	75# 35# or less	Infrequently Frequently
Heavy	100# 50# or less	Infrequently Frequently
Very Heavy	In excess of 100#	Infrequently

RESULTSDominance: ☒ Right ☐ Left ☐ AmbidextrousHeight: 5 feet 4 inchesWeight: 202 pounds

Pre-Test RHR: 101
 THR:
 BP: 140/85
 Pain Level:

Post-Test RHR: 107
 THR:
 BP: 150/85
 Pain Level: 5-6/10

Patient Name: Zeena Fletcher 9/21/10

MUSCULOSKELETAL EVALUATION

Posture: Flat thoracic spine, slight increase lordosis in lumbar spine.

Active Range of Motion:

Cervical	Flexion	WNLs
	Extension	WNLs
	Side Bending	R = 40 deg L = 50 deg
	Rotation	R = 75 deg L = 70 deg
Trunk	Flexion	90 deg, Lim 50%
	Extension	20 deg, Lim 50%
	Side Bending	R = 45 deg L = 42 deg
	Rotation	R = 75 deg L = 62 deg
Upper Extremity: WNLs		
Lower Extremity: WNLs		

MANUAL MUSCLE TEST

		R	L	Cogwheel
	Cervical Isometric	5	5	
(C4)	Shoulder Flexion	5	5	
(C5)	Shoulder Abduction	5	5	
(C6)	Elbow Flexion	5	5	
(C7)	Elbow Extension	5	5	
(C6)	Wrist Extension	5	5	
(C7)	Wrist Flexion	5	5	
(C8)	Thumb Extension	5	5	
(T1)	Hand Intrinsic	5	5	
(L2-3)	Hip Flexion	3+/5	5	n
(L4)	Knee Extension	4+/5	5	n
(L4)	Ankle Dorsiflexion	5	5	
(L5)	Toe Extension	5	5	
(S1-2)	Knee Flexion	4/5	5	n
(S1-2)	Ankle Plantarflexion	5	5	

Abdominals: 15 reps of 3 inch abdominal crunches in 19 sec (stopped with 5/10 LBP)

Trunk Extension: Fair strength and endurance.

PALPATION: Tender over R>L SI joints

BALANCE: Stork Stand R = 2 seconds.
Stork Stand L = 4 seconds.

SPECIAL TESTS: Tandem stance = 7 sec.

Pain with valgus stress to right knee but no ligament laxity.

Hamstring flexibility with hip flexed to 90deg: R = 32 deg, L = 38 deg.

Patient Name: Zeena Fletcher 9/21/10

Reflexes:

		R	L
UE	Biceps (C5)	2+	2+
	Brachioradial (C6)	2+	2+
	Triceps (C7)	2+	2+
LE	Knee (L4)	2+	2+
	Ankle (S1)	2+	2+

Waddell's Tests:

Tenderness	+	-
Superficial		x
Non?		x
Simulation		
Axial Loading		x
Unit Rotation		x
Distraction		
SLR (R)		62 deg
SLR (L)		65 deg
Regional		
Weakness		x
Sensory		x

JAMAR HAND GRIP TESTING

5 Position Test

	Position 1	Position 2	Position 3	Position 4	Position 5
R	20,15	30,25	26,26	24,24	20,20
L	25,23	26,26	25,24	18,18	16,16

3 Grip Test

	Trial 1	Trial 2	Trial 3	CV
R	30	35	33	WNLs
L	30	30	30	WNLs
Jamar Position:	#2			

Bell Curve: R: ☒ Yes ☐ No
L: ☒ Yes ☐ No

Rapid Exchange Test Peak Force: R 40 L 38

Rapid Exchange Test consistent with previous test: R y Ly

CV exceeded in 0 of 4 tests showing ☐ Submaximal inconsistent effort.
☒ Maximal consistent

Patient Name: Zeena Fletcher 9/21/10

DYNAMIC LIFTING ASSESSMENT

	HR	Unable	Occasional	Frequent	Constant	Test Stopped
Floor to Waist	125		15lb	8lb	not able	LBP 6/10
12" to Chest						
Waist to Shoulder	130		17lb	8lb	4lb	LBP 4/10
Shoulder to Overhead	121		10lb	5lb	not able	Shld and LBP 6/10
Carrying (x 20 ft)	128		15lb	8lb	4lb	Unsteady gait
Push (x 20 ft)	125		36lb			LBP 6/10
Pull (x 20 ft)	125		30lb			R knee pain 5/10

Test Stopped Key	
Max safe effort = M	Pain = P
Subject request = S	Body Mechanics = B

Proper Body Mechanics Instructed: ☐ Yes ☒ No

* Frequent and Constant Values are extrapolation unless otherwise indicated.

FUNCTIONAL ACTIVITY TOLERANCE

	HR	Unable	Occasional	Frequent	Constant	Comments
			1-33%	34-66%	67-100%	
Standing	105			X		
Walking (6 minute walk test)	106			X		Max 4:15 at 2.5 mph.
Bending (static at 30* for 5 minutes)	125			X		LBP 6/10
Repeated Squat	120		X			8 reps in 30 sec
Crouch (static)		Not able				Both knees gave away
Kneeling (10 minute test)	126		X			Max 2:25. 5/10 R knee pain
Overhead Reaches (2 minutes weighted or 5 minutes un-weighted)			X			Max 1:19 with 2 lb weight
Sitting	101				X	
Climbing Ladder	Not tested					
Climbing Stairs (20 step test)	119		X			10 rep step-up: R = .50 sec L = .40 sec
Crawling (15 feet)		X				Not able to get onto H&K

STATIC STRENGTH ASSESSMENT

	Leg	Arm	Push	Pull
Average	32 lb	14 lb	26	36 lb
CV%	11.5	6.6	1	2.3

Comments:

1. Coefficient of Variation is above the standard cutoff of 15% in 0 of 4 tests.
2. 8 of 8 tests compare favorably with dynamic lifting.

Patient Name: Zeena Fletcher 9/21/10

JOB SPECIFIC ACTIVITY

Activity:

Weight:

Time / Reps:

WHR:

Body Mechanics:

Center for *Emotional Restructuring*®

Robert A. Moss, Ph.D., ABPP

Clinical Psychologist

1

PSYCHOLOGICAL EVALUATION

NAME: Zeena Fletcher

DATE OF EVALUATION: 11/8/10

REASON FOR REFERRAL: Ms. Fletcher was referred by Kathryn Williams, Esquire, for a psychological evaluation and treatment recommendations tied to her work injury.

EVALUATION CONTENT: The present evaluation is based upon a clinical interview, a review of medical records, and the administration of the Personality Assessment Inventory (PAI) and the Malingering Probability Scale (MPS).

INTERVIEW DATA: Ms. Fletcher was injured on March 13, 2010. She slipped on paper, hitting her right knee followed by her left knee, then striking her back and head. She reports a probable brief loss of consciousness since she recalls the impact followed by her next memory being people looking down at her on the floor. She indicates her main problems have been related to her knees and back. Her right knee pain has ranged from 0 to 8 over the recent past, her left knee pain from 0 to 5, and her back pain from 3 to 9 (0 = no pain, 10 = maximum pain). Her current medications include Tramadol, Voltaren, and Diclofenac from Dr. Posta, and Methocarbam from Dr. Foster. She receives Starlic and Metformin from her family doctor. She also has Imitrex pm for migraine headaches.

Ms. Fletcher reports that Dr. Posta believes she will eventually require a knee replacement. She notes being told that her left knee pain is likely due to increased weight bearing on the left leg. He advised her to walk a total of 40 minutes a day. She had water therapy in the past which was beneficial. Her current restrictions are no bending, stooping, squatting or kneeling. She is also to get periodic rest breaks.

She reports frustration over the lack of treatment by Dr. Foster related to her back. He reportedly told her that he has back problems himself and she should be able to deal with hers since he can deal with his own. She indicates standing or walking too long, as well as lifting and twisting, increase the pain. She has been given no restrictions related to her back. She requested pain management, but says Dr. Foster has refused to refer her for this. She anticipates getting a second opinion soon.

She has never had any mental health treatment. She was placed on Zoloft for about 6 months following her mother's death in 2000. She does not smoke cigarettes. She denies the use of street drugs. She rarely drinks alcohol and has never been a heavy drinker. She denies prior legal problems.

Ms. Fletcher has sleep problems tied to pain and worry. Her appetite is normal. Her energy level is low. She has memory and concentration problems. She has only rare crying spells. She denies suicidal thoughts. She usually has dysphoric mood. She reports feeling hopeless and worthless. She denies feelings of guilt or helplessness. She finds decreased enjoyment in activities. She denies anxiety. She is irritable and snappy associated with increased pain. She denies hallucinations.

Ms. Fletcher was born in Maryland. She lived in various locations associated with

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Greenville, S.C. 29615

(864) 281-0600
Fax (864) 281-0645

P.O. Box 591
Travelers Rest, S.C. 29690

her father being in the Air Force. These included living in Japan and Italy. She was reared by both parents and both are deceased. Her father demonstrated no physical affection. He used fair punishment and was not verbally abusive. He drank alcohol excessively. Her mother worked in civil service positions on base. She used fair punishment and was not verbally abusive. She occasionally drank alcohol. Ms. Fletcher had 2 brothers, the older of which is deceased. She was close to her brothers when younger, though they became distant as adults.

Ms. Fletcher graduated high school. She made A's and B's. She was shy and admits to being picked on. She was in no trouble in school.

Ms. Fletcher's only marriage has been for 30 years, indicating it has gone well. She has a 30 year old son and a 25 year old daughter with whom she has a positive relationship. She had several other children that have lived with her, being her own children's friends who had family problems. She has one "foster" daughter with whom she is very close. She has 2 "grandchildren" by her.

Ms. Fletcher has worked for Dick's Sporting Goods for 2 years. She has functioned as the front end supervisor. She reports things went well until her injury. She feels that she has a positive relationship with her manager. Although there was initially a problem, management is now observing her restrictions.

Ms. Fletcher resides in a house with her husband and son. She does most cleaning, but has to take frequent breaks. Her son does the vacuuming. She does the laundry, shopping, and cooking. Her husband pays the bills. Her husband and son do the yard work. She watches television and listens to music. She reads various materials, estimating she does it daily from one to three hours. Her other hobbies are crocheting and doing needle point. She visits no one. Her children visit her once to twice a week. She goes out to eat about 3 times a month. She attends no movies or social activities. She does not attend church. She has taken no out of town trips in the past year.

MENTAL STATUS: Ms. Fletcher was oriented in all spheres. She answered questions in a relevant and coherent fashion. Pain behaviors were present but not overly exaggerated. Mood and affect were depressed. Memory for recent and remote events appears grossly intact. I see no evidence of hallucinations, delusions, or psychotic thought processes. She appears capable of recognizing and avoiding hazards. Insight tied to psychological factors appears limited.

TEST RESULTS: The PAI validity scales indicate the profile is interpretable free of qualifying remarks. This suggests she answered items in a reasonably forthright manner and did not attempt to present an unrealistic or inaccurate impression that was either more negative or more positive than the clinical picture would warrant. There are significant elevations across several scales. There are a number of difficulties reported consistent with a significant depressive experience. She has an unusual degree of concern over physical functioning and reports her daily functioning has been severely compromised by these problems. The diagnostic possibilities are major depressive disorder and somatization disorder.

The MPS had an inconsistency score of 52T, which means she adequately understood the items and responded to them in a consistent fashion. Her Malingering score of 49T means that there is little (0.4%) likelihood that she has attempted to use her

responses to exaggerate or fabricate symptomatic complaints. There is evidence mental distress.

DIAGNOSTIC IMPRESSIONS:

AXIS 1: Major Depressive Disorder

Psychological Factors Affecting Medical Condition

AXIS 2: Diagnosis deferred

AXIS 3: Chronic Pain; Diabetes; HTN (by history)

AXIS 4: Concerns Over Level of Medical Care

AXIS 5: Current GAF = 50

CONCLUSIONS: On the basis of the present examination, it is felt that Ms. Fletcher is experiencing psychological distress tied to her pain and associated restrictions from the work injury. I believe she could benefit from psychological treatment involving a schema based cognitive approach, education on normal emotional reactions to loss, emotional restructuring, and stress/pain management skills training. I also believe she is in need of antidepressant medication.



Robert A. Moss, Ph.D.
Clinical Psychologist

Diplomate in Clinical Psychology, American Board of Professional Psychology
Diplomate, American Board of Professional Neuropsychology

Oconee Orthopedic Clinic PA

George R. Bruce, M.D.

F.A.A.O.S., B.C.F.E.

10630 Clemson Blvd.

Suite 100

Seneca, SC 29678

Telephone (864) 482-6263

Fax (864) 482-7000

Zeena Lynn Fletcher
206 Lewis Road
Williamston SC 29697
DOB: 11-17-59

12-01-10 ORTHO: This patient is seen today for independent medical examination. The examination took place on December 01, 2010 in my office at Blue Ridge Orthopedics in Seneca, South Carolina. The records that were sent for my review prior to my evaluation of the patient included the records from Dr. Spencer of Med Central; AnMed Medical Care - Dr. Stumpff; Dr. Clemow from Blue Ridge Orthopedics 05-03-10 through 06-22-10; Upstate Physical Therapy 04-06-10 through 07-09-10; Anderson Radiology MRI (report and film) right knee 05-10-10; Carolina Orthopedic Center - Dr. Posta 07-21-10 through 07-28-10; Innervision MRI (report) right knee 07-22-10; Upstate Bone and Joint - Dr. Foster 08-11-10 through 08-19-10; MRI (report and disk) from Innervision MRI lumbar spine 08-13-10; Functional Capacity Evaluation 09-21-10; one time psychological evaluation - Dr. Moss 11-08-10.

This patient presents today with a history of while being employed by Dick's Sporting Goods where she had been employed for 18 months in customer service, sustained an injury on or about 03-13-10 when she slipped on a very thick piece of paper on the floor, falling on her right knee, left knee, her back and hitting her head. The patient went to the emergency room by private vehicle on the date of injury at AnMed Minor Care. She saw Dr. Stumpff who evaluated her right knee and did x-rays of her lumbar spine, cervical spine and right knee. The patient had no definite fractures. She was discharged home and referred to an orthopedist, but Workers Compensation sent her to Dr. Spencer on 03-17-10 at Med Central. She was given a work release. When followed up on 03-22-10, the knee pain was a little better with rest but it got worse if she had to do any walking. Physical therapy was ordered and she began this on 04-06-10 for the right knee. She states that the pain in the right knee and the back would wax and wane but activity would make both of them worse.

She eventually was referred to Dr. Clemow of Blue Ridge Orthopedics to evaluate the right knee. At this point he felt that there might be an ACL and medial collateral ligament injury and sent her for an MRI. This was done on 08-10-10 and showed no definite tear. She was complaining a great deal of her back at that time and he felt this needed to be evaluated by an MRI.

In the interim the patient was referred by Workers Compensation

PAGE TWO

Zeena Lynn Fletcher
206 Lewis Road
Williamston SC 29697

to Dr. Posta who saw her on 07-21-10 at Carolina Orthopedics. She was complaining of the right knee and also low back pain and some left knee pain at that time. X-rays showed narrowing of the medial compartment of the right knee, chondromalacia, and early osteoarthritis and he felt that the MRI was not of good enough quality to definitely visualize the ACL and he ordered a new MRI. This was performed on 07-22-10 with Innervision which showed the ACL intact with mild osteoarthritis and chondromalacia under the patella. The patient was continued on NSAIDS and rehab'd and returned to work on 08-02-10 with light duty times one month.

It was felt that she needed a back evaluation and she was then referred to Dr. Foster on 08-11-10 for evaluation of her back at Upstate Bone and Joint. At this time x-rays were taken which showed moderate lumbar spondylosis especially at L4 through the sacrum. An MRI was obtained from Innervision at 08-13-10 which showed degenerative changes of L2-3 through L5-S1 as well as central spinal stenosis at L2-3 and L3-4 level. There was a broad-based left paracentral protrusion and some foraminal stenosis seen at L4-5 and L5-S1 abutting the L5 and S1 nerve roots as they exited on the left side. The patient denied any true radicular symptoms, and it was felt this was just an aggravation of a degenerative condition in her back and not an operative lesion. She was released from Dr. Foster on 11-10-10 to return to work without restrictions.

She returned to Dr. Posta on 10-01-10 at which time it was felt that she had reached maximum medical improvement and he did put restrictions of no kneeling, bending or crawling.

The patient had developed a major depressive disorder as confirmed by Dr. Moss who she saw for a psychological evaluation secondary to her chronic pain in her low back and right knee and the inability to do all the activities that she had done before.

The patient was then sent by Workers Compensation for a functional capacity evaluation on 09-21-10 at which time she was seen to test for sedentary to light work and her job demand was considered light work. She did have a consistent effort. She states she works every day but hurts every day and has to come home and lie down after working and she has to be extremely careful with medications prior to going to work.

Medication taken currently is Robaxin and Tramadol, Voltaren Gel and tablets 75 mg twice a day, as well as Glucophage for her diabetes.

PAGE THREE

Zeena Lynn Fletcher
206 Lewis Road
Williamston SC 29697

The patient denies any previous difficulty with her back or either knee prior to her injury on 03-13-10 and I can find no evidence of difficulty prior to that injury in the medical records that I have been sent to review. The patient is a diabetic for some eight years and is under treatment. She has a history of migraines. The patient did have a depressive situation shortly after her mother's death in 2000 and she was treated for a few months. She had not taken any medications since that time for depression.

The patient completed her pain survey today which shows she complains of pain at 5/5 that can go up to 9/10 and it is directly aggravated by activity in regards to her back and her right knee. She denies again any true radiculopathy down either leg associated with her back. She has some pain at least 90% of the time. It limits her walking, standing and a lot of activities of daily living. She states she is able to do most of them but she constantly hurts. It has affected her psychologically with depression and anxiety as she relates on her survey.

PHYSICAL EXAMINATION: The patient presents today as a 5'4", 198 lb, right hand dominant female. She is well oriented as to time and place. She denies any difficulty with head, neck and upper extremities associated with this injury of 03-13-10.

On examination of the low back she has tenderness of both iliolumbar ligament areas and SI joints but has no tenderness in the lesser sciatic notch or posterior thigh. Using the double inclinometer technique, an average of three separate testings, the patient was seen to have a sacral flexion angle of 30°, with a total flexion of 70°, giving her a true flexion of 40°, extension of 10°, left deviation of 25°, and right deviation 25°. The patient has a positive straight leg raising on the right side but only up to 50°.

She was seen to have full range of motion of both hips as well as 5/5 strength in all parameters.

Examination of both knees reveals full range of motion with no evidence of intra-articular effusion, but she does have a fibrosed hematoma on the medial aspect of the right knee just distal to the joint line. She is also exquisitely tender over Voshell's bursa on the medial aspect of the right knee. There is mild crepitus in the right patella on flexion and extension under

PAGE FOUR

Zeena Lynn Fletcher
206 Lewis Road
Williamston SC 29697

any type of pressure. I do not feel any crepitus on the left side.

Anterior and posterior instability appears to be equal on right and left knee and no medial or lateral instability was evident. The patient was seen to have 5/5 strength on flexion and extension of both knees, dorsiflexion and plantar flexion of both ankles and both great toes. There was no atrophy in the lower extremities with both calves measuring 38 cm. Sensation appeared to be intact subjectively in regards to both right and left legs.

IMPRESSION: As this patient presents today, she denies any difficulty with her low back or either knee prior to her fall of 03-13-10. Therefore, to a reasonable degree of medical certainty, when she fell she aggravated a degenerative condition in her back and caused a contusion to her right knee resulting in a fibrohematoma to her right knee as well as traumatic Voshell's bursitis at the very least. The patient does not appear to have any locking in the right knee. I am unable to elicit a positive McMurray's click. Therefore I feel internal derangement is probably not involved. The patient does have chondromalacia under the patella as evidenced by crepitus in the right patella that I do not feel on the left patella.

As this patient presents today, it is my opinion to a reasonable degree of medical certainty that her back would best be evaluated under the range of motion model on the AMA Guides Fifth Edition on page 404 where she would fall into Category II-C. When this is combined with decreased range of motion, she would have 15% whole person which equates to 17% physical impairment of the lumbosacral spine. Her right knee with the combination of the crepitus and the hemofibroma and Voshell's bursa and marked tenderness in the right knee, I feel she has 10% physical impairment of the right lower extremity.

I do feel the patient has reached maximum medical improvement. However, she does have chronic back pain which may very well respond to epidural injections versus sacroiliac injections. A TENS unit could also very well be helpful with the patient, if authorized.

No additional appointment is given.

George R. Bruce, M.D.

GRB/ctl

PAGE FIVE

Zeena Lynn Fletcher
206 Lewis Road
Williamston SC 29697

The preceding IME is the opinion of Dr. George R. Bruce and is formed with the knowledge of 35 years of practicing orthopedic surgery as well as review of multiple records presented, interview with the patient, and physical examination.

This examination does not endorse or criticize the medical treatment of care providers. It is also understood and explained to the patient that this examination does not constitute the establishment of a doctor/patient relationship.

for

ANMED HEALTH

Emergency Department
800 N. Fani St. Anderson, SC 29621 (864) 512-1333
ED PHYSICIAN RECORD

Patient: Fletcher, Zeena Lynn
Pt Acont: 7363792
Home Address: 206 Lewis Rd

Age/DOB: 11/17/1959
Med Rord: 387655
Age: 52yr Sex: F

City: Williamston
State: SC Zip: 29697
Home Ph: (864)328-9961
Established Pt: _____

Arrival: 2/17/2012 1155
Area of Care: Zone 3
Dispo Summary Printed: 2/17/2012 1544
Time Left ED: 2/17/2012 1603

Acuity: 3
Mode of Arrival: Ambulance
Precautions: Falls Precautions

Disposition: Discharge - Home
Mode of Departure: Private Vehicle
Condition at Dispo: Stable

CC/Curr Imp: Back Pain

RN Triage: Kennedy, Paige R.N.
RN Eval: Deborah D. R.N.
RN Dispo: Louch, Teryi R.N.

MD ED: Grier, John M.D.
Res/PA/NP: _____

Home Medications

Arrival Medication	Last Dose	Comments	Source	Verified
Percocet 10/325 1 tablet by mouth every 4-6 hrs	this morning			2/17/2012 1201
Percocet 7.5/325 1 tablet by mouth every 4-6 hrs	unknown			2/17/2012 1201
Pristiq 50mg by mouth daily				2/17/2012 1202
Tizanidine 4mg by mouth daily; at bedtime	last night			2/17/2012 1202

Allergies

Allergic Substance	Reaction	Severity
1/P DYE		
atex		

Vital Signs

ys	Dia	Pulse	Resp	SAT	O2 Delivered	Temp (F)	Route	Pain Scale	Comment	Taken at	User Name
13	70	107	20	99%	RA	97.4 F	oral	7/10 Numeric		2/17/2012 1425	Kennedy, Paige R.N.
7	92	109	20	98%	RA	97.7 F	oral			2/17/2012 1425	Smith, Tina
2	83	113	18	97%	RA			6/10 Numeric	Disposition Vitals	2/17/2012 1605	Louch, Teryi R.N.

Input & Output			
Fluid Type	Intake	Output	I/O Time
IV NS BOLUS	1,000 mL		2/17/2012 1511
== TOTAL ==	1,000 mL		

ED Orders		
Order	Sched D/T	Comp D/T
CBC with Differential	2/17/2012 1247	2/17/2012 1332
CMP	2/17/2012 1247	2/17/2012 1350
Lipase BLD	2/17/2012 1247	2/17/2012 1350
EKG (Secretary to order in EOS)	2/17/2012 1247	2/17/2012 1310
Cardiac Enzyme Series	2/17/2012 1247	2/17/2012 1350
XR Chest (PORTABLE)	2/17/2012 1247	
IV NS BOLUS 1,000mL IV once - Gave 1,000mL IV#: _primary_line, IV_Fluid_Site: _hand_right. Start: 2/17/2012_1257, End: 2/17/2012_1511	2/17/2012 1247	2/17/2012 1511
MISC - Nurse Order ice chips	2/17/2012 1247	2/17/2012 1257
PHENERGAN IV (Promethazine HCL) 12.5mg (0.5mL of 25mg/mL) IV push once - Gave 12.5mg, IV#: _primary_line, IV_Med_Site: _hand_right, Given_At: 2/17/2012_1335	2/17/2012 1247	2/17/2012 1335
HOLD RED	2/17/2012 1353	
HOLD BLUE	2/17/2012 1353	
CANCELED (outside ED) 1443 - XR Chest (PA)	2/17/2012 1424	2/17/2012 1443
Vital Signs - Repeat	2/17/2012 1425	2/17/2012 1426
MORPHINE IV (Morphine Sulfate) 10mg (1mL of 10mg/mL) IV push once - Gave 10mg, IV#: _primary_line, IV_Med_Site: _hand_right, Given_At: 2/17/2012_1513	2/17/2012 1500	2/17/2012 1513
ZOFRAN IV (Ondansetron) 4mg (2mL of 4mg/2mL) IV push once - Gave 4mg, IV#: _primary_line, IV_Med_Site: _hand_right, Given_At: 2/17/2012_1513	2/17/2012 1500	2/17/2012 1513
CP 3 HR	2/17/2012 1540	

PMH	
Condition	Verified By
Migraine	Kennedy, Paige R.N.
Asthma	Kennedy, Paige R.N.
Glaucoma	Kennedy, Paige R.N.
Diabetes mellitus	Kennedy, Paige R.N.
Cancer	
Chronic back pain	Kennedy, Paige R.N.

PSH	
Procedure	Verified By
Cesarean section	Kennedy, Paige R.N.

Calls				
Name	Comments	Requested By	Call 1	Returned
All Rows Are Empty!				

EMS/PMID

Dx/Instr

ED Dx 1: Gastroenteritis (Not Otherwise Specified)

Admit Info

MD Chart

Status MD/rm: 2/17/2012 1236

Grier, John M.D. Created: 2/17/2012 1250 Last Entry: 1259

PHYSICIAN H&P (Nausea, Vomiting, Diarrhea)

(+Nursing Notes Reviewed

(+Allergies Reviewed

(+Medications Reviewed

===== PREHOSPITAL CARE: None

===== ED HPI: Patient complaining of:

Vomiting: 12 episodes over approximately 20hrs. Vomit Type: bilious.

Diarrhea: 1 episodes of diarrhea over approximately 20hrs. Diarrhea Type:

Abdominal Pain: Intermittent diffuse abdominal cramping over approximately 20hrs.

(-)recent antibiotic use, (-)recent foreign travel, (-)seafood ingestion, (-)Contaminated food, (-)Exposure to others with similiar symptoms.

Symptoms began after sleeping

Symptoms are worsened by nothing.

Symptoms are improved by nothing.

===== ROS: All other systems reviewed and negative except as noted in HPI. pt had back and chest pain after twisting motion earlier today

===== PMH List (See PMH Table) PSH List (See PSH Table)

===== SH: no tobacco, no alcohol, no drugs.

===== PHYSICAL EXAM:

CONSTITUTIONAL (VITAL SIGNS): reviewed as documented.

GENERAL APPEARANCE: well nourished, alert, cooperative, no acute distress, no obvious discomfort.

MENTAL STATUS (PYSCH): speech clear, oriented X 3, normal affect, responds appropriately to questions.

EYES: (-)scleral icterus, PERRL, EOMI, conjunctiva clear.

NOSE: no nasal discharge.

THROAT: no tonsillar inflammation, no airway obstruction.

NECK: no swelling/tenderness on the neck.

BACK: no costovertebral tenderness.

CHEST WALL: no chest tenderness.

CV HEART: normal rate, normal rhythm.

LUNGS: no wheezing, no rales, no rhonchi, (-)accessory muscle use, good air exchange bilateral.

GI ABDOMEN: normal BS, soft, no abd tenderness, (-)guarding, (-)rebound.

EXTREMITIES: no edema. mop calf tenderness

INTEGUMENT (SKIN): warm, dry, good color, no rash.

===== MEDICAL DECISION MAKING:

Complexity of Visit: The ED Physician performed a face-to-face history and physical,

Current radiology diagnostics reviewed.

Current labs reviewed.

Current EKG reviewed.

Differential Dx: gastroenteritis, pancreatitis, ACS, food poisoning

ED Treatments:

Administration of IV Fluid.
Administration of Medication.

PROCEDURE:

Grier, John M.D. Created: 2/17/2012 1314 Last Entry: 1314

MD Note:

EKG interpreted by ED Physician. sinus tachycardia, rate 108, no ischemic changes

Grier, John M.D. Created: 2/17/2012 1335 Last Entry: 1335

Results Reviewed by ED Physician:

CBC with Differential

Grier, John M.D. Created: 2/17/2012 1413 Last Entry: 1413

Results Reviewed by ED Physician:

CMP

Lipase BLD

Cardiac Enzyme Series

Grier, John M.D. Created: 2/17/2012 1454 Last Entry: 1454

MD Note:

CHEST X-RAY: Routine views, my reading. (-)infiltrate, (-)effusion, (-)pneumothorax.

Grier, John M.D. Created: 2/17/2012 1500 Last Entry: 1505

MD Note: re-examined is complaining of headache and naseau

Signatures:

MD Sgntr: Grier, John M.D. 2/17/2012 1544

Res/PA/NP Sgntr: _____

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***** ED HPI: states seen in ER yesterday for vomiting given phenergan states she is still vomiting having some chest pressure/tightness thinks she is dehydrated

Garriott, Randall M.D. Created: 2/18/2012 2248 Last Entry: 2328

PHYSICIAN H&P (Medical)

(+) Nurse's Notes Reviewed

(+) Allergies reviewed

(+) Medications reviewed

***** ED HPI: wasw seen here yesterday,, N V ,, did not get better, now with 3 days of N V and not able to keepa ny fluids down,, no prior hx,,

***** ROS: is diabetic,, 75 lb wt loss over last 2 years,, N V,, no D no B B pain kn back head abd chronic pain,,

***** PMH List (See PMH Table) PSH List (See PSH Table)

***** **PHYSICAL EXAM:**

CONSTITUTIONAL (VITAL SIGNS): reviewed as documented.

GENERAL APPEARANCE: well nourished, alert, cooperative, general malaise

MENTAL STATUS: speech clear, , normal affect, responds appropriately to questions.

NECK: supple, no neck tenderness

BACK: no back tenderness.

CHEST WALL: no chest tenderness.

LUNGS: no wheezing, no rales, no rhonchi, (-) accessory muscle use, good air exchange bilateral.

CV HEART: normal rate, normal rhythm, (-) gallop, no murmur, no rub.

GI ABDOMEN: normal BS, soft, mild general discomfort only (-) guarding, (-) rebound, no organomegaly, no abd masses.

EXTREMITIES: no swelling/tenderness in the extremities, no edema.

INTEGUMENT (SKIN): warm, dry, good color, no rash.

NEURO: motor intact,

***** **MEDICAL DECISION MAKING:**

Complexity of Visit: The ED Physician performed a face-to-face history and physical.

Differential Dx:

ED Treatments:

***** **PROCEDURE:**

Garriott, Randall M.D. Created: 2/18/2012 2325 Last Entry: 2327

MD Note: labs show pt to be ketotic ,, not acidotic,, elvated wbc,, will give IV fluids,, will need admit

Signatures

MD Sgntr: Garriott, Randall M.D. 2/18/2012 2328

Res/PA/NP Sgntr: Robertson, Judith P.A-C 2/18/2012 2026

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Calls				
Name	Comments	Requested By	Call 1	Returned
All Rows Are Empty!				

EMS/PMD

Dx/Instr

ED Dx 1: Gastroenteritis (Not Otherwise Specified)

RN/Triage

Sharp, Tiffanie R.N. Created: 2/17/2012 1156 Last Entry: 1159

Nurse Note: Per Williamston EMS pt c/o N/V, pt stated she fell approx. 1015 today 2-17-2012, when pt lays down she states her chest hurts and when she sits up it stops hurting, pt does have a history of back pain, pt is allergic to latex and IVP dye,

Kennedy, Paige R.N. Created: 2/17/2012 1203 Last Entry: 1206

NURSING TRIAGE (Adult)**ED HPI:**

Fall - Occurred hours ago, pt states that she had a back spasm and fell today (-)LOC, (-)neck tenderness.

PREHOSPITAL CARE:

IV Inserted 20ga left forearm 1000mL NS, (+)patent on arrival.

PMH List (See PMH Table) **PSH List** (See PSH Table)

SH: no tobacco, no alcohol, no drugs

Support System: lives w family or significant other.

Special Considerations: None Identified.

LEARNING BARRIERS: None Identified.

ABUSE NEGLECT ASSAULT SCREENING: None Identified.

Suicide Risk Screening:

Do you feel safe at home? yes.

Do you have any thoughts of harming self? no.

TRIAGE DATA:

History obtained from: patient

LMP: N/A.

Last Tetanus: never.

Immunizations:

Influenza (flu): never.

PHYSICAL EXAM:

AIRWAY: oral, (-)obstructed.

BREATHING: no breathing compromise.

CIRCULATION: no circulatory compromise, capillary refill <2 seconds.

GENERAL APPEARANCE: (adult) - well nourished, alert, oriented X 3, no acute distress, no obvious discomfort.

SKIN: warm, dry, good color, no rash.

NURSING INTERVENTION: None

Kennedy, Paige R.N. Created: 2/17/2012 1204 Last Entry: 1205

Nurse Note: pt presents to ed via ems/stretcher from home after a fall..pt states that she has chronic back pain and had a back spasm today and fell..pt denies any loc..pt states that she is nauseated and has been vomiting for a few days..pt states that she has also been having diarrhea..pt states that she is having some stomach cramps also

A GENERAL**PHYSICAL EXAM:**

AIRWAY: oral, (-)obstructed.

BREATHING: no breathing compromise.

CIRCULATION: no circulatory compromise, capillary refill <2 seconds.

GENERAL APPEARANCE: alert, cooperative, no obvious discomfort.

HEART: normal rate, normal rhythm.

LUNGS: no wheezing, no rales, no rhonchi, (-) accessory muscle use, good air exchange bilateral.

ABDOMEN: no vomiting, no diarrhea, normal BS, soft, no abd tenderness, (-) guarding,

EXTREMITIES: good pulses in all extremities, no tenderness/swelling in the extremities, no edema.

SKIN: warm, dry, good color, no rash, no decubitus.

Swallow screen: not applicable

FALLS ASSESSMENT (Adult):

AGE: Less than 60yrs 0

COGNITIVE: Fully alert and oriented 0

ELIMINATION: Independent with bowel bladder control 0

MEDICATIONS: No meds listed given 0

EQUIPMENT: None in room 0

MOBILITY TEST: Independent steady gait gets up down without assist 0

ADMITTING DIAGNOSIS: None known 0

HISTORY OF FALLS: Fall within 30 days 20

FALL RISK SCORE: High Risk (over 23).

Plan of Care to Decrease Fall Risk: Low/Moderate Risk Interventions include - (+) Oriented to room, (+) Instruct to call for help/call bell within reach, (+) Use nonskid footwear, (+) Family/caregiver at bedside, (+) Bed in low position, (+) Bed/stretchers brakes on, (+) Bed rails up, (+) Uncluttered environment.

Kennedy, Paige R.N. Created: 2/17/2012 1257 Last Entry: 1257

Order(s) in Progress by "Nurse"

- IV NS BOLUS 1,000mL IV once - Start: 2/17/2012 1257

Order(s) performed by "Nurse":

- MISC - Nurse Order ice chips

Kennedy, Paige R.N. Created: 2/17/2012 1310 Last Entry: 1310

Order(s) performed by "Nurse":

- EKG (Secretary to order in EOS)

Kennedy, Paige R.N. Created: 2/17/2012 1324 Last Entry: 1324

Nurse Note:

IV INSERTED - 2/17/2012 1324 - 22ga right hand after 1 attempt(s) by Kennedy, Paige R.N.. Skin was prepped with chlorhexadine. Blood specimens were not obtained and sent to lab. Two patient identifiers confirmed, procedure explained to patient. Education provided for procedure performed. Patient tolerated procedure.

Davenport, Deborah R.N. Created: 2/17/2012 1336 Last Entry: 1336

Order(s) performed by "Nurse":

- PHENERGAN IV (Promethazine HCL) 12.5mg (0.5mL of 25mg/mL) IV push once - Gave 12.5mg, IV#: primary line, IV Med Site: hand right, Given At: 2/17/2012 1335

Kennedy, Paige R.N. Created: 2/17/2012 1426 Last Entry: 1426

Order(s) performed by "Nurse":

- Vital Signs - Repeat

Davenport, Deborah R.N. Created: 2/17/2012 1516 Last Entry: 1516

Order(s) performed by "Nurse":

- MORPHINE IV (Morphine Sulfate) 10mg (1mL of 10mg/mL) IV push once - Gave 10mg, IV#: primary line, IV Med Site: hand right, Given At: 2/17/2012 1513

- ZOFTRAN IV (Ondansetron) 4mg (2mL of 4mg/2mL) IV push once - Gave 4mg, IV#: primary line, IV Med Site: hand right, Given At: 2/17/2012 1513

- IV NS BOLUS 1,000mL IV once - Gave 1,000mL, IV#: primary line, IV Fluid Site: hand right, Start: 2/17/2012 1257, End: 2/17/2012 1511, Volume Given: 1000 mL

Louch, Teryi R.N. Created: 2/17/2012 1605 Last Entry: 1605

Nurse Note:

DSP DISCHARGE - Plan of care discussed with patient. Patient discharged with printed instructions. () Duplicate instructions provided in Spanish. Patient verbalizes understanding and ability to comply. Patient stable and condition is now improved. Patient left ED via ambulatory and with family. Medical Driving Restrictions: no driving with narcotics.

Signatures:

RN Sgntr: Louch, Teryi R.N. 2/17/2012 1606

AnMed Health
Anderson, S.C.
Medical Records

FLETCHER, ZEENA LYNN
Keshava L Maragondanahalli, MD
7364701 DOB:1959/11/17

History and Physical

PRIMARY CARE PHYSICIAN: Erin Cooksey, MD

DATE PATIENT SEEN: February 18, 2012.

TIME CALLED BY ER PHYSICIAN: 10:45 p.m.

TIME SEEN BY ME: 11 p.m.

PAIN SPECIALIST: Carolina Pain Center in Greenville, Dr. Satterthwaite.

CHIEF COMPLAINT: Vomiting, abdominal cramps.

HISTORY OF PRESENT ILLNESS: This is a 52-year-old patient with history of diabetes mellitus, who is noncompliant, not taking any medications, chronic back pain, migraine, comes in with nausea and vomiting for the last 5 days. She has been having abdominal cramps in the lower abdomen. Denies any diarrhea. No fever, chills or rigors. No chest pain. No cough or phlegm. No focal weakness. No dizziness.

REVIEW OF SYSTEMS: A 14-point review of systems negative.

PAST MEDICAL HISTORY: Mentioned above.

SOCIAL HISTORY: Lives with family. Nonsmoker. No history of alcohol use.

ALLERGIES : IV DYE.

HOME MEDICATIONS: Please see universal medication list.

FAMILY HISTORY: Reviewed and noncontributory.

PHYSICAL EXAMINATION: GENERAL APPEARANCE: Patient is conscious, alert, oriented. VITAL SIGNS: Blood pressure 152/86, pulse 82, respirations 18, 97% saturation. Temperature 98. HEENT: Normocephalic, atraumatic. Pupils round, regular, reactive. Neck examination is supple. Oral mucosa is dry. No pallor. No icterus. No cyanosis. CARDIOVASCULAR: Heart sounds S1, S2 heard. CHEST: Clear breath sounds bilaterally. ABDOMEN: Soft, nontender. Bowel sounds present. EXTREMITIES: No edema noted. SKIN: Intact. PSYCHIATRIC: The patient is in normal mood. No signs of depression or suicidal ideation. CENTRAL NERVOUS SYSTEM: The patient is alert, oriented x3. No focal neurological deficits.

LAB DATA: Electrolytes: Sodium 133, potassium 4, chloride 102, CO2 14, BUN 14, creatinine 0.4, glucose 224. ABG shows pH of 7.41, pCO2 26, PO2 98 and 98% saturation. Urinalysis shows pyuria, leukocyte esterase, glucosuria. Cardiac enzymes negative. White count 17, hemoglobin 16, hematocrit 45, platelets 332.

Chest x-ray to my interpretation does not have obvious infiltrate or effusion.

EKG to my interpretation is sinus rhythm without any ischemic changes.

ASSESSMENT:

1. Diabetic ketoacidosis.
2. Urinary tract infection.
3. Dehydration.

and on the day of discharge it was 139. Her glucose was 138 on the day of discharge, and BUN and creatinine were 5 and 0.32. When she came in, her WBC was 18.9. On the day of discharge, it was 10.4. Hemoglobin and hematocrit were 13.6 and 38.8.

RADIOLOGIC INVESTIGATION: Chest x-ray revealed left lower lobe atelectasis.

DISCHARGE MEDICATIONS: For complete list of medications, please see the medication reconciliation list.

DISCHARGE INSTRUCTIONS: Follow up with PCP. Check blood sugars 4 times a day and follow up with PCP in 1-week. Check blood pressure, and follow up with PCP in 1-weeks time.

Ram K Kaveti, MD

MLS: 97245

47490174 /47490174

Dictate Date: Tue Feb 21 10:41:14 2012

Transcribe Date: Wed Feb 22 21:26:36 2012

Authenticated by Ram K. Kaveti, MD On 02/23/2012 09:13:22 AM

4. Noncompliance.
5. Leukocytosis.
6. Chronic pain syndrome.

PLAN AND RECOMMENDATIONS:

1. The patient will be admitted to intensive care unit to Dr. Ram Kaveti.
2. Aggressive hydration with fluids.
3. Empiric antibiotics with IV Rocephin.
4. Insulin infusion protocol for DKA.
5. Monitor electrolytes.
6. DVT prophylaxis.
7. Diabetic diet.

Thank you for allowing me to take care of this patient.

Keshava I Maragondanahalli, MD

MLS: 23820

47419938 /47419938

Dictate Date: Sun Feb 19 00:59:14 2012

Transcribe Date: Sun Feb 19 07:47:21 2012

cc: Erin Cooksey, MD

Authenticated by Keshava Maragondana, MD On 02/22/2012 11:59:15 PM

Discharge Summary

DATE OF ADMISSION: 02/18/2012

DATE OF DISCHARGE: 02/21/2012

ADMITTING PHYSICIAN: Keshava L. Maragondanahalli, MD

ATTENDING PHYSICIAN DURING HOSPITALIZATION: Ram K. Kaveti, MD

PRIMARY CARE PHYSICIAN: Unassigned.

PROBLEM LIST:

1. Metabolic acidosis, which has been resolved.
2. Diabetic ketoacidosis, which has been resolved.
3. Uncontrolled diabetes, which has been stable.
4. Urinary tract infection. The patient has been treated with IV antibiotics. Cultures were negative.
5. Hypokalemia. The patient has been supplemented with potassium and discharged him with potassium supplementation. Advised to repeat potassium levels in 1-week time.
6. Chronic back pain, for which she has been following up with pain management.
7. Leukocytosis, secondary to the above, which has been resolved.
8. Noncompliance. The patient has been counseled extensively regarding compliance with medications.
9. Abdominal pain, nausea, and vomiting, secondary to the above, which has been resolved.
10. Gastrointestinal and deep vein thrombosis prophylaxis.

HISTORY OF PRESENT ILLNESS: For detailed history and physical please see the H&P dictation, which was done by Dr. Keshava L. Maragondanahalli. In brief, Ms. Fletcher is a 52-year-old Caucasian female patient with past medical history significant for diabetes mellitus and noncompliance with medication, came to the emergency department with chief complaint of vomiting and abdominal pain. Initially, the patient has been admitted to the ICU and started on IV insulin, with which her sugars have been resolved, and her acidosis has been resolved gradually. We moved her to the regular floor and changed the IV insulin to long-acting insulin with short-acting insulin with each meal, with which her blood sugars were controlled greatly. We hydrated her aggressively with IV fluids, and we are also initially treated with broad-spectrum antibiotics for her urinary tract infection, but the cultures was negative, and she did not have any further fever or chills, and her white count came back completely normal, so we discontinued her antibiotics. On the day of discharge, the patient was hemodynamically stable. Her blood pressure was little high secondary to the IV fluids, so we discontinued the fluids and advised her to follow up with her PCP for rechecking her blood pressure, and if necessary, the patient may need to be started on an antihypertensive medication. The patient has also undergone diabetic education during the hospitalization. On the day of discharge, her vomiting and abdominal pain have resolved. She is feeling better, and she wants to go home. The patient has been discharged home with appropriate outpatient followup.

DISCHARGE MEDICATIONS: For complete list of discharge medications, please see the medication reconciliation form.

INVESTIGATIONS DONE DURING HOSPITALIZATION: Basic metabolic panel. When she came in, her CO2 was 14. On the day of discharge it was 25. Sodium was "132"

ANMED HEALTH

Emergency Department
800 N. Fant St. Anderson, SC 29621 (864) 512-1333
ED NURSING RECORD

Patient: Fletcher, Zeena Lynn
Pt Acct: 7364701
Home Address: 206 Lewis Rd

City: Williamston
State: SC Zip: 29697
Home Ph: (864)328-9961
Established Pt: _____

Acuity: 3
Mode of Arrival: Wheelchair
Precautions: _____

CC/Curr Imp: V/D

RN Triage: Brownlee, Sanquinette R.N.
RN Eval: Kelcie C., R.N.
RN Dispo: Kennedy, Bonnie R.N.

Age/DOB: 11/17/1959

Med Rcd: 387655

Age: 52yr Sex: F

Arrival: 2/18/2012 1728

Area of Care: Zone 2

Dispo Summary Printed: 2/18/2012 2353

Time Left ED: 2/19/2012 0149

Disposition: Admit - CCU/ICU

Mode of Departure: Stretcher

Condition at Dispo: Stable

MD ED: Garriott, Randall M.D.
Res/PA/NP: Robertson, Judith P.A.-C

Home Medications

Arrival Medication	Last Dose	Comments	Source	Verified
Percocet 10/325 1 tablet by mouth every 4-6 hrs	this morning			
Percocet 7.5/325 1 tablet by mouth every 4-6 hrs	unknown			
Pristiq 50mg by mouth daily				
Tizanidine 4mg by mouth daily, at bedtime	last night			
Phenergan 25mg by mouth, as needed for nausea				2/18/2012 1740

Allergies

Allergic Substance	Reaction	Severity
IVP Dye		
BANANAS		
DYE CONTRAST MEDIA (IODINE; IODINE CONTAINING)		
IVP Dye		
IVP Dye		
Latex		
INACTIVE - Ibuprofen		
LATEX GLOVES		
SHELLFISH		
OPTIRAY 320		

Vital Signs

Sys	Dia	Pulse	Resp	SAT	O2 Delivered	Temp (F)	Route	Pain Scale	Comment	Taken at	User Name
152	86	82	18	97%	RA	98 F	oral	6/10 Numeric		2/18/2012 1749	Brownlee,

Special Considerations: None Identified.

LEARNING BARRIERS: None Identified.

ABUSE NEGLECT ASSAULT SCREENING: None Identified.

***** Suicide Risk Screening:

Do you feel safe at home? yes.

Do you have any thoughts of harming self? no.

***** TRIAGE DATA:

History obtained from: patient

LMP: N/A.

Last Tetanus: more than 5yrs but less than 10yrs.

Immunizations:

Influenza (flu): Not Current.

***** PHYSICAL EXAM:

AIRWAY: oral, (-)obstructed.

BREATHING: no breathing compromise.

CIRCULATION: no circulatory compromise, capillary refill <2 seconds.

GENERAL APPEARANCE: (adult) - well nourished, alert, oriented X 3, no acute distress, no obvious discomfort.

SKIN: warm, dry, good color, no rash.

***** NURSING INTERVENTION: None

Brownlee, Sanquinnette R.N. Created: 2/18/2012 1741 Last Entry: 1741

Order(s) performed by "Nurse":

- ZOFRAN ODT (Ondansetron ODT) 4mg (1 tablet of 4mg/tablet) by mouth once - Gave 4mg, Given At: 2/18/2012 1741

Norryce, Christy R.N. Created: 2/18/2012 1812 Last Entry: 1812

Nurse Note: pt to room via wheelchair, given a gown to change into and warm blanket given. Male visitor remains at bedside with pt. Call light within reach. cnrm

Constance, Kelcie R.N. Created: 2/18/2012 1919 Last Entry: 1923

Nurse Note: Pt presents to ED with complaints of N/V x 3 days. Pt was seen in ED yesterday and states, "I wasn't feeling any better so I came back." Pt admits chest discomfort when vomiting. Pt describes chest discomfort as "tightness". Pt denies any diarrhea. Pt states, "I am really worried about being dehydrated because I haven't had anything to eat or drink in 3 days". Pt skin noted to be warm and dry at this time. kcm

A GENERAL

***** PHYSICAL EXAM:

AIRWAY: oral, (-)obstructed, (+)vocalizes, (+)patent.

BREATHING: no breathing compromise, good air exchange bilateral.

CIRCULATION: no circulatory compromise, capillary refill <2 seconds.

GENERAL APPEARANCE: alert, cooperative, no obvious discomfort.

HEART: normal rate, normal rhythm.

LUNGS: no wheezing, no rales, no rhonchi, (-)accessory muscle use, good air exchange bilateral.

ABDOMEN: no vomiting, no diarrhea, normal BS, soft, no abd tenderness, (-)guarding.

EXTREMITIES: good pulses in all extremities, no tenderness/swelling in the extremities, no edema.

SKIN: warm, dry, good color, no rash, no decubitus.

Swallow screen: not applicable

***** FALLS ASSESSMENT(Adult):

AGE: Less than 60yrs 0

COGNITIVE: Fully alert and oriented 0

ELIMINATION: Independent with bowel bladder control 0

MEDICATIONS: No meds listed given 0

EQUIPMENT: None in room 0

MOBILITY TEST: Independent steady gait gets up down without assist 0

ADMITTING DIAGNOSIS: None known 0

HISTORY OF FALLS: No Fall within 30days 0

***** FALL RISK SCORE: Low Risk (0-15).

***** Plan of Care to Decrease Fall Risk: Low/Moderate Risk Interventions include - (+)Oriented to room, (+)Instruct to call for help/call bell within reach, (+)Use nonskid footwear, (+)Family/caregiver at bedside, (+)Bed in low position, (+)Bed/stretcher brakes on, (+)Bed rails up, (+)Uncluttered environment.

Norryce, Christy R.N. Created: 2/18/2012 2001 Last Entry: 2002

AND HEAL
Emergency Department
800 N. Fani St. Anderson, SC 29621 (804) 512-1333

Patient: Fletcher, Zeena Lynn
Med Rcd: 367855
Pt Acct: 7364701

ADMISSION MEDICATION RECONCILIATION ORDERS - FAX TO PHARMACY

Patient: Fletcher, Zeena Lynn
Age/DOB: 11/17/1959

Age: 52

Meds Review Printed: 2/18/2012 2325

CC/Curr Imp: VID

MD ED: Garriott, Randall M.D.

PMD: _____

RN: Trage: Brownlee, Sanquinnette R.N.

Pharm: Kelcie C., R.N.

**FAXED TO
MEDICAL RECORDS**

Allergies		
Allergic Substance	Reaction	Severity
IVP DYE		

Home Medications (Admit)			
Arrival Medication	Last Dose	Comments	Check to Continue
Percocet 10/325 1 tablet by mouth every 4-6 hrs <u>pm</u>	this morn g		☒
Percocet 7.5/325 1 tablet by mouth every 4-6 hrs	unknown		☒
Pristiq 50mg by mouth daily			☒
Tizanidine 4mg by mouth daily; at bedtime	last night		☒
Phenergan 25mg by mouth; as needed for nausea			☒

The ABOVE list of medications was what the Emergency Department was informed the patient is currently taking.
The ED physician has reviewed the medications on this visit.
All medications were reviewed and will remain managed by the prescribing doctor.

Admitting MD Signature: _____

Date/Time: 2/18/12

Admitting MD Signature: _____

Date/Time: _____

This is the Last Page

FAX AICU

FAXED



Emergency Department
800 N. Earl St. Anderson, SC 29621 (864) 512-1333



Patient: Fletcher, Zeena Lynn
Med Rcd: 387656
Pt Acct: 7363792

DISPOSITION SUMMARY (Discharge)

Patient: Fletcher, Zeena Lynn
Home Address: 206 Lewis Rd
City: Williamston SC 29697

Age/DOB: 11/17/1959
Age: 52yr
Home Ph: (864)328-9981

Arrival: 2/17/2012 1155
Dispo Summary Printed 2/17/2012 1544

Disposition: Discharge - Home
Rm (last): 22

MD ED: Grier, John M.D.
Res/PA/NP: _____

RN Eval: Deborah D. R.N.

PMD: _____
Chief Cmplnt: Back Pain

PMD Ph: _____

ED Dx 1: Gastroenteritis (Not Otherwise Specified)

Engl Dx 1 STOMFLU,ESW ICD-9 1558.9

Rx 1: Phenergan Tablets (promethazine)

25mg

1 tablet by mouth every 4-6 hours as needed for nausea

#12 tablets

Disposition

Follow-up 1: _____

F/U MD Ph: _____
F/U MD Fax: _____

Follow-up 1 Date: _____

Other Instr: no solid food today but small amounts of clear liquids are ok- no milk products or greasy foods for the next 2 days- return if you get worse or if you are not improved by lunch time tomorrow/ don't drive for 6 hours after the morphine you were given in EC

May return to work/scho 3 Days

MY SIGNATURE BELOW INDICATES:

- > I have received and understood the oral instructions regarding my current medical problem.
- > I will arrange follow-up care as instructed above.
- > I acknowledge receipt of the written instructions as outlined on this and any previous page(s).
I will read and review these instructions.
- > I authorize AnMed Health Medical Center to disclose information from this Emergency Department record about my identity, diagnosis, test results, and treatment, including psychiatric conditions, drug and alcohol use/dependencies; or HIV or AIDS testing or status, to (initial all that apply).

_____ the follow-up physician listed above

_____ my primary care physician _____

This consent is valid for 90 days unless revoked in writing by me.

X _____ x J. D. R.N.
Patient (or Legal Guardian) Signature Staff (Witness) Signature

114 7/10
132/83
97%

R.N.

South Carolina Workers' Compensation Commission
 1333 Main Street, Suite 500 • Post Office Box 5
 Columbia, South Carolina 29202-1715
 (803) 737-5723
 www.wcc.sc.gov



Physician's Statement

Claimant's Name: Zeena Fletcher
 Physician's Name: Dr. Alan Posta-
 Practice/Clinic: Carolina Orthopedic

Employer's Name: Dicks Sporting Goods

Insurance Carrier: _____

SCWCC File No: _____

Preparer's Name: _____

Phone: (____) _____

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her Injury by accident pursuant to §§ 42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 3-13-10

Date of first office visit: 7-21-10

Date of last visit: 9-29-10

Diagnosis or nature of Injury or illness: Early osteoarthritis (R) knee

Body part(s) injured: Right knee

Body part(s) affected: Right lower extremity

Date of Maximum Medical Improvement: 9-29-10

Based on the AMA Guidelines, the claimant has sustained a 4 % medical impairment to Rt knee injured body part(s) and a 2 % medical impairment to whole body other affected body part(s).

____ The claimant is able to return to work without restriction.

☒ The claimant is able to return to work with the following restrictions:

No kneeling, bending or crawling.

____ The claimant is unable to return to work at his or her current employment.

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

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

____ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

ALAN SPURGE POSTAK, MD
 ORTHOPAEDIC SURGERY

Treating Physician

Date

10/1/10



Physician's Statement

Claimant's Name: Zeena Fletcher

Employer's Name: Dick's Sporting Goods

Physician's Name: Dr. C. David Tollison

Insurance Carrier: Federal Ins. Co./Chubb Group of Ins. Companies

Practice/Clinic: Carolinas Center for the Advanced Management of Pain

SCWCC File No: 1003172

Preparer's Name: Andrew D. Smith

Phone: (864) 963-0310

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 03/13/2010

Date of first office visit: 2/17/11

Date of last visit: 9/22/11

Diagnosis or nature of injury or illness: FACET ARTHROPATHY
LUMBAR DISC HERNIATION, RIGHT KNEE INJURY, DEPRESSION

Body part(s) injured: LOW BACK, RIGHT KNEE Body part(s) affected: RIGHT LEG, BACK

Date of Maximum Medical Improvement: 10/14/11

Based on the AMA Guidelines, the claimant has sustained a 10% medical impairment to LUMBAR SPINE Injured body part(s) and a 4% medical impairment to RIGHT KNEE 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:

NO BENDING, TWISTING, STOPPING, SQUATING CONTINUOUSLY. WALKING, STANDING AS TOLERATED, NO CARRYING > 25-30 POUNDS OCC.

The claimant is unable to return to work at his or her current employment.

RECEIVED

FEB 08 2012

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:

MEDICATIONS, INJECTIONS, INTERMITTENT PT

Signature of Physician

Date

10/14/11



Physician's Statement

Claimant's Name: Zeena Fletcher

Employer's Name: Dick's Sporting Goods

Physician's Name: Dr. C. David Tollison

Insurance Carrier: Federal Ins. Co./ Chubb Group of Ins. Companies

Practice/Clinic: Carolinas Center for the Advanced Management of Pain

SCWC File No: 1003122

Preparer's Name: Andrew D. Smith

Phone: (864) 963-0310

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 03/13/2010

Date of first office visit: 3-16-11 Date of last visit: 11-28-11

Diagnosis or nature of injury or illness: Psychic secondary chronic pain

Body part(s) injured: _____ Body part(s) affected: psyche

Date of Maximum Medical Improvement: 11-28-11

Based on the **AMA Guidelines**, the claimant has sustained a 5 % medical impairment to psyche injured body part(s) and a _____ % medical impairment to _____ other affected body part(s).

☒ The claimant is **able to return to work** without restriction.

☐ The claimant is **able to return to work with the following restrictions:**

defer to physician for physical restriction

☐ The claimant is **unable to return to work** at his or her current employment.

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

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

☒ **will** need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Psychological treatment of Adjustment Disorder associated with pain interference, duration and lifestyle alteration resulting from work injury. Psychological treatment x 5-6 per year

C. David Tollison MD
Treating Physician

12-12-11
Date

2218

Smith | Poe, PA

Attorneys and Counselors at Law

634 B Fairview Road, Suite #2
Simpsonville, South Carolina 29680330 East Coffee Street
Greenville, South Carolina 29601Telephone: (864) 963-0310
Facsimile: (864) 228-7845

January 11, 2013

(via electronic mail and U.S. Mail)Dr. Alan G. Posta
Carolina Orthopedic Center
209 Patewood Drive, Suite 200
Greenville, SC 29615

Re: Zeena L. Fletcher v. Dick's Sporting Goods
SCWCC: 1003122
Claim No.: 003619-001324-WC01
Our File No.: 7000-01
Date of Accident: 03/13/2010

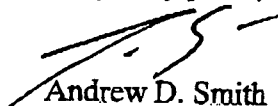
Dear Dr. Posta:

As you are aware, I represent the Employer/Carrier in regard to the above-referenced matter. We have requested that you see the Claimant back for possible additional treatment. It is my understanding, upon your review of the medical records, that the Claimant has not sustained a change of condition for the worse and does not need additional treatment to her right knee causally related to her on-the-job injury of March 13, 2010.

For your convenience, I have enclosed a statement. I would obviously be happy to reimburse you for your time and attention to the matter. If you would be so kind as to sign the statement and return it to my office, it would be greatly appreciated.

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

Very truly yours,


Andrew D. Smith

ADS/dkp

Enclosures

cc: Glendora Bastion, Gallagher Bassett Services (via email)
Marla McClary, Dick's Sporting Goods (via email)
Kathryn Williams, Esquire

STATEMENT OF Dr. ALAN G. POSTA

I last saw Zeena Fletcher on September 29, 2010. It was my opinion at that time the Claimant had a (4%) four percent impairment to the right lower extremity. I was asked by the Employer/Carrier to reevaluate the Claimant on January 8, 2013. Upon my review of the Claimant's updated medical records, it is my opinion the Claimant has not sustained a change of condition for the worse related to the on-the-job injury of March 3, 2010. This is my opinion (more likely than not, within a reasonable degree of medical certainty).

Date

Dr. Alan G. Posta

* Dr. Posta will not be able to sign this statement - Patient would need to be evaluated by an arthritis MD - ie: Dr. Bridgway with Piedmont Orthopaedics.

Thank,

Ethel White

Employment Separation Form for DICK'S Sporting Goods, Inc.

Associate's Last Name, First Name Fletcher, Zeena	Associate ID # 187770	Termination Date 6/27/12	
--	--------------------------	-----------------------------	--

Date this form was given or mailed to the associate. 6/27/12	Status at Termination (circle one) TEMP PART ☒ FULL SAL	Store # or Department # 780
---	--	--------------------------------

All future correspondence, including your final paycheck, will be mailed to the address listed here, unless otherwise noted.

Most current address: Street 206 Lewis Fe, Williamston, SC 29697	City State ZIP Code	Phone (include area code) ()
---	---------------------------	----------------------------------

The following is a brief overview of the status of your benefits (where applicable) upon termination.

Vacation	If you have an unused vacation balance, you may be eligible for reimbursement. Your manager will discuss your eligibility for payment with you. If applicable, the Manager should indicate here the number of unused company-paid vacation days that you are eligible to be compensated for: <u>0</u> days. If you purchased vacation time, you may be eligible to be reimbursed for the amount paid in to date, less any time taken. Did the associate purchase vacation? Yes ☒ No ☐ Note: For store associates, management must enter the <u>company-paid only</u> vacation time into KRONOS. Management: Please refer to the Associate Handbook page 21 for appropriate unused vacation reimbursement instructions (25%- 1 st quarter, 50% -2 nd quarter, 75%- 3 rd quarter, 100% -4 th quarter).
Medical/Dental/Vision	If you are full-time or salaried, your coverage will end on the last day of the month in which your termination date falls. If you are part-time, your benefits will end on the last day of the pay period for which a deduction was taken. You may continue your current benefits under COBRA at an additional cost. You will receive information regarding your continuation options via mail. The information will be sent to the address listed above.
Life Insurance	Your Group Term Life/Accidental Death & Dismemberment/Supplemental Life/Dependent Life Insurance ceases on your last day of work. You have 31 days from the last day worked to submit conversion paperwork to the carrier. Please contact Dick's Benefit Support Center at 1-800-690-7655, ext. 3012 option 1 to obtain conversion paperwork.
STD/LTD	Your short-term disability/long-term disability coverage(s) ceases on your last day of work. If you are currently receiving disability benefits, you must contact the Corporate Benefits Department in order to determine if you are eligible to continue receiving benefits.
401(k) Plan	Your participation in the plan ceases on your last day worked. If your account balance is \$1,000 or more, you have three election options: 1) roll over your funds into another 401(k) or an IRA; 2) take a lump sum cash distribution; or 3) leave your funds in the Dick's 401(k) plan. If your account balance is less than \$1,000, you may elect option 1 or 2 as described above. The Vanguard Group will send you a Termination Kit, including distribution instructions. If The Vanguard Group does not receive a distribution request within 90 days, your account will automatically be distributed to you with the applicable state and federal taxes withheld. Additionally, you may incur an early withdrawal penalty. If you have an outstanding loan balance, contact The Vanguard Group, 1-800-523-1188, to discuss payment options, taxes and penalties.
Employee Stock Purchase Plan	Your participation in the plan ceases on your last day worked for any reason other than retirement or death. Any contributions made through payroll deduction for the current purchase period will be refunded to you. You can expect to see this refund in your last paycheck following the processing of your termination paperwork.
Personal Days	Your personal days cannot be used to extend your termination date, and they are not reimbursable at the time of termination.
Repayment for relocation, tuition and sign on bonus	If you signed a Relocation Repayment Acknowledgment Form, received a sign on bonus or participated in the tuition reimbursement program, you must contact the Corporate Human Resources Department to determine if you will be required to make a repayment.
Associate Discount	Your Associate Discount privileges cease on your termination date.
Questions	Questions can be directed to the Benefits Support Center at 1-800-690-7655 X 3012, option 1.

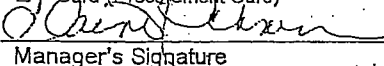
Miscellaneous Dick's Property to be Returned:

(Please reference the policy manual section "Retrieval of Company Property" for further details.)

- ☒ Associate/Dependent Discount Card(s)
- ☐ Corporate Credit Card
- ☐ Corporate Phone Card
- ☐ Cell Phone
- ☐ P Card (Procurement Card)

- ☒ Name Badge
- ☐ Corporate Office Access Card
- ☐ IS Equipment/Software/Laptop
- ☒ Kronos Swipe Card

- ☐ Keys
- ☐ Vehicle Property
- ☐ Expenses reimbursed
- ☐ Other (please list)


Manager's Signature

6/27/12

Date

ASSOCIATE COPY

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

SCWCC Number: 1003122

Zeena Fletcher, Employee, Respondent,

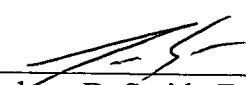
v.

Dick's Sporting Goods, Employer, and Federal Insurance Co., Carrier, Appellants.

CERTIFICATE OF COUNSEL

The undersigned certifies that this Appendix to the Record on Appeal complies
with Rule 209(c) and does not contain matter which is irrelevant to the appeal.

This 16th day of April, 2014



Andrew D. Smith, Esquire
Andrew D. Smith, LLC
147 Wappoo Creek Dr. STE 104
Charleston, South Carolina 29412
(843) 737- 4619
Attorney for Defendant

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

SCWCC Number: 1003122

Zeena Fletcher, Employee, Respondent,

v.

Dick's Sporting Goods, Employer, and Federal Insurance Co., Carrier, Appellants.

PROOF OF SERVICE

I certify that I have served the Respondent's BRIEF OF APPELLANT to Respondent/Appellant by depositing a copy of this document in the United States mail, first class postage prepaid, on April 16th, 2014 to Zeena Fletcher's Counsel of record Kathryn Williams, Esquire, Kathryn Williams, P.A., P.O. Box 10693, Greenville, South Carolina 29603.

This 16th day of April, 2014



Andrew D. Smith, Esquire
Andrew D. Smith, LLC
147 Wappoo Creek Dr. STE 104
Charleston, South Carolina 29412
(843) 737- 4619
Attorney for Defendant