

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

T. SCOTT BECK, COMMISSIONER, CHAIR
DERRICK L. WILLIAMS, COMMISSIONER

W.C.C. FILE NO.:0810190

Bobby Baker, ...Employee/Claimant/Appellant,

vs.

Hilton Hotels Corporation, Employer, and
Ace American Insurance Company,.....Carrier/Defendants, Respondents.

RECORD ON APPEAL
VOLUME II

Luke Rankin
Rankin & Rankin
Post Office Box 851
Conway, South Carolina 29528-0851
(843) 248-2405
Attorneys for Appellant

OTHER COUNSEL OF RECORD:
William Thomas Bacon, IV
Amy L. Neuschäfer
Collins & Lacy, P.C.
200 Meeting Street, Suite 403
Charleston, South Carolina 29401
(843) 714-2500
Attorneys for Respondents

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SC Court of Appeals

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GRAND STRAND REGIONAL MEDICAL CENTER

ER REPORT

NAME: BAKER, BOBBY E

MED. REC #: [REDACTED]

PHYSICIAN: DESALVO, MATTHEW J

ACCOUNT #: [REDACTED]

PT: BAKER, BOBBY E

DOS: [REDACTED]

DICT PHY: MATHEW J DESALVO, MD

CC: "I got hit in the head with a ceiling tile."

HX: A 50-year-old male was installing ceiling tiles, one of them fell down and hit him on the top of the head, and he suffered a scalp laceration. He is complaining of neck pain. He has not injured anywhere else. He did lose consciousness. He stated it did knock him down to the ground, but he has not injured anywhere else.

ALLERGIES: Codeine.

MEDICAL HISTORY: Hypercholesterolemia.

CURRENT MEDS: Noted.

SH: Noted.

PE: VITAL SIGNS: Temperature is 97.4, blood pressure 164/103, heart rate 64, and respiratory rate 16. GENERAL: He is awake, alert, and in no acute distress, sitting comfortably at the side of the bed. He was placed in a C-collar in triage. HEENT: His head normocephalic. He has a 6-cm laceration on the scalp. NECK: Supple. There is really no localizable tenderness to the spinous processes of the C-spine or T-spine. He is left in a C-collar. C-spine x-rays are obtained.

EMERGENCY DEPARTMENT COURSE: C-spine x-ray was read as no acute fracture by the radiologist. His scalp wound was cleansed and prepped and draped in usual sterile fashion, skin anesthetized with 1% lidocaine with epinephrine and cleaned. The partial thickness of the scalp was closed using wound clips with good reapproximation of the skin edges.

TREATMENT PLAN: I clinically cleared from the C-collar. He is discharged home with instructions to follow up with his primary care physician for recheck within the next week. Have the staples removed in 10 to 12 days.

CLINICAL IMP: Scalp laceration, 6 cm and head contusion.

DISPOSITION: Home.

IN: ED/F.HIM/DESMA/31ANO S: [REDACTED]

D: 05/06/2008 02:02

T: 05/06/2008 05:39 CONF#: 964171 / JOB#: 27343867

DESALVO, MATTHEW J

South Carolina PCI *LIVE* (PCI: OE Database COCQV)

Run: 05/14/08-10:34 by CARNEGIE, STEPHANIE S

DRAFT COPY

Page 1 of 1



RETURN TO WORK FORM

☐ SURFSIDE MEDICAL CENTER
1600 Hwy. 17 North
Surfside Beach, S.C. 29575
236-1481

☐ GEORGETOWN
1088 North Fraser St.
Georgetown, S.C. 29440
645-7200

GRAND STRAND AREA

☐ STRAND MEDICAL CENTER
1220 21st. Ave., North
Myrtle Beach, S.C. 29577
639-9379

☐ CORNWAY
1400 Main St.
Cornway, S.C. 29526
246-6269

☒ NORTH MYRTLE BEACH
1714 Highway 17 South
North Myrtle Beach, S.C. 29522
661-6706

NAME: Bobby DeckerDATE: 6/16/08ARRIVAL TIME: NoonDISCHARGE TIME: 1:05 PMCOMPANY NAME: Hilti

WORK STATUS: (Check appropriate boxes)

☐ 1. May perform Full Duty work as of _____ without accommodations.

☐ 2. Off Duty due to work-related condition.

Estimated return to work date modified duty: _____

Estimated return to work date full duty: _____

Return for re-evaluation at this office on 6/16/08 Time: _____

☒ 3. May work with the following accommodations as of: _____

☒ No lifting more than 5 lbs.

☐ No operation of hazardous or fast-moving machinery; no driving.

☒ Ground level work only, no ladder or heights.

☒ No repeated bending, stooping, squatting, pushing, jerking, twisting or bouncing.

☒ No continuous standing and/or sitting.

☒ Minimum walking, climbing (includes stairs).

☐ Limited use of _____

☐ No overhead lifting.

☐ No high-repetitive hand activities for extended periods of time.

☐ No use of _____

☐ 4. Has reached Maximum Medical Improvement (MMI).

☐ 5. Return for re-evaluation at this office on _____ Time: _____

COMMENTS: _____

PATIENT DISCHARGE INSTRUCTIONS:

Medications: ☐ as directed ☐ as needed

Wound Care or Injury Care:

☐ keep dry & clean

☐ elevate extremity

☐ warm soaks

☐ wear elastic support/immobilizer/keep taped

☐ do not remove dressing

☐ apply ice every _____

☐ apply heat every _____

☐ Home exercise instructions given

☐ Follow instruction sheet given

☐ Bed rest for _____

Diagnosis: Low back strain

REFERRAL: (If a referral is made to Therapy, or another Physician, please complete this section)

To: _____

Date: _____

Time: _____

For: Ortho referral

Address: _____

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my Employer.

EMPLOYEE SIGNATURE: Bobby Decker

PHYSICIAN SIGNATURE: [Signature]



FAXED

Date: 6/16/08

Date: 6/16/08

**STRAND REGIONAL SPECIALTY ASSOCIATES
CONSULTATION**

Patient Name: Bobby Baker

Date of Exam: 6/26/2008

Chart #: [REDACTED]

SSN: [REDACTED]

The patient is seen at the request of Janet Land, NCM.

CHIEF COMPLAINT: Low back pain.

HISTORY OF PRESENT ILLNESS: The patient is a 55-year-old, right-handed white male, seen at the request of Janet Land for low back pain. The patient was working in Kingston Plantation. He was inspecting the wall with his supervisor. When he stepped back fire proof ceiling from 12 feet above fell on top of the patient and struck him on the left occipital region of his scalp. He suffered a very brief loss of conscious with a laceration to the occipital area requiring 12 stitches at Grand Strand Regional Medical Center. He went to Doctor's Care the next day and was told go back to work. Unfortunately, he developed a bad upper respiratory infection. He was seen by his primary care physician and was in bed for two to three days after this accident. On 06/14/2008, he developed severe low back pain. He was seen at Grand Strand Regional Medical Center and given intravenous medication. He was subsequently seen at Doctor's Care for low back pain with bilateral leg radiation (right greater than left). He underwent an MRI of the lumbosacral spine, which showed degenerative disc disease at the L4-L5 level. He notes a cold dysesthesia in his left leg when ambulating. His initial accident occurred on 05/06/2008. He is no longer having any occipital pain or neck pain.

PAST MEDICAL HISTORY: Unremarkable.

PAST SURGICAL HISTORY: Significant for right inguinal hernia repair in 2001.

PREVIOUS HOSPITALIZATIONS OTHER THAN SURGERY: None.

MEDICATIONS AT PRESENT: None.

ALLERGIC HISTORY: He is allergic to CODEINE.

FAMILY HISTORY: His mother is 68 years old, alive and well. His father is 68 years old, who suffers from coronary artery disease, status post CABG. He has three brothers, one of whom was 48 years old with asthma. He has a son, who is 24 and a daughter is 22, alive and well. He has four grandchildren, alive and well.

SOCIAL HISTORY: He smokes less than a pack a day. He is a nondrinker. He denies recreational drug use. He has never had a blood effusion. He is married. He is a Horry County native. He works as an Engineer at Kingston Plantation.

REVIEW OF SYSTEMS: General: He has had weakness, fatigue, and difficulty sleeping since the time of the accident. Dermatological: Negative. HEENT: He wears glasses and has intermittent ringing in his ears. Breast: Negative. Pulmonary: Negative. Cardiovascular: He has some leg pain with exertion. He does have history of varicose veins. Gastrointestinal: He has a history of hemorrhoids. Genitourinary: He has frequent urination with history of impotence. Rheumatological: He has low back pain with bilateral leg radiation and cold dysesthesia in his left leg. Neurological: He has intermittent ringing in his ears. Some muscle weakness and recent closed-head injury. Endocrine: He has frequent urination with micturition at night. He has intermittent muscle cramping in his lower extremities. He has difficulty climbing stairs and arising from the chair secondary to low back pain.

PHYSICAL EXAM:

VITAL SIGNS:

Today, height was 5 feet 8 inches. Weight 187 pounds. Blood pressure 122/88. Pulse 80 and regular.

GENERAL:

The patient is a well-built, well-nourished, and well-groomed white male, in no acute distress, examined in the office.

HEENT:

Normocephalic, atraumatic. EOML. No noted ptosis, nystagmus, or visual field cuts. Pupils are 6 mm to 4 mm bilaterally to direct and consensual light. No afferent pupillary defects. No sensory or motor deficits to the face. Tongue midline without fasciculations. Symmetrical palatal rise with good gag reflex. Hearing intact bilaterally.

NECK:

The neck showed 5/5 strength of the flexors, extensors, and lateral rotators. There were no carotid bruits or thyromegaly. There was no nuchal rigidity.

HEART:

The heart has regular rate and rhythm. S1 and S2 were auscultated. There were no murmurs, rubs, or gallops.

RESPIRATORY:

Trachea was midline. Lungs were clear to auscultation bilaterally with no rales, wheezes, or rhonchi.

EXTREMITIES:

There was no edema, cyanosis, or clubbing. There were 2+ radial and dorsalis pedis pulses bilaterally.

NEUROLOGICAL EVALUATION:

MENTAL STATUS:

Oriented to person, place, and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty in discussing current events.

CRANIAL NERVES:

Normal visual fields. PERLA. EOMs full. No nystagmus. No ptosis. Facial sensation is intact. Corneal reflex intact. Facial movement is symmetric. Hearing intact bilaterally. Palate midline. Normal SCM/trapezius. Tongue midline.

POWER:

Power was 5/5 throughout. There was no noted pronator drift. Muscle bulk and tone within normal limits. No evidence of cogwheel rigidity.

SENSORY:

Showed decreased sensation over the L5 dermatome of the right lower extremity to pinprick and light touch. He had a positive bilateral straight leg raise. There are no sensory deficits at the upper extremity to pinprick and light touch. There were no sensory deficits at the left lower extremity to pinprick and light touch.

CEREBELLUM:

Examination showed finger-nose-finger and heel-to-shin testing intact bilaterally. Normal rapid alternating movements bilaterally.

DTRs:

+2 in the upper extremities and knee jerks, 1+ ankle jerks with downgoing plantars.

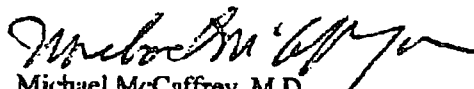
GAIT:

Within normal limits. Romberg testing negative.

IMPRESSION:

1. Low back pain with right leg radiation. We will check a nerve conduction study EMG of the right lower extremity to evaluate for any evidence of active lumbar radiculopathy. I will start the patient on tramadol 50 mg orally q.6h. p.r.n. pain.
2. Closed-head injury with a left occipital laceration. The patient's laceration is completely healed. He is having no residual symptoms from this.

PLAN: I will see the patient in followup at the time of his nerve conduction study and EMG of the right lower extremity.


Michael McCaffrey, M.D.

MC/trans

Bobby Baker

6/26/2008

Page 4

MC/trans

Stran Regional Specialty Associates, LLC

8170 Rourke Street, Myrtle Beach, SC 29572 • 843-449-2336 Fax: 843-497-2505
9250 A Hwy. 17 Bypass, Murrells Inlet, SC 29576 • 843-215 1700 Fax: 843-215 1700
2376 Cypress Circle, Suite 103, Conway SC 29526 • 843 234-1710 Fax: 834-234-1715

Initial Visit/Follow-Up

DATE	NAME	AGE	HANDEDNESS	RACE	SEX
6/20/08	Bobby Baker	50	Right/Left	C	M/F
HEIGHT	WEIGHT	TEMP	PULSE	RESP	B/P
5 ft 8 in.	187 lbs.		88		132/88

REFERRING M.D. Janet Land NCM

PT'S PRESENTING PROBLEM:

ALLERGIES:

LBP

Codeine

SUBJECTIVE OR HISTORY OF PRESENT ILLNESS:

OBJECTIVE OR PHYSICAL EXAM:

Constitutional: (see top of page)

General appearance:

HEENT:

Neck:

Heart:

Lungs:

Extremities:

Spine:

Orientation:

Attention span:

Language:

Memory/MMSE:

Fund of Knowledge:

Cranial Nerves:

II -

III, IV, VI -

V -

VII -

VIII -

IX, X -

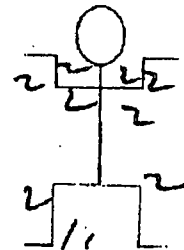
XI -

XII -

Motor Tone & Bulk:

Motor Strength:

Deep Tendon Reflexes:



Coordination:

Gait & Station:

Sensation:

↓ L5 NLE
⊕ Bilateral SLR

pp1.) LBP ⊕ leg
rod

- V NCS/EMG NLE

- Trawel 50 @ 6" per sec

ASSESSMENT/PLAN:

Counseling Time:

Return to Clinic:

Janet Land

M.D.

WORK LIMITATIONS



NEUROLOGICAL SURGERY
David B. Roe, Jr., M.D.
Eugene M. Giddens, M.D.
James L. Zochner, ACNP-C
Lisa Smith, ACNP-PNP-CS

NEUROLOGY
Julien N. Hayes, M.D.
Barbara L. Sarr, D.O.
Michael McCaffrey, M.D.
George M. Sandoz, M.D.
Jeff A. Benjamin, D.O.
Thomas F. Stout, M.D.

EYE PHYSICIAN & SURGEON
George M. Sandoz, M.D.



**ORTHOPAEDIC SURGERY
& SPORTS MEDICINE**
Thomas J. Chambers, M.D.
Jerry A. Scheinaydor, Jr., M.D.
Edward J. Mikol, M.D.
Elin L. Kirby, PA-C

**PHYSICAL MEDICINE
& REHABILITATION**
Anthony W. Alexander, M.D.



**PLASTIC & RECONSTRUCTIVE
SURGERY**
Ralph F. Conant, M.D.

This is to certify that Bobby Baker was examined on 6/26/08 and
is under my treatment for Lumbar Radiculopathy

WORK STATUS: REGULAR DUTIES, STARTING
LIGHT DUTY (Restrictions Listed Below)
☒ NO WORK UNTIL FURTHER NOTICE

Restrictions are in effect: for 4 days / weeks months July 24, 2008
until follow up appointment on

Shoulder Injury: No overhead lifting with affected extremity. No lifting more than 10 lbs. May use elbow, wrist, and hand as otherwise tolerated below shoulder level.

Elbow Injury: No repetitive elbow flexion or extension. No repetitive gripping with hand of affected extremity. No lifting more than 5 lbs. with affected extremity.

Hand Injury: No repetitive use of affected hand. No gripping or grasping with affected hand.

Leg Injury: Seated work only Must elevate leg Must wear brace

Must ambulate with crutches / walker / cane

No weight-bearing Partial weight-bearing Full weight-bearing

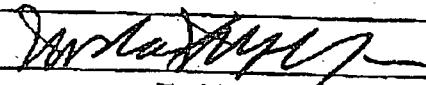
No repetitive climbing squatting push/pulling

No standing longer than

Back Injury: No repetitive stooping or bending of back. No lifting, carrying, pushing or pulling of more than 20 lbs.

Neck Injury: No repetitive bending of neck or side-to-side turning. No lifting more than 10 lbs. May otherwise use arms as tolerated.

Other:


Physician's Signature

MYRTLE BEACH LOCATION
8171 Rough Street
Myrtle Beach, SC 29572
ph. (843) 449-2336
fax (843) 497-2505

MURRELLS INLET LOCATION
9250 A Hwy. 17 Bypass
Murrells Inlet, SC 29576
ph. (843) 215-1700
fax (843) 215-1702

CONWAY LOCATION
2376 Cypress Circle, Suite 103
Conway, SC 29526
ph. (843) 234-1710
fax (843) 234-1715

LITTLE RIVER LOCATION
4000 Hwy. 9 East, Suite 215
Little River, SC 29566
ph. (843) 350-0033
fax (843) 350-0036

Faxed to Leslie
HR Dept.



Strand Regional Specialty Associates

WORK LIMITATIONS



NEUROLOGICAL SURGERY
David B. Koe, Jr., M.D.
Lugene M. Giddens, M.D.
Jamil L. Znein, ACP-C

NEUROLOGY
Julien N. Hayes, M.D.
Barbara L. Sarb, D.O.
Michael McGaffey, M.D.
George M. Slender, M.D.
Jeffrey Benjamin, D.O.
Thomas F. Stout, M.D.

EYE PHYSICIAN & SURGEON
George W. Sandoz, M.D.



ORTHOPEDIC SURGERY
& SPORTS MEDICINE
Thomas J. Chaffee, M.D.
Jerry A. Schenck, Jr., M.D.
Edward J. Mullen, M.D.
Erin L. Kibby, P.A.

PHYSICAL MEDICINE
& REHABILITATION
Anthony W. Alexander, M.D.



PLASTIC RECONSTRUCTIVE
SURGERY
Ralph A. Czar, M.D.

This is to certify that Bobby Baker was examined on 6/26/08 and
is under my treatment for Lumbar Radiculopathy

WORK STATUS: REGULAR DUTIES, STARTING

✓ LIGHT DUTY (Restrictions Listed Below)

✓ NO WORK UNTIL FURTHER NOTICE

Restrictions are in effect: for 4 days / 0 weeks / months Aug 14, 2008
until follow up appointment on

____ Shoulder Injury: No overhead lifting with affected extremity. No lifting more than 10 lbs. May use elbow, wrist, and hand as otherwise tolerated below shoulder level.

____ Elbow Injury: No repetitive elbow flexion or extension. No repetitive gripping with hand of affected extremity. No lifting more than 5 lbs. with affected extremity.

____ Hand Injury: No repetitive use of affected hand. No gripping or grasping with affected hand.

____ Leg Injury: ____ Seated work only ____ Must elevate leg ____ Must wear brace

____ Must ambulate with crutches / walker / cane

____ No weight-bearing ____ Partial weight-bearing ____ Full weight-bearing

____ No repetitive ____ climbing ____ squatting ____ push/pulling

____ No standing longer than ____

____ Back Injury: No repetitive stooping or bending of back. No lifting, carrying, pushing or pulling of more than 20 lbs.

____ Neck Injury: No repetitive bending of neck or side-to-side turning. No lifting more than 10 lbs. May otherwise use arms as tolerated.

____ Other: _____

Michael W. Czar
Physician's Signature

MYRTLE BEACH LOCATION
117 E. Fourth Street
Myrtle Beach, SC 29572
ph. (843) 449-2336
fax (843) 497-2505

MURRELLS INLET LOCATION
9250 A Hwy. 17 Bypass
Murrells Inlet, SC 29576
ph. (843) 213-1700
fax (843) 213-1702

CONWAY LOCATION
2376 Cypress Circle, Suite 103
Conway, SC 29526
ph. (843) 234-1710
fax (843) 234-1715

LITTLE RIVER LOCATION
4000 Hwy. 9 East, Suite 215
Little River, SC 29566
ph. (843) 390-0033
fax (843) 390-0036

Strand Regional Specialty Associates, LLC Patient Data Base

Providing information about your personal and family medical history is one of the best ways to help your physician learn a great deal about your health in a short period of time. The questions in the Medical History Worksheet are designed to help you remember and communicate important details of your past and current health history. Complete as much of the worksheet as possible, answering as many of the questions as you can.

Name Bobby E. Baker

Date of Birth _____

Height 5'8" Weight 180 #s

☒ Right-handed

☐ Left-handed

Please describe the problem you are experiencing:

Fireproof ceiling (12 feet)

Lower Back

Kaystar Plantation

How long have you been having this problem?

5-6-06

→ fall out of patient

How often does this problem occur?

Every Day

① output

How severe is the problem?

☒ Very severe

☐ Moderately severe

☐ Mild

Are there things that make this problem worse?

① LOC ① location

Sitting + Riding in car + Bending + Lifting

in brief

12 stitches

Are there things that make this problem better?

GSAC

when lying down

What activities can you no longer do because of this problem?

Went to Dr's office next day

none

Do you experience this problem with movement?

☒ Yes

☐ No

Do you experience this problem at rest?

☒ Yes

☐ No

→ told to go back to work

Medical History

Current Medical Problems (Include any Neurological and/or Orthopaedic related problems):

→ URI → DR → in bed 2-3 days

6/14/08 → severe

URI → severe

→ FM work

Surgeon's History (List all operations and dates):

PIH

2001-2002

Bowel

Hernia Surgery

CANC

→ Dr's office

① leg feels cold

for LBP ① leg ① leg rotation

more L's of 0004-5

Previous Hospitalizations other than Surgery (List reason for hospitalization and dates):

Medications (List all present medications with dosages - include over-the-counter vitamins, Tylenol, etc.):

Allergic History to Medications (List medication and specific allergy and/or reaction)

Family History (List age and medical problems of parents, siblings, and children - if any deaths have occurred in the family please list age and cause of death):

Other: ↑ 68 yo M
Other: ↑ 68 yo CAP 5/10 CAR
Other(s): 3 ↑ 48 yo M
Other(s): 4
Children: ↑ 10 yo M ↑ 2 yo F

Social History

Do you smoke?

☒ Yes ☐ No

How long have you smoked?

Have you ever quit?

☒ Yes ☐ No For How Long? 12 years

Do you drink alcohol?

☐ Yes ☒ No

If yes, indicate the number of drinks (and type) you take in an average week

(Please include beer and wine)

Do you use other drugs?

☐ Yes ☒ No

Have you ever had a blood transfusion?

☐ Yes ☒ No

Marital Status: ☐ Single ☒ Married ☐ Widowed ☐ Divorced ☐ Widowed/Divorced/Remarried

Location prior to living in Myrtle Beach area

Present Occupation/Past Occupations

Harry Natus
Engineer Kingston Plantation

Review of Body Systems

Do you have a present or past history of any of the following (Please place an appropriate check next to each item):

General	Present	Past	Never	Pulmonary	Present	Past	Never
Overweight	☐	☒	☐	Shortness of breath	☐	☐	☒
Acid indigestion	☐	☐	☒	Wheezing	☐	☐	☒
Headaches	☐	☐	☒	Chronic Cough	☐	☐	☒
Weight change (loss or gain)	☐	☐	☒	Blood-streaked sputum	☐	☐	☒
Weakness	☒	☐	☐	Bronchitis	☐	☐	☒
Fatigue	☒	☐	☐	Pneumonia	☐	☐	☒
Swollen Glands	☐	☐	☒	Asthma	☐	☐	☒
Difficulty Sleeping	☒	☐	☐	Abnormal chest x ray	☐	☐	☒
Dermatologic	Present	Past	Never	Cardiovascular	Present	Past	Never
New Skin Growths	☐	☐	☒	Chest Pain	☐	☐	☒
Change in color or size of skin growth	☐	☐	☒	Chest pain w/ walking/exercise	☐	☐	☒
Rashes	☐	☐	☒	Heart murmur	☐	☐	☒
Mouth sores	☐	☐	☒	Rheumatic fever	☐	☐	☒
Hair loss	☐	☐	☒	Fainting	☐	☐	☒
Temperature sensitivity	☐	☐	☒	Swelling in ankles	☐	☐	☒
Finger nail changes	☐	☐	☒	Sleep on more than one pillow	☒	☐	☒
Eyes, Ears, Nose, Throat	Present	Past	Never	Calf or leg pain	☒	☐	☒
Wear eye glasses	☒	☐	☐	Varicose veins	☒	☐	☒
Eye pain	☐	☐	☒	Abnormal electrocardiogram	☐	☐	☒
Hearing loss	☐	☒	☐	Gastrointestinal	Present	Past	Never
ringing in ears	☒	☐	☐	Nausea	☐	☐	☒
Ear infections	☐	☐	☒	Vomiting	☐	☐	☒
Stomach disorders	☐	☐	☒	Indigestion	☐	☒	☒
Post nasal drip	☐	☐	☒	Heartburn	☐	☒	☒
Nose bleeds	☐	☐	☒	Recurring diarrhea	☐	☐	☒
Phlegm in throat	☐	☐	☒	Frequent constipation	☐	☐	☒
Frequent colds or sore throats	☐	☐	☒	Recent change in bowel habits	☐	☐	☒
Hoarseness	☐	☐	☒	Blood in bowel movements	☐	☐	☒
Difficulty swallowing	☐	☒	☐	Black bowel movements	☐	☐	☒
Breast	Present	Past	Never	Jaundice	☒	☐	☒
Fibrocystic breast disease	☐	☐	☒	Hemorrhoids	☒	☒	☐
Genitourinary	Present	Past	Never	Rheumatologic	Present	Past	Never
Blood in urine	☐	☐	☒	Pain, stiffness or swelling in joints	☐	☐	☒
Mucus in urine	☐	☐	☒	Bursitis	☐	☐	☒
Painful urination	☒	☐	☐	Arthritis	☒	☐	☒
Frequent urination	☒	☐	☐	Low back pain	☒	☐	☒
Urgent urination	☐	☐	☒	Low back stiffness	☒	☐	☒
Kidney infection	☐	☐	☒	Numbness or tingling in legs	☐	☐	☒
Bladder infection	☒	☐	☒	Foot pain	☐	☐	☒
Prostate infection	☒	☐	☒				
Erectile dysfunction	☒	☐	☒				
Genital discharge	☐	☐	☒				

cold feeling

	Present	P	Never
neurologic			
current headaches	☐	☐	☒
migraine headaches	☐	☐	☒
dizziness	☐	☐	☒
memory loss	☐	☐	☒
seizures	☐	☐	☒
visual disturbances (blurred/double)	☐	☐	☒
speech difficulty	☐	☐	☒
muscle weakness	☒	☐	☐
muscle paralysis	☐	☐	☒
falling in cars	☒	☐	☐
history of head injury	☒	☐	☐

	Present	Past	Never
Endocrine			
Frequent Urination	☒	☐	☐
Urination at night	☒	☐	☐
Muscle cramps/weakness	☒	☐	☐
Weight change	☐	☐	☐
Heat/cold intolerance	☐	☐	☐
Tremors	☐	☐	☐
Difficulty climbing stairs	☒	☐	☐
Difficulty arising from chair	☒	☐	☐
Palpitations	☐	☐	☒
Hair Loss	☐	☐	☒
Excessive hair growth	☐	☐	☒

Bobby E. Baker
 Person Completing Form

Relationship to Patient _____

Signature _____

Date _____

- ☒ Hx. Reviewed with patient - no changes
- ☒ Hx. Reviewed with patient - see note for changes

[Signature]
 Physician Signature

6/28/08
 Date

- ☒ Hx. Reviewed with patient - no changes
- ☒ Hx. Reviewed with patient - see note for changes

Physician Signature _____

Date _____

- ☐ Hx. Reviewed with patient - no changes
- ☐ Hx. Reviewed with patient - see note for changes

Physician Signature _____

Date _____

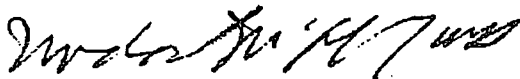
**STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP**

Patient Name: Bobby Baker
Date of Exam: 7/7/2008
Chart #: 80480
SSN:

CHIEF COMPLAINT: Low back pain.

HISTORY OF PRESENT ILLNESS: The patient is a 50-year-old right-handed white female seen in followup for low back pain with right leg radiation. Nerve conduction study and EMG of the right lower extremity was performed in the office today. Nerve conduction study of the right lower extremity demonstrated a mild sensory neuropathy versus tarsal tunnel syndrome. Needle electrode exam of the right lower extremity is within normal limits. I will refer the patient for lumbar epidural steroid injections.

PLAN: I will see the patient in followup in approximately six to eight weeks.



Michael McCaffrey, M.D.

MC/trans

cc: Janet Land, Nurse Case Manager.
Phone #: 800-558-4251, Extn. 73853
Insurance Company: Special Risk Services.
Phone #: 800-551-0271, Extn. 67629
Intra Corp.
P.O. Box 6050
Scranton, Pennsylvania 18505
Adjusters Name: Michael Harris
Fax #: 860-756-8422
Claim #: YTEC01212
Employers Name: Kingston Plantation.
Date of Injury: 05/05/2008.

Strand Regional Specialty Associates, LLC

8170 Rourke Street, Myrtle Beach, SC 29572 • 843-449-2336 Fax: 843-497-2505
9250 A Hwy. 17 Bypass, Murrells Inlet, SC 29576 • 843-215-1700 Fax: 843-215-1700
2376 Cypress Circle, Suite 103, Conway SC 29526 • 843-234-1710 Fax: 834-234-1715

Initial Visit/Follow-Up

DATE	NAME	AGE	HANDEDNESS	RACE	SEX
7/7/08	Bobby Baker	50	Right/Left	C	M/F
HEIGHT	WEIGHT	TEMP	PULSE	RESP	B/P
5 ft 8 in.	187 lbs.		68		120/88
REFERRING M.D.					Janet Lane NMD
PT'S PRESENTING PROBLEM:					ALLERGIES:

LBP

Codene

SUBJECTIVE OR HISTORY OF PRESENT ILLNESS:

OBJECTIVE OR PHYSICAL EXAM:

Constitutional: (see top of page)

General appearance:

HEENT:

Neck:

Heart:

Lungs:

Extremities:

Spine:

Orientation:

Attention span:

Language:

Memory/MMSE:

Fund of Knowledge:

Cranial Nerves:

II -

III, IV, VI -

V -

VII -

VIII -

IX, X -

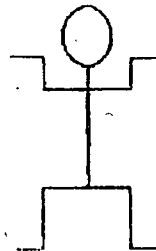
XI -

XII -

Motor Tone & Bulk:

Motor Strength:

Deep Tendon Reflexes:



Coordination:

Gait & Station:

Sensation:

NCS/EMG RLE
w/nc
except mild SN on
TTS

→ refer for cervical
spiculus

PTZ - 6-8 week

ASSESSMENT/PLAN:

Counseling Time:

Return to Clinic:

[Signature]

M.D.

Ocean Spine & Neurological Inst.
8170 Rourke Street
Myrtle Beach, SC 29572
(843) 449-2336

Patient: Baker, Bobby
 Sex: Male
 Age: 50
 I.D.#: A80480-1\
 Ref. M.D.: Doctor's Care

Physician: Dr McCaffrey
 Test Date: 07/07/08

History/Comments:

DOB Leg and low back pain. DOI 05-05-08 Object fell on head. Now pain in back and leg.
 Left leg becomes cold at times.

Motor Nerve Study

Right Peroneal Nerve						
Rec Site: EDB	Lat (ms)	Norm Lat	Amp (mV)	Norm Amp	C.V. (m/s)	Norm C.V.
Stim Site						
Ankle	4.0	6.6	3.7	2		42
Fib.Head	11.3		2.7		44.1	
Pop.Fos.	12.9		3.3		48.0	

Right Tibial Nerve						
Rec Site: AH	Lat (ms)	Norm Lat	Amp (mV)	Norm Amp	C.V. (m/s)	Norm C.V.
Stim Site						
Ankle	6.0	6.6	8.3	2		42
Pop.Fos.	14.3		5.3		44.4	

Sensory Nerve Study

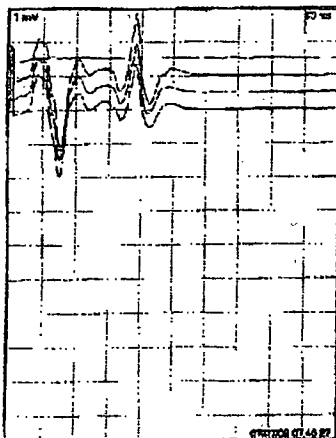
Plantar Nerve						
Rec Site: Ankle	Norm Lat	Pk Lat (ms)		Amp (uV)		Norm Amp
Stim Site		L	R	L	R	
1st toe	3.7	3.7	3.9	13.7	18.3	10
4th toe		4.0	3.8	13.0	22.3	
		3.8	3.8	12.0	11.7	

Sural Nerve						
Rec Site: Ankle	Norm Lat	Pk Lat (ms)		Amp (uV)		Norm Amp
Stim Site		L	R	L	R	
mid calf	4.5	3.9	4.3	11.3	24.3	5
		4.0	4.2	12.3	19.7	
		3.8	4.2	18.3	16.7	

Patient: Baker, Bobby
I.D.#: A80480-1\

Test Date: 07/07/08.

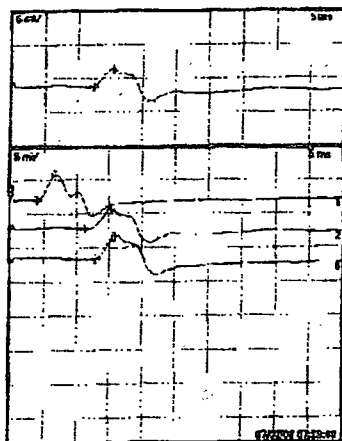
R. Tibial H-reflex



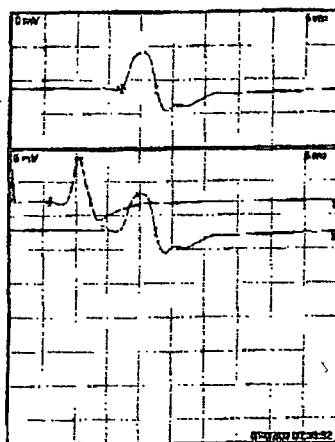
Patient: Baker, Bobby
I.D.#: A80480-1\

Test Date: 07/07/08

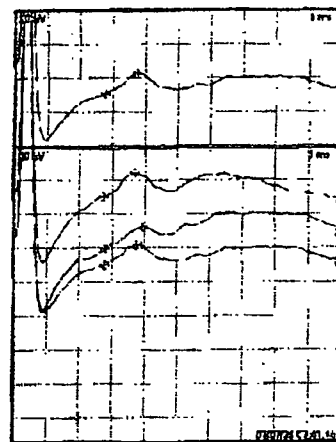
R. Peroneal MNC



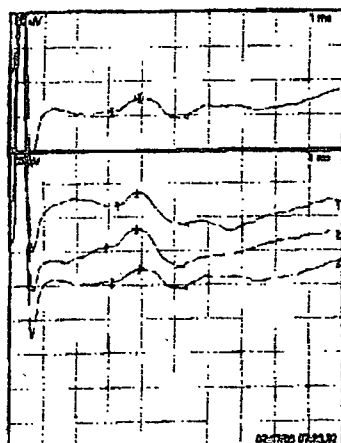
R. Tibial MNC



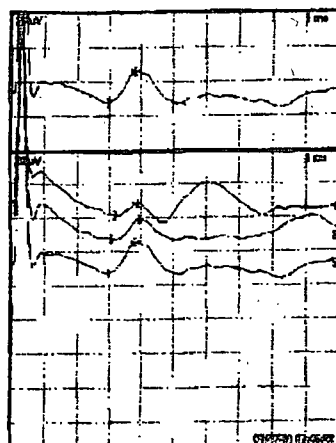
L. Plantar SNC



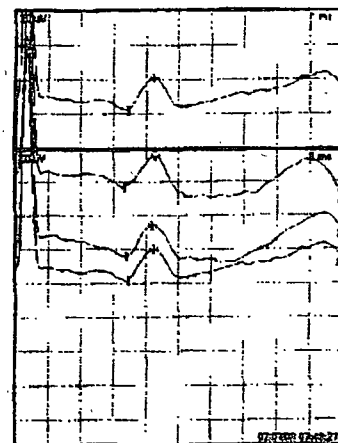
R. Plantar SNC



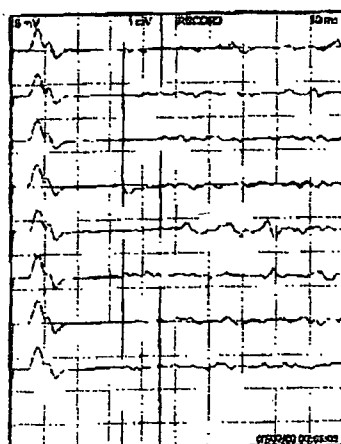
L. Sural SNC



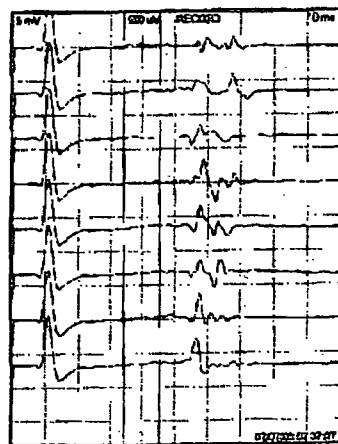
R. Sural SNC



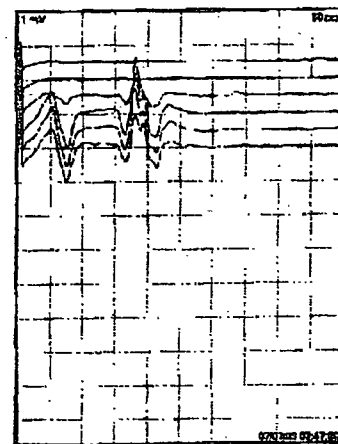
R. Peroneal F-wave



R. Tibial F-wave



L. Tibial H-reflex



Patient: Baker, Bobby
I.D.#: A80480-1\

Test Date: 07/07/08

Summary/Interpretation:

Right peroneal CMAP normal distal latency, amplitude, and conduction velocity. F-waves normal.
Right tibial CMAP normal distal latency, amplitude, and conduction velocity. F-waves normal.
Left plantar SNAP prolonged distal latency and normal amplitude.
Right plantar SNAP prolonged distal latency and normal amplitude.
Left sural SNAP normal distal latency and amplitude.
Right sural SNAP normal distal latency and amplitude.
Left tibial H-reflex normal responses.
Right tibial H-reflex normal responses.

Needle electromyography examination of the right lower extremity and right lumbar paraspinal muscles demonstrated: Within normal limits.

Impression: 1. Mild bilateral sensory neuropathy vs mild bilateral tarsal tunnel syndrome.
2. No evidence of radiculopathy.
3. Clinical correlation is recommended.


Michael McCaffrey, M.D.

Patient: Baker, Bobby
 I.D.#: A80480-1\

Test Date: 07/07/08

K-Wave Study

Right Peroneal Nerve
 Rec Site: EDB
 Stim Site: Ankle

	Latency ms	Normal Latency
M wave	5.17	
F wave	45.50	56.4

Right Tibial Nerve
 Rec Site: AH
 Stim Site: Ankle

	Latency ms	Normal Latency
M wave	7.33	
F wave	45.50	55

H Reflex Study

Tibial Nerve
 Rec Site: Soleus
 Stim Site: Pop.Fos.

	Latency ms		Normal Latency
	L	R	
M wave	5.50	6.00	
H wave	28.17	28.83	32

EMG Study

Name	Ins Act	Fibs	PSW	Fascics	Polyph	MU Amp	MU Dur	Config	Pattern	Recruit
R. Ant Tibialis	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Gastroc. Med. H.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Vastus Lat.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. TFL	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Iliopsoas	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Low Lum Para	norm	none	none	none	none	norm	norm	norm	norm	norm

STRAND REGIONAL SPECIALTY ASSOCIATES

FOLLOWUP

Patient Name: Bobby Baker

Date of Exam: 7/11/2008

Chart #: 80480

SSN:

CHIEF COMPLAINT: Low back pain.

HISTORY OF PRESENT ILLNESS: The patient is a 50-year-old right-handed white male seen for followup of low back pain. Since his last visit he has not yet undergone lumbar epidural steroid injections. He is having severe low back pain radiating in to his right leg, which does not improve with Ultram.

MEDICATIONS AT PRESENT: Today, I will start him on Dilaudid 4 mg one orally t.i.d. p.r.n. pain.

ALLERGIC HISTORY: He is allergic to CODEINE.

PHYSICAL EXAM:

VITAL SIGNS:

Today, height was 5 feet 8 inches. Weight 183 pounds.

Blood pressure 122/82. Pulse was 80 and regular.

HEENT:

Normocephalic, atraumatic. EOML. No noted ptosis, nystagmus, or visual field cuts. Pupils are 6 mm to 4 mm bilaterally to direct and consensual light. No afferent pupillary defects. No sensory or motor deficits to the face. Tongue midline without fasciculations. Symmetrical palatal rise with good gag reflex. Hearing intact bilaterally.

NEUROLOGICAL EVALUATION:

MENTAL STATUS:

Oriented to person, place, and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty in discussing current events.

CRANIAL NERVES:

Normal visual fields. PERLA. EOMs full. No nystagmus. No ptosis. Facial sensation is intact. Corneal reflex intact. Facial movement is symmetric. Hearing intact bilaterally. Palate midline. Normal SCM/trapezius. Tongue midline.

POWER:

Power was 5/5 throughout. There was no noted pronator drift. Muscle bulk and tone within normal limits. No evidence of cogwheel rigidity.

SENSORY:

Showed patchy sensory loss over the L5 dermatome on the right lower extremity to pinprick and light touch. He had a positive straight leg raise on the right lower extremity with

Bobby Baker
7/11/2008
Page 2

CEREBELLUM:

a mild contralateral straight leg raise on the left side. He had no sensory deficits in the left lower extremity and bilateral upper extremities to pinprick and light touch. Examination showed finger-nose-finger and heel-to-shin testing intact bilaterally. Normal rapid alternating movements bilaterally.

DTRs:

+2 throughout. Plantar reflexes downgoing bilaterally.

GAIT:

Within normal limits. Romberg testing negative.

IMPRESSION: Low back pain with right leg radiation. We will start the patient on the Dilaudid 4 mg orally t.i.d. p.r.n. pain. We await his appointment for lumbar epidural steroid injections.

PLAN: I will see the patient in followup after his injections are completed. He will remain out of work until then.

Michael McCaffrey, M.D.

MC/trans

cc: Nurse Case Manager: Janet Land.

Stran Regional Specialty Associates, LLC

8170 Roubk Street, Myrtle Beach, SC 29572 • 843-449-2336 Fax: 843-497-2505
9250 A Hwy. 17 Bypass, Murrells Inlet, SC 29576 • 843-215-1700 Fax: 843-215-1700
2376 Cypress Circle, Suite 103, Conway SC 29526 • 843-234-1710 Fax: 834-234-1715

Initial Visit/Follow-Up

DATE: 7/11/08 NAME: Bobby Baker AGE: 50 HANDEDNESS: Right/Left RACE: C SEX: MA
HEIGHT: 5 ft. 8 in. WEIGHT: 183 lbs. TEMP: 80 PULSE: 82 RESP: 12 B/P: 122/82 REFERRING M.D.: Janet Land (Ncm)
PT'S PRESENTING PROBLEM: C/O Rx mgmt LBP ALLERGIES: Codine

SUBJECTIVE OR HISTORY OF PRESENT ILLNESS:

OBJECTIVE OR PHYSICAL EXAM:

Constitutional: (see top of page)

General appearance:

HEENT:

Neck:

Heart:

Lungs:

Extremities:

Spine:

Orientation:

Attention span:

Language:

Memory/MMSR:

Fund of Knowledge:

Cranial Nerves:

I -

III, IV, VI -

V -

VII -

VIII

IX, X -

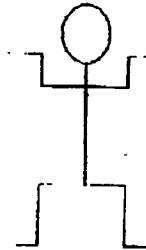
XI -

XII -

Motor Tone & Bulk:

Motor Strength:

Deep Tendon Reflexes:



Coordination:

Gait & Station:

Sensation:

ASSESSMENT/PLAN:

Counseling Time:

Return to Clinic:

[Signature]

M. D.

Pt Name Bobby Baker

Date: 7/11/08



Strand Regional Specialty Associates

In order for the physician to be more effective in meeting your medical needs, please answer the following questions for today's visit:

Why are you here today?

Do you have any new problems or symptoms? IF so, what are they?

Please list ALL medications taken and how often you take them:

<u>Ultram</u>	<u>Every Six hours</u>

Do you need any of these medications refilled? if so, please place a check in the box by that medication above.

Do you have any specific questions for the doctor? Please list below

yes,
about MRI

Thank you for allowing us to be of service to you today. Please follow these directions to best assist in the care of your medical condition:

Medications:

☐ No Changes

Make the following changes:

Add the following medications:

☐ Tests to be done:

☐ Call _____ for an Appt at _____

☐ Other Instructions:

☐ You will be contacted. Check info

Contact Number: _____

☐ Follow up appointment is scheduled for: _____

OCEAN AMBULATORY SURGERY CENTER

PATIENT: NAME: BAKER, BOBBY
ACT#: SS#: AGE: 50
DOB: DR: SARH, BARBARA L DO
SURGERY DATE: DOS: 07/17/08
SURGEON: Barbara Sarh, D.O.

Epidural Steroid Injection

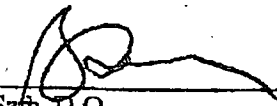
Diagnosis: Lumbar Radiculopathy

Procedure: Lumbar Epidural Steroid Injection

Risks and benefits of the lumbar epidural steroid injection were discussed with the patient including, bleeding, infection, and puncture of the spinal fluid space with possible transient numbness, weakness and post spinal headache. Informed consent for lumbar epidural steroid injection was obtained from the patient.

Description of Procedure: The patient was placed prone on the x-ray table and the lumbar region was sterilely prepped and draped. 1cc of 1% Lidocaine was injected subcutaneously as a local anesthetic at the L4-5 level. Then under fluoroscopic guidance a 20 gauge needle was inserted into the epidural space using loss of resistance technique. There was no aspiration of blood or spinal fluid. 1cc of Omnipaque 300 was injected to confirm needle placement in the epidural space. 80mg of Depo-Medrol and 2cc of 2% Xylocaine, preservative free were injected into the epidural space over several minutes. The needle was then removed. The patient tolerated the procedure well. Vital signs were monitored prior, during and status post procedure. The patient was taken to the recovery room and monitored for an additional 30 minutes.

Upon re-evaluation of the patient, the patient denied any numbness, or weakness. The patient was able to ambulate without assistance, and was discharged to home in stable condition, with limited activity over the next 48 hours, and no driving for the remainder of today. The patient will contact me over the next several days regarding their progress and for further recommendations.


Barbara Sarh, D.O.

OCEAN AMBULATORY SURGERY CENTER

NAME: BAKER, BOBBY
ACI#: SS#:
DOB: AGE: 50
PATIENT: DR: SARB, BARBARA L DO
DOS: 07/31/08
SURGERY DATE:
SURGEON: Barbara Sarb, D.O.

Epidural Steroid Injection

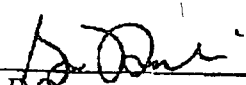
Diagnosis: Lumbar Radiculopathy

Procedure: Lumbar Epidural Steroid Injection

Risks and benefits of the lumbar epidural steroid injection were discussed with the patient including, bleeding, infection, and puncture of the spinal fluid space with possible transient numbness, weakness and post spinal headache. Informed consent for lumbar epidural steroid injection was obtained from the patient.

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Upon re-evaluation of the patient, the patient denied any numbness, or weakness. The patient was able to ambulate without assistance, and was discharged to home in stable condition, with limited activity over the next 48 hours, and no driving for the remainder of today. The patient will contact me over the next several days regarding their progress and for further recommendations.


Barbara Sarb, D.O.

STRAND REGIONAL SPECIALTY ASSOCIATES

FOLLOWUP

Patient Name: Bobby Baker

Date of Exam: 8/11/2008

Chart#: 80480

SSN:

CHIEF COMPLAINT: Low back pain.

HISTORY OF PRESENT ILLNESS: The patient is a 50-year-old, right-handed white male, seen for followup of left occipital headaches and low back pain secondary to Workmen's Comp injury. Since his last visit, he underwent two lumbar epidural steroid injections on 07/17/2008 and 07/31/2008. He only received 10% improvement with this form of therapy. He is mainly taking Ultram for his low back pain. Occasionally takes Dilaudid for severe pain of his low back. He is walking with a cane at present secondary to recurrent falls from severe right lower extremity pain with subsequent onset of right leg weakness. He has had increasing problems with his left occipital headaches, which initially resolved. These last for less than five minutes and are sharp in nature and resolved spontaneously.

MEDICATIONS AT PRESENT: Include, Dilaudid 4 mg orally t.i.d. p.r.n. pain, Ultram 50 mg orally q.8h. p.r.n. pain/spasm.

ALLERGIC HISTORY: He has no known drug allergies.

PHYSICAL EXAM:

VITAL SIGNS:

Today, height was 5 feet 8 inches. Weight 187 pounds.
Blood pressure 120/76. Pulse 72 and regular.

HEENT:

Normocephalic, atraumatic. EOMI. No noted ptosis, nystagmus, or visual field cuts. Pupils are 6 mm to 4 mm bilaterally to direct and consensual light. No afferent pupillary defects. No sensory or motor deficits to the face. Tongue midline without fasciculations. Symmetrical palatal rise with good gag reflex. Hearing intact bilaterally.

NEUROLOGICAL EVALUATION:

MENTAL STATUS:

Oriented to person, place, and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty in discussing current events.

CRANIAL NERVES:

Normal visual fields. PERLA. EOMs full. No nystagmus. No ptosis. Facial sensation is intact. Corneal reflex intact. Facial movement is symmetric. Hearing intact bilaterally. Palate midline. Normal SCM/trapezius. Tongue midline.

Bobby Baker
8/11/2008
Page 2

POWER: Power was 5/5 throughout. There was no noted pronator drift. Muscle bulk and tone within normal limits. No evidence of cogwheel rigidity.

SENSORY: Showed patchy sensory loss over the L5 dermatome of the right lower extremity to pinprick and light touch. He had a positive straight leg raise on the right lower extremity with a mild contralateral straight leg raise on the left side. There were no sensory deficits in the bilateral upper extremities to pinprick and light touch.

CEREBELLUM: Examination showed finger-nose-finger and heel-to-shin testing intact bilaterally. Normal rapid alternating movements bilaterally.

DTRs: +2 throughout. Plantar reflexes downgoing bilaterally.

GAIT: Showed the patient to walk consciously on his right leg secondary to pain. Romberg testing was negative. There were no frontal release signs.

IMPRESSION:

1. Low back pain with right leg radiation. I will refer the patient to a chronic pain specialist for further evaluation and treatment of his problem. We will have to remain out of work until 10/14/2008. We will continue him on Ultram and Dilaudid at their present dosages.
2. Left occipital headaches. These have been worsening over the time. He may need to be put on a prophylactic medication for atypical migraine/cluster headaches in the very near future.

PLAN: I will see the patient in followup in approximately two months.

Wrist Specialist
Phone #: 800-551-0271, Extension: 6769

Intracorp
P.O. Box 6050
Scranton, PA 18505

ADJUSTER'S NAME: Michael Harris
Fax #: 860-756-8422

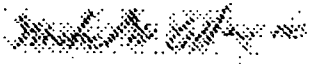
Janet Land, MCM
Phone #: 800-558-4251, Extension: 73853

CLAIM #: YTEC01212

Bobby Baker
8/11/2008
Page 3

EMPLOYER'S NAME: Kingston Plantation

DATE OF INJURY: 05/05/2008.


Michael McCaffrey, M.D.

MC/trans

Strand Regional Specialty Associates, LLC

8170 Rourke Street, Myrtle Beach, SC 29572 • 843-449-2336 Fax: 843-497-2505
9250 A Hwy. 17 Bypass, Murrells Inlet, SC 29576 • 843-215-1700 Fax: 843-215-1700
2376 Cypress Circle, Suite 103, Conway SC 29526 • 843-234-1710 Fax: 843-234-1715

Initial Visit/Follow-Up

DATE	NAME	AGE	HANDEDNESS	RACE	SEX
8/11/08	Bobby Baker	50	Right/Left	C	MA
HEIGHT	WEIGHT	TEMP	PULSE	RESP	R/P
5 ft. 8 in.	187 lbs.	72	120	176	
REFERRING M.D.					
Janet Land					
PT'S PRESENTING PROBLEM:					ALLERGIES:

Low Back Pain

SUBJECTIVE OR HISTORY OF PRESENT ILLNESS:

DOA 5/15/08

Abundant 4-7 p.m. to
last night
7/11/08

OBJECTIVE OR PHYSICAL EXAM:

Constitutional: (see top of page)

General appearance:

HEENT:

Neck:

Heart:

Lungs:

Extremities:

Spine:

Orientation:

Attention span:

Language:

Memory/MMSE:

Fund of Knowledge:

Cranial Nerves:

II -

III, IV, VI -

V -

VII -

VIII -

IX, X -

XI -

XII -

Motor Tone & Bulk:

Motor Strength:

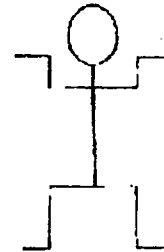
Deep Tendon Reflexes:

no need a care
to ambulate

will refer to
chronic pain
specialist

to evaluate

recurrent falls
20 some people



Coordination:

Gait & Station:

Sensation:

c/o pain
Occupational
per where
but in hand
very tight

ASSESSMENT/PLAN:

Counseling Time:

Return to Clinic:

Mr M.D.

Pt Name DAVEY CARL

Date: 11/10/08



Strand Regional Specialty Associates

In order for the physician to be more effective in meeting your medical needs, please answer the following questions for today's visit:

Why are you here today? See Doctor

Do you have any new problems or symptoms? IF so, what are they? _____

Please list ALL medications taken and how often you take them:

Do you need any of these medications refilled? if so, please place a check in the box by that medication above.

Do you have any specific questions for the doctor? Please list below

yes

Thank you for allowing us to be of service to you today. Please follow these directions to best assist in the care of your medical condition:

Medications:

☐ No Changes

Make the following changes: _____

Add the following medications: _____

☐ Tests to be done: _____

☐ Call _____ for an Appt. at _____ ☐ You will be contacted. Check info

☐ Other Instructions: _____ Contact Number: _____

☐ Follow up appointment is scheduled for: _____



Strand Regional Specialty Associates, LLC

WORK LIMITATIONS



NEUROLOGICAL SURGERY
David B. Kee, Jr., M.D.
Eugene M. Oddens, M.D.
Jamie L. Zoelner, ACNP-C

NEUROLOGY

Julian N. Hayes, M.D.
Barbara L. Serb, D.O.
Michael McCaffrey, M.D.
George M. Sanchez, M.D.
Jeff A. Benjamin, D.O.
Thomas F. Stout, M.D.

EYE PHYSICIAN & SURGEON
George M. Sanchez, M.D.



**ORTHOPAEDIC SURGERY
& SPORTS MEDICINE**
Thomas J. Chambers, M.D.
Jerry A. Schenayder, Jr., M.D.
Edward J. Mitchell, M.D.
Erin L. Kirby, P.A.

**PHYSICAL MEDICINE
& REHABILITATION**
Anthony W. Alexander, M.D.



**PLASTIC & RECONSTRUCTIVE
SURGERY**
Ralph F. Cozart, M.D.

This is to certify that Bobby Baker was examined on 8/11/08 and
is under my treatment for Chronic LBP & Right leg radiation

WORK STATUS: _____ **REGULAR DUTIES, STARTING** _____
_____ **LIGHT DUTY (Restrictions Listed Below)**
☒ **NO WORK UNTIL FURTHER NOTICE**

Restrictions are in effect: for 2 days / weeks / months Oct 14, 2008
until follow up appointment on

- _____ **Shoulder Injury:** No overhead lifting with affected extremity. No lifting more than 10 lbs. May use elbow, wrist, and hand as otherwise tolerated below shoulder level.
- _____ **Elbow Injury:** No repetitive elbow flexion or extension. No repetitive gripping with hand of affected extremity. No lifting more than 5 lbs. with affected extremity.
- _____ **Hand Injury:** No repetitive use of affected hand. No gripping or grasping with affected hand.
- _____ **Leg Injury:** _____ Seated work only _____ Must elevate leg _____ Must wear brace
_____ Must ambulate with crutches / walker / cane
_____ No weight-bearing _____ Partial weight-bearing _____ Full weight-bearing
_____ No repetitive _____ climbing _____ squatting _____ push/pulling
_____ No standing longer than _____
- _____ **Back Injury:** No repetitive stooping or bending of back. No lifting, carrying, pushing or pulling of more than 20 lbs.
- _____ **Neck Injury:** No repetitive bending of neck or side-to-side turning. No lifting more than 10 lbs. May otherwise use arms as tolerated.
- _____ **Other:** _____

Physician's Signature

MYRTLE BEACH LOCATION
8171 Rouse Street
Myrtle Beach, SC 29572
ph. (843) 449-2336
fax (843) 497-2505

MURRELLS HOLE LOCATION
9250 A Hwy. 17 Bypass
Murrells Inlet, SC 29576
ph. (843) 215-1700
fax (843) 215-1702

CONWAY LOCATION
2376 Cypress Circle, Suite 103
Conway, SC 29526
ph. (843) 234-1710
fax (843) 234-1715

LITTLE RIVER LOCATION
4000 Hwy. 9 East, Suite 215
Little River, SC 29566
ph. (843) 390-0033
fax (843) 390-0036

STRAND REGIONAL SPECIALTY ASSOCIATES

FOLLOWUP

Patient Name: Bobby Baker
Date of birth:
Date of exam: 10/2/2008
Chart #:
SSN:

CHIEF COMPLAINT: Low back pain.

HISTORY OF PRESENT ILLNESS: The patient is a 50-year-old right-handed white male seen for followup of low back pain and previous closed head injury secondary to workmen's compensation accident. Since his last visit, he has had intermittent sharp headaches with upper extremity tremor. He also has continued low back with right leg radiation. He has had increasing problems with impotence since the time of his second lumbar epidural steroid injection. He has had no response to Cialis or Levitra to help improve erectile dysfunction.

MEDICATIONS AT PRESENT: Include Dilaudid 4 mg p.o. t.i.d. Today, we will start him on Viagra 100 mg 30 minutes prior to intercourse.

ALLERGIC HISTORY: He has no known drug allergies.

PHYSICAL EXAM:

VITAL SIGNS:

Today, height was 5 feet 8 inches. Weight 192 pounds.
Blood pressure 130/92. Pulse 72 and regular.

HEENT:

Normocephalic, atraumatic. EOMI. No noted ptosis, nystagmus, or visual field cuts. Pupils are 6 mm to 4 mm bilaterally to direct and consensual light. No afferent pupillary defects. No sensory or motor deficits to the face. Tongue midline without fasciculations. Symmetrical palatal rise with good gag reflex. Hearing intact bilaterally.

NEUROLOGICAL EVALUATION:

MENTAL STATUS:

Oriented to person, place, and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty in discussing current events.

CRANIAL NERVES:

Normal visual fields. PERLA. EOMs full. No nystagmus. No ptosis. Facial sensation is intact. Corneal reflex intact. Facial movement is symmetric. Hearing intact bilaterally. Palate midline. Normal SCM/trapezius. Tongue midline.

POWER:

Power was 5/5 throughout. There was no noted pronator drift. Muscle bulk and tone within normal limits. No

SENSORY:

evidence of cogwheel rigidity.

Shows patchy sensory loss over the L5 dermatome of the right lower extremity to pinprick and light touch. He had positive straight leg raise in the right lower extremity. There is mild contralateral straight leg down on the left side. He had normal vibration, sense of proprioception of the lower extremity. There were no sensory deficits of the bilateral upper extremities to pinprick and light touch.

CEREBELLUM:

Examination showed finger-nose-finger and heel-to-shin testing intact bilaterally. Normal rapid alternating movements bilaterally.

DTRs:

+2 throughout. Plantar reflexes downgoing bilaterally.

GAIT:

Once again showed the patient walk cautiously in his right leg secondary to pain. Romberg testing was negative. There were no frontal release signs.

ASSESSMENT:

- Low back pain with right leg radiation. We will continue the patient on Dilaudid 4 mg p.o. t.i.d. The patient has been seen by Dr. Jason Rosenberg and we will await further approval for treatment of his chronic low back pain. He is developing worsening problems with impotence and we will start him on Viagra 100 mg 30 minutes prior to intercourse.

Intermittent headaches with upper extremity tremor. This appeared to be stable at present. He had a very mild 6 to 8 Hz tremor in the upper extremity, which worsened on finger-nose-finger testing.

PLAN: I will see the patient in followup in approximately two months. The patient will remain out of work until December 04, 2008.

Michael McCaffrey, M.D.

MC/lak

cc:

Intracorp

P.O. Box 5060 Scranton, PA 18505

Adjuster's name: Michael Harris

Fax #: 806-756-8422.

Janet Land.

Phone #: 800-558-4251, Extn.: 73853

Bobby Baker
10/2/2008
Page 3

Claim#: YTEC01212

Employer's name: _____

Date of Injury: 05/05/08

Stran Regional Specialty Associates, LLC

8170 Rourke Street, Myrtle Beach, SC 29572 • 843-449-2336 Fax: 843-497-2505
9250 A Hwy. 17 Bypass, Murrells Inlet, SC 29576 • 843-215-1700 Fax: 843-215-1700
2376 Cypress Circle, Suite 103, Conway SC 29526 • 843-234-1710 Fax: 834-234-1715

Initial Visit/Follow-Up

#

DATE	NAME	AGE	HANDEDNESS	RACE	SEX
10/2/08	Bobby Baker	50	Right/Left	C	MF
HEIGHT	WEIGHT	TEMP	PULSE	RESP	B/P
5'8" in.	192 lbs.		72		130/92
					REFERRING M.D.

PT'S PRESENTING PROBLEM:

ALLERGIES:

DOI 5-5-08

LBP

W100A

SUBJECTIVE OR HISTORY OF PRESENT ILLNESS:

OBJECTIVE OR PHYSICAL EXAM:

Constitutional: (see top of page)

General appearance:

HEENT:

Neck:

Heart:

Lungs:

Extremities:

Spine:

Orientation:

Attention span:

Language:

Memory/MMSE:

Fund of Knowledge:

Cranial Nerves:

II -

III, IV, VI -

V -

VII -

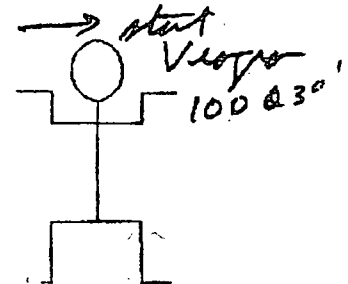
VIII -

IX, X -

XI -

XII -

↑ impotence since
2nd opiod not
→ no response to
Motor Tone & Bulk: *normal*
Motor Strength: *normal*
Deep Tendon Reflexes: *normal*



inter sharp HA
c ue trem
(6-8 Hz)
postural

cont LBP c @ leg

@ belt leg pain
when supine

Coordination:

Gait & Station:

Sensation:

ASSESSMENT/PLAN:

→ cont Meds & PT
→ work on posture
→ await further

Counseling Time:

→ off work 2 weeks

Return to Clinic:

PTC - Dec
4, 2008

MM

M.D.

Pt Name Sally B. [initials]

Date: 10/2/08



Strand Regional Specialty Associates

In order for the physician to be more effective in meeting your medical needs, please answer the following questions for today's visit:

Why are you here today? Return visit

Do you have any new problems or symptoms? IF so, what are they? _____

Please list ALL medications taken and how often you take them:

☐	<u>Wiliadid 4mg</u>	☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	

Do you need any of these medications refilled? If so, please place a check in the box by that medication above.

Do you have any specific questions for the doctor? Please list below

PHYSICIAN REFILL - PHYSICIAN ONLY

Thank you for allowing us to be of service to you today. Please follow these directions to best assist in the care of your medical condition:

Medications:

☐ No Changes

Make the following changes: _____

Add the following medications: _____

☐ Tests to be done: _____

☐ Call _____ for an Appt at _____ ☐ You will be contacted. Check info

☐ Other Instructions: _____ Contact Number: _____

☐ Schedule a follow up appointment on or near: _____

Call for follow up appointment at 449-2336 on the day you prefer to be seen or the day before you wish to be seen.



Strand Regional Specialty Associates

WORK LIMITATIONS



NEUROLOGICAL SURGERY
David B. Kea, Jr., M.D.
Eugene M. Cadden, M.D.
Janale L. Zoellner, ACNP-C
Lisa Smith, ACNP-PNP-CS

NEUROLOGY
Julian N. Hayes, M.D.
Barbara L. Sarb, D.O.
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Jeff A. Benjamin, D.O.
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George M. Sandoz, M.D.



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Edward J. Mikel, M.D.
Erin L. Kirby, PA-C

**PHYSICAL MEDICINE
& REHABILITATION**
Anthony W. Alexander, M.D.



**PLASTIC & RECONSTRUCTIVE
SURGERY**
Ralph F. Cuzart, M.D.

This is to certify that Bobby Baker was examined on 10/2/08 and
is under my treatment for Chronic Lumbar Podiatry

WORK STATUS: REGULAR DUTIES, STARTING

LIGHT DUTY (Restrictions Listed Below)

☒ NO WORK UNTIL FURTHER NOTICE

Restrictions are in effect: for (2) days / weeks / months
until follow up appointment on Dec 4, 2008

Shoulder Injury: No overhead lifting with affected extremity. No lifting more than 10 lbs. May use elbow, wrist, and hand as otherwise tolerated below shoulder level.

Elbow Injury: No repetitive elbow flexion or extension. No repetitive gripping with hand of affected extremity. No lifting more than 5 lbs. with affected extremity.

Hand Injury: No repetitive use of affected hand. No gripping or grasping with affected hand.

Leg Injury: Seated work only Must elevate leg Must wear brace

Must ambulate with crutches / walker / cane

No weight-bearing Partial weight-bearing Full weight-bearing

No repetitive climbing squatting push/pulling

No standing longer than

Back Injury: No repetitive stooping or bending of back. No lifting, carrying, pushing or pulling of more than 20 lbs.

Neck Injury: No repetitive bending of neck or side-to-side turning. No lifting more than 10 lbs. May otherwise use arms as tolerated.

Other:

Michael M. Kelly, MD
Physician's Signature

MYRTLE BEACH LOCATION
8771 Rouse Street
Myrtle Beach, SC 29572
ph. (843) 449-2336
fax (843) 497-2505

MURRELLS INLET LOCATION
9250 A Hwy. 17 Bypass
Murrells Inlet, SC 29576
ph. (843) 215-1700
fax (843) 215-1702

CONWAY LOCATION
2376 Cypress Circle, Suite 103
Conway, SC 29526
ph. (843) 234-1710
fax (843) 234-1715

LITTLE RIVER LOCATION
4000 Hwy. 9 East, Suite 215
Little River, SC 29566
ph. (843) 390-0033
fax (843) 390-0036

Ameritox, Ltd.9930 W Hwy 80, Midland, TX 79706
Phone: 866-237-7594
Fax: 432-361-5619Location: Ocean Spine & Neurology Institute
OSNESCOAddress: 8170 Roubt Street
Myrtle Beach, SC 29572
Fax: (843) 692-2174

Patient Name: BAKER, BOBBY

Birth Date:
Height: 68
Weight: 192
Gender: Male

Accession: P1109074

Lab Accession: 7081607101

Date Collected: 10/02/2008

Received By Lab: 10/06/2008 08:44 AM

Reported: 10/06/2008 10:45 AM

Physician: Dr Michael McCaffery, MD

Patient ID:

Test Ordered (ug/ml)	Lab Result	Assay Cutoff	Normalized Value	Expected Low	Range High	Range Interpretation	Medication Interpretation
Amphetamines	Negative	1000					
Barbiturates	Negative	300					
Benzodiazepines	Negative	100					
Methadone	Negative	150					
Methadone Metabolite (EDDP)	Negative	150					
Propoxyphene	Negative	200					
Opiates	<u>NEGATIVE</u>	50					<u>INCONSISTENT</u>
Oxycodone by ELA	Negative	100					
Cocaine	Negative	200					
Phencyclidine	Negative	25					
Cannabinoids	Negative	30					
Other:							
Creatinine - Urine	201.2			5	300		
PH - Urine	5.6			5	11		
Specific Gravity - Urine	1.0195			1.000	1.035		

Prescribed Drug	Drug Name	Drug Class	Dose (mg)	Freq (Low / High)	# Dose (Low / High)	PERN
DILAUDID	HYDROMORPHONE	Opiates	4	TID / QID	1 / 1	N

The normalizations of drug concentrations by PPIA are based on standard lean body mass calculations and specific properties of the drug of interest, e.g., hydrocodone, morphine, etc. These normalizations are compared to ranges based on known compliant patients. The normalizations are only meant to be used as a guide in conjunction with other clinical and behavioral information known to the treating physician. Due to many factors no single method can be accurate for all individuals.

*** SEE VTOX SUPPLEMENTAL EXPLANATION FOR ALL INCONSISTENT RESULTS ***

*** End of Report ***

Patient Name: BAKER, BOBBY
Physician: Dr Michael McCaffery, MDLocation: Ocean Spine & Neurology
Accession: P1109074

Page: 1 of 1

Ameritox, Ltd.

9930 Wilby St, Midland, TX 79706
Phone: 806-387-7584
Fax: 432-361-8519

Location: Ocean Spine & Neurology
Institution:

OSNISCO

Address: 8170 Routh Street
Myrtle Beach, SC 29572
Fax: (843) 692-2124

Physician: Dr Michael McCaffrey, MD

Patient: BAKER, BOBBY

Birth Date:

Height: 68

Weight: 192

Gender: Male

Patient ID: N/A

Accession: P1109074

Lab Accession: 7081007101

Date Collected: 10/02/2008

Received by Lab: 10/06/2008

Reported: 10/06/2008

Supplemental Explanation Report

Test / Drug Class / Medication	Explanation

Opiates

THE IMMUNOASSAY RESULT IS NEGATIVE FOR ALL THE OPIATES CLASS OF DRUG. THIS INDICATES IT HAS BEEN SEVERAL DAYS SINCE THE LAST DOSE OF DILAUDID.

*** End of Report ***

Disclaimer: This report is meant to supplement the main RX Guardian toxicology report explaining any INCONSISTENT lab results. Patient care treatment decisions are dependent upon numerous factors. The Ameritox RX Guardian Report is another piece of information that the physician can utilize in determining appropriate patient care. The RX Guardian report is not meant to be a sole determining factor for a patient's care but to serve as an additional tool that the provider can review in conjunction with all other factors used in providing care for the patient.

**STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP**

Patient Name: Bobby Baker
Date of birth:
Date of exam: 11/24/2008
Chart #:
SSN:

DATE OF INJURY: 05/05/2008

EMPLOYER'S NAME: HILTON HOTELS

ADJUSTER'S NAME: Janet Land, fax#: 646-378-6277

CLAIM#: 4TEC01212

Michael Harris, fax #: 806-756-8422.

CHIEF COMPLAINT: Headaches/Low back pain.

HISTORY OF PRESENT ILLNESS: The patient is a 50-year-old right-handed white male seen for followup of headaches and low back pain secondary to the Workman's Comp injury. The patient was last seen my office on 10/02/2008. He was subsequently been seen and followed by Dr. Jason Rosenberg and underwent radiofrequency ablation of the lumbar spine. Unfortunately, he did not have the notes from this procedure. The patient has developed reaction to the local anesthetic that was used at that time. He continues the pain in the left occipital scar on a scalp.

MEDICATIONS AT PRESENT: Include Dilaudid 4 mg orally t.i.d.

ALLERGIC HISTORY: He has no known drug allergies.

PHYSICAL EXAM:

VITAL SIGNS:

Today, height was 5 feet 8 inches. Weight 193 pounds.
Blood pressure 130/92. Pulse 76 and regular.

HEENT:

Normocephalic, atraumatic. EOMI. No noted ptosis, nystagmus, or visual field cuts. Pupils are 6 mm to 4 mm bilaterally to direct and consensual light. No afferent pupillary defects. No sensory or motor deficits to the face. Tongue midline without fasciculations. Symmetrical palatal rise with good gag reflex. Hearing intact bilaterally.

NEUROLOGICAL EVALUATION:

MENTAL STATUS:

Oriented to person, place, and time. No difficulty with

Bobby Baker
11/24/2008
Page 2

short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty in discussing current events.

CRANIAL NERVES: Normal visual fields. PERLA. EOMs full. No nystagmus. No ptosis. Facial sensation is intact. Corneal reflex intact. Facial movement is symmetric. Hearing intact bilaterally. Palate midline. Normal SCM/trapezius. Tongue midline.

POWER: Power was 5/5 throughout. There was no noted pronator drift. Muscle bulk and tone within normal limits. No evidence of cogwheel rigidity.

SENSORY: Shows patchy sensory loss over the L5 dermatome of the right lower extremity to pinprick and light touch. He had positive straight leg raise in the right with a mild contralateral straight leg raise on the left cerebellum.

CEREBELLUM: Examination showed finger-nose-finger and heel-to-shin testing intact bilaterally. Normal rapid alternating movements bilaterally.

DTRs: +2 throughout. Plantar reflexes downgoing bilaterally.

GAIT: Showed the patient walk with a cane secondary to right leg pain. Romberg testing was negative. There were no frontal release signs.

ASSESSMENT:

Low back pain with right leg radiation. The patient developed side effects to the recent procedure done by Dr. Rosenberg. We will continue him Dilaudid 4 mg orally t.i.d. Intermittent migraine headaches with mild upper extremity tremor. This appears to be stable at present.

PLAN: I will see the patient in followup in approximately two months. The patient will remain out of work until January 24, 2009.

Michael McCaffrey, M.D.

MC/mvn

cc:

InterCorp

Cama Hilton

Phone #: 800-558-4251, Extn.: 73853

Bobby Baker
11/24/2008
Page 3

P.O. Box 5060 Scranton, PA 18505

Initial Visit/Follow-Up

DATE 11/24/08 NAME Bobby Baker AGE 50 HANDEDNESS Right/Left RACE C SEX M/F
HEIGHT 5 ft. 8 in. WEIGHT 193 lbs. TEMP 97.6 PULSE 76 RESP 130 B/P 92 REFERRING M.D.

PT'S PRESENTING PROBLEM:

Intermittent HA /
LBP c (R) leg Rad

ALLERGIES:

None

SUBJECTIVE OR HISTORY OF PRESENT ILLNESS:

lost visit 10/2/08

OBJECTIVE OR PHYSICAL EXAM:

Constitutional: (see top of page)

General appearance:

HEENT:

Neck:

Heart:

Lungs:

Extremities:

Spine:

Orientation:

Attention span:

Language:

Memory/MMSE:

Fund of Knowledge:

Cranial Nerves:

II -

III, IV, VI -

V -

VII -

VIII -

IX, X -

XI -

XII -

Motor Tone & Bulk:

Motor Strength:

Deep Tendon Reflexes:

Seen by Rosenberg
→ ? RFA → do
not have notes

? pain ? reaction
to head avertate
no trace

do pain - @ occipital area

Coordination:

Gait & Station:

Sensation:

cont bloodwork & TIS

ASSESSMENT/PLAN:

PR - 2 weeks
→ out of work 2 weeks
JMM

Counseling Time:

Return to Clinic:

M.D.

Pt Name Bobby Baker

Date: 11-24-08



Strand Regional Specialty Associates

In order for the physician to be more effective in meeting your medical needs, please answer the following questions for today's visit:

Why are you here today?

Return visit

Do you have any new problems or symptoms? IF so, what are they?

Please list ALL medications taken and how often you take them:

☐	<u>Diazepam 4 mg</u>	☐	
☐	<u>ACE Inhibitor</u>	☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	

Do you need any of these medications refilled? If so, please place a check in the box by that medication above.

Do you have any specific questions for the doctor? Please list below

PHYSICIAN USE ONLY - DO NOT WRITE BELOW THIS LINE

Thank you for allowing us to be of service to you today. Please follow these directions to best assist in the care of your medical condition:

Medications:

☐ No Changes

Make the following changes: _____

Add the following medications: _____

☐ Tests to be done: _____

☐ Call _____ for an Appt at _____ ☐ You will be contacted. Check info

☐ Other Instructions: _____ Contact Number: _____

☐ Follow up appointment is scheduled for: _____



Strand Regional Specialty Associates

WORK LIMITATIONS



NEUROLOGICAL SURGERY
David B. Kee, Jr., M.D.
Eugene M. Giddens, M.D.
James L. Zoelner, ACNP-C
Lisa Smith, ACNP-FNP-CS

NEUROLOGY

Julian N. Hayes, M.D.
Barbara L. Sarb, D.O.
Michael McCaffrey, M.D.
George M. Sandoz, M.D.
Jeff A. Benjamin, D.O.
Thomas F. Stout, M.D.

EYE PHYSICIAN & SURGEON
George M. Sandoz, M.D.



**ORTHOPAEDIC SURGERY
& SPORTS MEDICINE**
Thomas J. Chambers, M.D.
Jerry A. Schornaydes, Jr., M.D.
Edward J. Mikol, M.D.
Erin L. Kirby, PA-C

**PHYSICAL MEDICINE
& REHABILITATION**
Anthony W. Alexander, M.D.



**PLASTIC & RECONSTRUCTIVE
SURGERY**
Wolff E. Cozart, M.D.

This is to certify that Bobby Baker was examined on 11/24/08 and
is under my treatment for LBP / (C) occipital HA'S

WORK STATUS: _____ REGULAR DUTIES, STARTING _____
_____ LIGHT DUTY (Restrictions Listed Below)
☒ NO WORK UNTIL FURTHER NOTICE

Restrictions are in effect: for 2 days / weeks (months)
until follow up appointment on Jan 24, 2009

- _____ **Shoulder Injury:** No overhead lifting with affected extremity. No lifting more than 10 lbs. May use elbow, wrist, and hand as otherwise tolerated below shoulder level.
- _____ **Elbow Injury:** No repetitive elbow flexion or extension. No repetitive gripping with hand of affected extremity. No lifting more than 5 lbs. with affected extremity.
- _____ **Hand Injury:** No repetitive use of affected hand. No gripping or grasping with affected hand.
- _____ **Leg Injury:** _____ Seated work only _____ Must elevate leg _____ Must wear brace
_____ Must ambulate with crutches / walker / cane
_____ No weight-bearing _____ Partial weight-bearing _____ Full weight-bearing
_____ No repetitive _____ climbing _____ squatting _____ push/pulling
_____ No standing longer than _____
- _____ **Back Injury:** No repetitive stooping or bending of back. No lifting, carrying, pushing or pulling of more than 20 lbs.
- _____ **Neck Injury:** No repetitive bending of neck or side-to-side turning. No lifting more than 10 lbs. May otherwise use arms as tolerated.
- _____ **Other:** _____

Physician's Signature

MYRTLE BEACH LOCATION
8171 Rourke Street
Myrtle Beach, SC 29572
ph. (843) 449-2336
fax (843) 497-2505

MURRELLS INLET LOCATION
9250 A Hwy. 17 Bypass
Murrells Inlet, SC 29576
ph. (843) 215-1700
fax (843) 215-1702

CONWAY LOCATION
2376 Cypress Circle, Suite 103
Conway, SC 29526
ph. (843) 234-1710
fax (843) 234-1715

LITTLE RIVER LOCATION
4000 Hwy. 9 East, Suite 215
Little River, SC 29566
ph. (843) 390-0033
fax (843) 390-0036

**STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP**

Patient Name: Bobby Baker
Date of birth:
Date of exam: 1/15/2009
Chart #:
SSN:

CHIEF COMPLAINT: Headaches, neck pain, and low back pain.

HISTORY OF PRESENT ILLNESS: The patient is a 50-year-old right-handed white male seen in followup for Workmen's Comp injury with resolved headaches, neck pain, and low back pain. Since his last visit, he was seen by Dr. Rosenberg before Christmas 2008. He had radiofrequency ablation done in the right lumbar region with improvement of the symptoms. He underwent a block in the left side of his lumbar spine, which worsened the symptoms. He developed a rash in the lumbar region lasting three to four weeks after this procedure. He continues to have left occipital headaches, which radiate into the left shoulder. These do start in a scar where he suffered a laceration in his left high parietal/occipital region of the scalp. He is having chronic impotence secondary to Dilaudid which improves with Viagra.

MEDICATIONS AT PRESENT: Include Dilaudid 4 mg orally three times a day as needed for pain. Today, we will start him on gabapentin 600 mg one-half to one orally three times a day, Viagra 100 mg 30 minutes prior to intercourse.

ALLERGIC HISTORY: He has no known drug allergies.

PHYSICAL EXAM:

VITAL SIGNS:

Height: 5 feet 8 inches. Weight: 192 pounds. Blood pressure: 128/98. Pulse: 70 and regular.

HEENT:

Normocephalic, atraumatic. EOMI. No noted ptosis, nystagmus, or visual field cuts. Pupils are 6 mm to 4 mm bilaterally to direct and consensual light. No afferent pupillary defects. No sensory or motor deficits to the face. Tongue midline without fasciculations. Symmetrical palatal rise with good gag reflex. Hearing intact bilaterally.

NEUROLOGICAL EVALUATION:

MENTAL STATUS:

Oriented to person, place, and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty in discussing current events.

CRANIAL NERVES:

Normal visual fields. PERLA. EOMs full. No nystagmus. No ptosis. Facial sensation is intact. Corneal reflex intact.

Bobby Baker

1/15/2009

Page 2

POWER:

Facial movement is symmetric. Hearing intact bilaterally. Palate midline. Normal SCM/trapezius. Tongue midline. Power was 5/5 throughout. There was no noted pronator drift. Muscle bulk and tone within normal limits. No evidence of cogwheel rigidity.

SENSORY:

Showed patchy sensory loss over the L5-S1 dermatome of the right lower extremity to pinprick and light touch. There were no sensory deficits of the left lower extremity and bilateral upper extremities to pinprick and light touch.

CEREBELLUM:

Examination showed finger-nose-finger and heel-to-shin testing intact bilaterally. Normal rapid alternating movements bilaterally.

DTRs:

+2 in the upper extremities and knee jerks, 1+ ankle jerks with downgoing plantars.

GAIT:

Exam showed unsteadiness on Tandem gait and standing on one leg. Romberg testing was negative. There were no frontal release signs.

ASSESSMENT:

- Low back pain with right leg radiation. I may hold to put him on further intervention of lower back secondary to a rash that developed after the procedure. We will continue him on Dilaudid 4 mg orally three times a day as needed for pain. The patient does develop chronic impotence secondary to Dilaudid, which improves with Viagra which we will continue on 100 mg 30 minutes prior to intercourse.
- Left occipital headaches/neck pain. I will start the patient on gabapentin 600 mg one-half to one orally three times a day.

PLAN: I will see the patient in followup in approximately two months.

Michael McCaffrey, M.D.

MC/vcs

Stral Regional Specialty Associates, LLC

8170 Rourke Street, Myrtle Beach, SC 29572 • 843-449-2336 Fax: 843-497-2505
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2376 Cypress Circle, Suite 103, Conway SC 29526 • 843-234-1710 Fax: 834-234-1715

Initial Visit/Follow-Up

DATE NAME AGE HANDEDNESS RACE SEX
1/5/09 Bobby Baker 50 (Right/Left) C (M)

HEIGHT WEIGHT TEMP PULSE RESP B/P REFERRING M.D.
5'8 in. 192 lbs. — 70 — 128/98 W/C

PT'S PRESENTING PROBLEM:

Intermittent HA /

LBP & (R) leg radicul.

ALLERGIES:

NKDA

SUBJECTIVE OR HISTORY OF PRESENT ILLNESS:

OBJECTIVE OR PHYSICAL EXAM:

Constitutional: (see top of page)

General appearance:

HEENT:

Neck:

Heart:

Lungs:

Extremities:

Spine:

Orientation:

Attention span:

Language:

Memory/MMSE:

Fund of Knowledge:

Cranial Nerves:

II -

III, IV, VI -

V -

VII -

VIII -

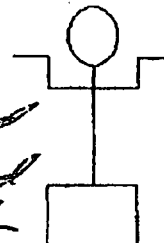
IX, X -

XI -

XII -

4% Occupied HA
(non pain)
→ Calypso
Motor Tone & Bulk: 600 L to R
Motor Strength: TD
Deep Tendon Reflexes:

Barby Rosenberg
before Christmas 2008
→ RA (R side) → improved
RA (L side) → worsened
c block



improved
c RA

Coordination:
Gait & Station:
Sensation:

→ developed rad in lumbar
region lasting 3-4 weeks
after procedure

ASSESSMENT/PLAN:

Chronic impotence 2°
Delayed

Counseling Time:

→ improved
c Viagra 100 mg

Return to Clinic:

M.D.

Pt Name Bobby Baker

Date: 1-15-09



Strand Regional Specialty Associates

In order for the physician to be more effective in meeting your medical needs, please answer the following questions for today's visit:

Why are you here today?

See Doctor

Do you have any new problems or symptoms? IF so, what are they?

Please list ALL medications taken and how often you take them:

<u>Same as file</u>	

Do you need any of these medications refilled? if so, please place a check in the box by that medication above.

Do you have any specific questions for the doctor? Please list below

about my Pain

DO NOT WRITE BELOW: PHYSICIAN ONLY

Thank you for allowing us to be of service to you today. Please follow these directions to best assist in the care of your medical condition:

Medications:

☐ No Changes

Make the following changes: _____

Add the following medications: _____

☐ Tests to be done: _____
☐ Call _____ for an Appt at _____
☐ Other Instructions: _____

☐ You will be contacted. Check info

Contact Number: _____

☐ Schedule a follow up appointment on or near:

Call for follow up appointment at 449-2336 on the day you prefer to be seen or the day before you wish to be seen.

WORK LIMITATIONS



NEUROLOGICAL SURGERY
David B. Kae, Jr., M.D.
Eugene M. Giddens, M.D.
Janile L. Zocifner, ACNP-C
Lisa Smith, ACNP-PNP-CS

NEUROLOGY
Julian N. Hayes, M.D.
Barbara L. Sarb, D.O.
Michael McCaffrey, M.D.
George M. Sandoz, M.D.
Jeff A. Benjamin, D.O.
Thomas F. Stout, M.D.

EYE PHYSICIAN & SURGEON
George M. Sandoz, M.D.



**ORTHOPAEDIC SURGERY
& SPORTS MEDICINE**
Thomas J. Chambers, M.D.
Jerry A. Schenckayder, Jr., M.D.
Edward J. Millot, M.D.
Erin L. Kirby, PA-C

**PHYSICAL MEDICINE
& REHABILITATION**
Anthony W. Alexander, M.D.



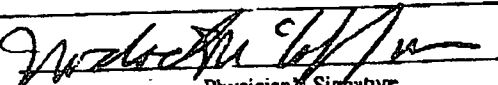
**PLASTIC & RECONSTRUCTIVE
SURGERY**
Ralph F. Coxart, M.D.

This is to certify that Bobby Baker was examined on 1/15/09 and
is under my treatment for HA's / Neck Pain / Lumbar Radiculopathy

WORK STATUS: _____ **REGULAR DUTIES, STARTING** _____
_____ **LIGHT DUTY (Restrictions Listed Below)** _____
☒ **NO WORK UNTIL FURTHER NOTICE**

Restrictions are in effect: for 2 days / weeks / months March 16, 2009
until follow up appointment on _____

- _____ **Shoulder Injury:** No overhead lifting with affected extremity. No lifting more than 10 lbs. May use elbow, wrist, and hand as otherwise tolerated below shoulder level.
- _____ **Elbow Injury:** No repetitive elbow flexion or extension. No repetitive gripping with hand of affected extremity. No lifting more than 5 lbs. with affected extremity.
- _____ **Hand Injury:** No repetitive use of affected hand. No gripping or grasping with affected hand.
- _____ **Leg Injury:** _____ Seated work only _____ Must elevate leg _____ Must wear brace
_____ Must ambulate with crutches / walker / cane
_____ No weight-bearing _____ Partial weight-bearing _____ Full weight-bearing
_____ No repetitive _____ climbing _____ squatting _____ push/pulling
_____ No standing longer than _____
- _____ **Back Injury:** No repetitive stooping or bending of back. No lifting, carrying, pushing or pulling of more than 20 lbs.
- _____ **Neck Injury:** No repetitive bending of neck or side-to-side turning. No lifting more than 10 lbs. May otherwise use arms as tolerated.
- _____ **Other:** _____


Physician's Signature

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fax (843) 234-1715

LITTLE RIVER LOCATION
6000 Hwy. 9 East, Suite 215
Little River, SC 29566
ph. (843) 360-0033
fax (843) 360-0036

STRAND REGIONAL SPECIALTY ASSOCIATES

FOLLOWUP

Patient Name: Bobby Baker

Date of birth:

Date of exam: 3/11/2009

Chart #:

SSN:

CHIEF COMPLAINT: Headaches/neck pain/low back pain.

HISTORY OF PRESENT ILLNESS: The patient is a 51-year-old right-handed white male seen for followup of headaches/neck pain/low back pain secondary to workmen's comp injury. Since his last visit on January 15, 2009, he continues to have left occipital headaches, which have not improved with gabapentin. He does note that Viagra works for his impotence, which is secondary to Dilaudid. He continues to have macular rash in the left posterior flank after previous treatment with radiofrequency ablation by Dr. Jason Rosenberg. He has not yet been evaluated for the cause of a presumed allergic reaction to the medication use during this procedure.

MEDICATIONS AT PRESENT: Include Dilaudid 4 mg by mouth t.i.d. p.r.n. pain, Viagra 100 mg 30 minutes prior to intercourse. Today, we will discontinue gabapentin.

ALLERGIC HISTORY: He has no known drug allergies.

PHYSICAL EXAM:

VITAL SIGNS:

Today, height was 5 feet 8 inches. Weight: 196 pounds.
Blood pressure: 130/94. Pulse: 72 and regular.

HEENT:

Normocephalic, atraumatic. EOMI. No noted ptosis, nystagmus, or visual field cuts. Pupils are 6 mm to 4 mm bilaterally to direct and consensual light. No afferent pupillary defects. No sensory or motor deficits to the face. Tongue midline without fasciculations. Symmetrical palatal rise with good gag reflex. Hearing intact bilaterally.

NEUROLOGICAL EVALUATION:

MENTAL STATUS:

Oriented to person, place, and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty in discussing current events.

CRANIAL NERVES:

Normal visual fields. PERLA. EOMs full. No nystagmus. No ptosis. Facial sensation is intact. Corneal reflex intact. Facial movement is symmetric. Hearing intact bilaterally. Palate midline. Normal SCM/trapezius. Tongue midline.

POWER:

Power was 5/5 throughout. There was no noted pronator

drift. Muscle bulk and tone within normal limits. No evidence of cogwheel rigidity.

SENSORY: Exam showed decreased sensation over the L5-S1 dermatome of the right lower extremity to pinprick and light touch.

CEREBELLUM: Examination showed finger-nose-finger and heel-to-shin testing intact bilaterally. Normal rapid alternating movements bilaterally.

DTRs: +2 in the upper extremities and knee jerks, 1+ ankle jerks with downgoing plantars.

GAIT: Exam showed unsteadiness on Tandem gait and standing on one leg. Romberg testing was negative. There were no frontal release signs.

ASSESSMENT:

Low back pain with right leg radiation. We will continue the patient on Dilaudid 4 mg by mouth t.i.d. p.r.n. pain. We will also continue him on Viagra for chronic impotence.

Left occipital headaches/neck pain. This did not improve with gabapentin. Unfortunately, he has developed an allergic reaction to a previous treatment by Dr. Rosenberg. He may be a candidate for Botox injection in the near future.

PLAN: I will see the patient in followup as needed. I think the patient is at his maximum medical improvement and can be released from my care at this time. I think the patient is totally/permanently disabled within a reasonable degree of medical certainty in reference to his low back pain, neck pain, and headaches.

Michael McCaffrey, M.D.

MC/raj

cc: Luke Rankin, attorney.

Pt Name Bobby Baker

Date: 3-11-09



Strand Regional Specialty Associates

In order for the physician to be more effective in meeting your medical needs, please answer the following questions for today's visit:

Why are you here today?

SFE Doctor

Do you have any new problems or symptoms? IF so, what are they?

Please list ALL medications taken and how often you take them:

☒	<u>Same as last</u>	
☐		
☐		
☐		
☐		
☐		

Do you need any of these medications refilled? if so, please place a check in the box by that medication above.

Do you have any specific questions for the doctor? Please list below

DO NOT WRITE BELOW: PHYSICIAN ONLY

Thank you for allowing us to be of service to you today. Please follow these directions to best assist in the care of your medical condition:

Medications:

☒ No Changes

Make the following changes: _____

Add the following medications: _____

☐	Tests to be done: _____
☐	Call _____ for an Appt at _____
☐	Other Instructions: _____

☐ You will be contacted. Check info

Contact Number: _____

☐ Schedule a follow up appointment on or near:

Call for follow up appointment at 449-2336 on the day you prefer to be seen or the day before you wish to be seen.

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2376 Cypress Circle, Suite 103, Conway SC 29526 • 843-234-1710 Fax: 834-234-1715

Initial Visit/Follow-Up

DATE 3/11/09 NAME Bobby Baker AGE 51 HANDEDNESS Right/Left RACE C SEX M
HEIGHT 5'8" in. WEIGHT 196 lbs. TEMP — PULSE 72 RESP — B/P 130/94 REFERRING M.D. —

PT'S PRESENTING PROBLEM:

HA

ALLERGIES:

LBP (R) Leg Rad.

NKA

SUBJECTIVE OR HISTORY OF PRESENT ILLNESS:

Cont @ occipital HA
→ not improved w/ Gabapentin

OBJECTIVE OR PHYSICAL EXAM:

Constitutional: (see top of page)

General appearance:

HEENT:

Neck:

Heart:

Lungs:

Extremities:

Spine:

Orientation:

Attention span:

Language:

Memory/MMSE:

Fund of Knowledge:

Cranial Nerves:

II -

III, IV, VI -

V -

VII -

VIII -

IX, X -

XI -

XII

↓ per L5-S1, ME

100 mg Vioxx works
for impotence
→ 2° to Defundid

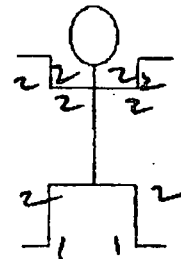
at HMI
→ released

Cont Motus w/ ① postm plank
(plank)
plank

Motor Tone & Bulk:

Motor Strength:

Deep Tendon Reflexes:



Coordination:

Gait & Station:

Sensation:

ASSESSMENT/PLAN:

Counseling Time:

Return to Clinic:

[Signature] M.D.
Luka Parker

X

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

Name of Patient (Print) <u>Bobby Baker</u>		Date of Birth	Policy Number
Present Address	Street	City	State Zip Code

The patient is responsible for the completion of this form without expense to the Company. Space is available on the reverse side if you wish to amplify your answers.

1. HISTORY

- a. When did symptoms first appear or accident happen?
- b. Date patient ceased work because of disability?
- c. Is condition a result of complications of pregnancy?
- d. Is condition a result of patient's employment?
- e. Is condition due to a motor vehicle accident?
- f. Has patient ever had a same or similar condition? (If yes, please describe)
- g. Names and addresses of other treating physicians
- h. Have you ever treated patient prior to this? (If yes, for what and when?)
- i. Does patient have other disability coverage? (If yes, please identify)

Date: 5/5/08

Date: 5/5/08

☐ Yes ☒ No

☒ Yes ☐ No

☐ Yes ☒ No

☐ Yes ☒ No

☐ Yes ☒ No

☐ Yes ☒ No

ALL PARTS OF SECTION 2, 3, 5 AND 6 MUST BE COMPLETED TO CONSIDER THIS CLAIM

2. DIAGNOSIS

- a. Diagnosis (including any complications) Lumbar Radiculopathy / Herniated 2° CHI
- b. Date of last examination 1/15/09
- c. Subjective symptoms LBP & @ leg radiation; @ occipital HT & neck radiation
- d. Objective findings (include current X-rays, EKG's, laboratory data, and any clinical data) MK US Spine 6/23/08 DDPL4-1
NCS/EMG 7/2/08 - mild SN @ rad

3. DATES OF TREATMENT

- a. Date of first visit Date: 6/26/08
- b. Date of last visit Date: 1/15/09
- c. Frequency ☐ Weekly ☐ Monthly ☒ Other (specify): Q 2 weeks

5. NATURE OF TREATMENT (Surgery, medications, etc.)

Medication

4. CARDIAC (if applicable)

- a. Functional Capacity (American Heart Ass'n)
 - ☒ Class 1 (No Limitation)
 - ☐ Class 2 (Slight Limitation)
 - ☐ Class 3 (Marked Limitation)
 - ☐ Class 4 (Complete Limitation)

b. Blood Pressure (last visit) 128 / 98
Systolic Diastolic

6. EXTENT OF DISABILITY

IMPORTANT

- a. Are you aware of the main duties the patient performs in his/her usual job/work/business? ☒ Yes ☐ No
- b. Are you aware of the patient's background (education training, experience, etc.)? ☒ Yes ☐ No
- c. Is patient **DISABLED** from performing HIS/HER JOB/WORK/BUSINESS?
If yes, give DATES of DISABILITY

FROM 5/5/08 TO 12/31/09

d. If patient is able to perform some of the main duties of his/her job/work/business, please give...

DATES of PARTIAL DISABILITY

FROM _____ TO _____

e. Based on your knowledge of the patient's background (see 6b.), is patient **DISABLED** from performing ALL OTHER TYPES OF JOB/WORK/BUSINESS?
☒ Yes ☐ No

1. If still DISABLED, when will patient be able to perform HIS/HER JOB/WORK/BUSINESS DUTIES?

- ☐ 1-3 Months ☐ 3-6 Months ☐ 6-12 Months
☐ More than 12 months ☒ Indefinite

2. If still DISABLED, when will patient be able to perform ANY OTHER JOB/WORK/BUSINESS? *Base your opinion on your knowledge of patient's background (6b).*****

- ☐ 1-3 Months ☐ 3-6 Months ☐ 6-12 Months
☐ More than 12 months ☒ Indefinite

h. If PARTIALLY DISABLED, when will patient be able to resume full duties?

i. Date patient was able to resume his/her normal work or business activities?

Date: _____

Date: _____

Do you believe the patient is competent to endorse checks and direct the use of the proceeds? ☒ Yes ☐ No

INSURED'S STATEMENT FOR CONTINUANCE OF DISABILITY BENEFITS

POLICY NO. _____

COMPANY	TYPE	YEAR OF ISSUE	MONTHLY BENEFIT	POLICY NUMBER	BENEFIT PERIOD

***If you have received an approval or denial of these benefits listed below, send photocopies of all documentation.

WORKER'S COMPENSATION	STATE CASH SICKNESS (If you live in California, Hawaii, Puerto Rico, New Jersey, New York, Rhode Island)	SOCIAL SECURITY BENEFITS
(a) Have you received a monetary Worker's Compensation award? ☐ Yes ☐ No	(a) Are you receiving benefits? ☐ Yes ☐ No	(a) Have you applied for benefits? ☐ Yes ☐ No
(b) If yes, when did payment begin? ____/____/____	(b) When did these benefits begin? ____/____/____	(b) Have you been approved? ☐ Yes ☐ No
(c) What amount did/are you receiving? \$ ____	(c) What amount are you receiving? \$ ____	(c) Give total approved amount \$ ____
(d) The award was/is payable: ☐ Weekly ☐ Biweekly ☐ Monthly	(d) Are you receiving these benefits ☐ Weekly ☐ Biweekly ☐ Monthly	(e) If denied, have you appealed? ☐ Yes ☐ No
(e) Give date if payments have ceased ____/____/____		
(f) Give name of worker's compensation carrier and claim number if known.		
(g) Provide the documentation to support the information given above.		

IMPORTANT - BE CERTAIN TO DATE AND SIGN THIS FORM AND HAVE YOUR TREATING PHYSICIAN COMPLETE THE ATTENDING PHYSICIAN'S STATEMENT PART C.

Bobby Baker

Patient

Date

Jan 22 - 2009

Witness

Ray Havelle

Signed

Bobby Baker

IMPORTANT NOTICE

CALIFORNIA CLAIMANTS: For your protection California law requires the following to appear on this form: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinements in state prison."

ALL OTHER CLAIMANTS: A law of your state requires us to inform you that any person knowingly and with intent to defraud any insurance company or other persons files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

8. PROGRESS

a. Has patient... ☐ Recovered ☐ Improved ☒ Unchanged ☐ Retrogressed

If recovered, date patient able to return to work?

Date:

b. Has patient been hospital confined? ☐ Yes ☒ No

Admitted

Discharged

Please give name and address of hospital

9. PHYSICAL IMPAIRMENT (*As defined in Federal Dictionary of Occupational Titles)

- ☐ Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions (0-10%)
☐ Class 2 - Medium manual activity* (15-30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity* (60-70%)
☒ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity* (75-100%)
☐ Remarks:

10. MENTAL/NERVOUS IMPAIRMENT (if applicable)

- ☒ Class 1 - Patient able to function under stress and able to engage in interpersonal relations (No limitations)
☐ Class 2 - Patient able to function in most stress situations and engage in most interpersonal relations (Slight limitation)
☐ Class 3 - Patient able to engage in only limited stress situations and engage in limited interpersonal relations (Moderate limitation)
☐ Class 4 - Patient unable to engage in stress situations or engage in interpersonal relations (Marked limitation)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitation)
☐ Remarks:

11. REHABILITATION

- a. Is patient a suitable candidate for rehabilitation? ☐ Yes ☒ No
 b. If yes, please explain

12. REMARKS

DATE 11/19/09 PHYSICIAN'S NAME (PRINT) Michael M. Caffrey MD SIGNATURE [Signature] DEGREE Neurology
 NPI (National Provider Identifier) 1902863103 *SOCIAL SECURITY OR TAX I.D. NUMBER _____
 STREET ADDRESS 8170 Rowle St CITY OR TOWN Myrtle Beach STATE OR PROVINCE SC ZIP CODE 29572 TELEPHONE (843) 449-2336

* Public Law 89-397 requires recipients of dividend, interest or other payments to furnish Social Security Numbers or Tax Identification Numbers to payors required to report such payment to the Internal Revenue Service. This Number must be furnished to the payor whether or not the payee is required to file a tax return, or is covered by Social Security.

WORK LIMITATIONS



ORTHODONTIC SURGERY
David B. Kee, Jr., M.D.
Jagene M. Goddard, M.D.
Rene L. Zolnier, ACNP-C

ENTHOLOGY
Alan N. Hayes, M.D.
Barbara L. Sarb, D.O.
Michael McCaffrey, M.D.
George M. Sandoz, M.D.
H. A. Benjamin, D.O.
Thomas F. Stout, M.D.

ORTHOPEDIC SURGEON
George M. Sandoz, M.D.



ORTHOPEDIC SURGERY
SPORTS MEDICINE
Thomas J. Chambers, M.D.
Ray A. Schenck, Jr., M.D.
David J. Miskol, M.D.
John L. Kirby, P.A.

PHYSICAL MEDICINE
REHABILITATION
Thomas W. Alexander, M.D.



ASTIC & RECONSTRUCTIVE
PLASTIC
Philip E. Coxart, M.D.

This is to certify that Bobby Baker was examined on 3/11/09 and
is under my treatment for Lumbar Post-surgery / CHIE @ occupational / 11A

WORK STATUS: ☐ REGULAR DUTIES, STARTING ☐
☐ LIGHT DUTY (Restrictions Listed Below)
☒ NO WORK UNTIL FURTHER NOTICE

Restrictions are in effect: for 9 days / weeks / months
until follow up appointment on 12/31/09

☐ **Shoulder Injury:** No overhead lifting with affected extremity. No lifting more than 10 lbs. May use elbow, wrist, and hand as otherwise tolerated below shoulder level.

☐ **Elbow Injury:** No repetitive elbow flexion or extension. No repetitive gripping with hand of affected extremity. No lifting more than 5 lbs. with affected extremity.

☐ **Hand Injury:** No repetitive use of affected hand. No gripping or grasping with affected hand.

☐ **Leg Injury:** ☐ Seated work only ☐ Must elevate leg ☐ Must wear brace
☐ Must ambulate with crutches / walker / cane

☐ No weight-bearing ☐ Partial weight-bearing ☐ Full weight-bearing

☐ No repetitive ☐ climbing ☐ squatting ☐ push/pulling

☐ No standing longer than _____

☐ **Back Injury:** No repetitive stooping or bending of back. No lifting, carrying, pushing or pulling of more than 20 lbs.

☐ **Neck Injury:** No repetitive bending of neck or side-to-side turning. No lifting more than 10 lbs. May otherwise use arms as tolerated.

☒ Other: Patient at MMI. Total / Permanent disability
20 to W.C. Injury

Physician's Signature

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fax (843) 215-1702

CONWAY LOCATION
2376 Cypress Circle, Suite 103
Conway, SC 29526
ph. (843) 234-1710
fax (843) 234-1715

LITTLE RIVER LOCATION
4000 Hwy. 9 East, Suite 215
Little River, SC 29566
ph. (843) 390-0033
fax (843) 390-0036

RE: BOBBY BAKER

- A. DO YOU CONCUR WITH THE ATTACHED RESTRICTIONS AND
IMPAIRMENT RATINGS OF MAY 18, 2009 BY PHILLIP LOWE,
PT/CERTIFIED DISABILITY EXAMINER?

☒ YES

☐ NO

→ 14% improvement lumbar
spine
5% improvement sexual
dysfunction

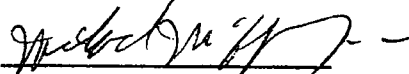
- B. IS YOUR ANSWER BASED UPON A REASONABLE DEGREE OF
MEDICAL CERTAINTY?

☒ YES

☐ NO

18% whole person
improvement

DATE: 3/22/10


Dr. Michael McCaffrey

RE: BOBBY BAKER

- A. DO YOU CONCUR WITH THE OPINION OF DR. RANDOLPH WAID THAT BOBBY BAKER HAS SUSTAINED A PERMANENT PHYSICAL BRAIN INJURY (SEE NEUROPSYCHOLOGICAL EVALUATION ATTACHED)?

☒ YES

☐ NO

- B. IS YOUR ANSWER BASED UPON A REASONABLE DEGREE OF MEDICAL CERTAINTY (MORE LIKELY THAN NOT)?

☒ YES

☐ NO

DATE: 10/12/10


Dr. MICHAEL MCCAFFREY

Waccamaw Community Hospital

PAIN CENTER CONSULT

Pt. Status: REG SDC

Rpt#: 0922-0102

PT DOB: .

PATIENT: BAKER, BOBBYMEDICAL RECORD #:CONSULTING PHYSICIAN:
ROSENBERG, JASON C MDACCOUNT #:CHIEF COMPLAINT:

Low back and right lower extremity pain.

HISTORY OF PRESENT ILLNESS:

Mr. Bobby Baker is a very pleasant 50-year-old right-handed white male who presents to Waccamaw Pain Management Center at the request of Dr. McCaffrey on 09/10/08 with complaints of low back and right lower extremity pain.

Mr. Baker was involved in a job related injury on 05/05/08. He was installing ceiling tiles. One of the ceilings fell down and hit him on top of the head from approximately ten feet. He fell onto the ground. He had a laceration to his scalp.

Since that time, he has had pain in his right low back radiating down to his leg. His right leg "hurts".

There is pain, which ranges from six out of ten to ten out of ten on the visual analog scale. His back pain is greater than his leg pain. He has episodes approximately one time per day, which causes whole leg pain.

He further describes stiffness in the morning. There is increased pain associated with change in the weather. There is no change with coughing or sneezing.

Mr. Baker further describes severe, aching, sharp, stabbing, throbbing, tender pain. There is a cramping component, which comes and goes.

He underwent an EMG nerve conduction study on 07/07/08. I have a copy of the report, which reveals mild bilateral sensory neuropathy versus mild bilateral tarsal tunnel syndrome with no evidence of radiculopathy. The study was performed by Dr. McCaffrey.

There is an MRI of the patient's lumbosacral spine with the report dated 06/23/08. I have a copy of the report, which reveals diffuse annular protrusion projecting right greater than left lateral recess with annular tears, right greater than left and facet hypertrophy at L4-L5. These are per report as the films are not available at the time of dictation.

Mr. Baker had an epidural steroid injection performed on two occasions. It helped with his "suicidal pain." He unfortunately had no lasting relief.

Mr. Baker is also complaining of pain in his neck. This is secondary to his back and leg pain.

Mr. Baker was referred today to discuss further diagnostic and treatment options.

PAST MEDICAL HISTORY:

Significant for:

1. Scalp laceration secondary to trauma.
2. Hernia repair.
3. Hand surgery

MEDICATIONS:

Hydromorphone 4 milligrams taking three times a day.

ALLERGIES:

CODEINE.

FAMILY HISTORY:

Patient's parents are age 68.

SOCIAL HISTORY:

Patient is married with two children. He is not working. He smokes one half pack of cigarettes per day. He denies any alcohol use.

REVIEW OF SYSTEMS:

Upon review of systems, he has numbness in his right leg, weakness in his right leg, hemorrhoids, decreased visual acuity requiring glasses. All other systems were asked and were negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.1, blood pressure 146/98, pulse 67, respiratory rate 16.

MENTAL STATUS: The patient is alert, oriented, cooperative, and follows commands well. Speech is clear and language is normal. Abstract function is normal. Attention and memory are normal.

CRANIAL NERVES:

II. Visual fields are intact to confrontation bilaterally. Fundi were not visualized.

III, IV, VI: There are full eye movements without nystagmus.

V: Facial sensation is normal. There is no weakness of masticatory muscles.

VII: There is no facial weakness or asymmetry.

VIII: Auditory acuity is grossly normal.

IX, X: The uvula is midline and the palate elevates symmetrically.

XI: There is normal sternocleidomastoid and trapezius strength.

XII: The tongue does not deviate.

MOTOR SYSTEM: Strength is 5/5 and symmetric in the bilateral upper and lower extremities. Tone and muscle bulk are normal. There is no pronator drift.

COORDINATION: Intact finger-to-nose, heel-to-shin, and rapid alternating movements. There is no tremor.

REFLEXES: The deep tendon reflexes are 2+ and symmetric in all four extremities. Plantar reflexes are flexor bilaterally.

SENSATION: Sensation was tested to touch, temperature, pinprick, and vibration times four extremities and were found to be decreased in the right L4 dermatomal pattern to soft touch, pinprick, and vibration.

GAIT: Patient ambulates with a cane and has an antalgic gait.

CARDIOVASCULAR: Regular rate and rhythm.

LUNGS: Clear to auscultation bilaterally.

ABDOMEN: Soft, nontender. Bowel sounds present.

MUSCULOSKELETAL: There is tenderness to palpation over the right lumbar paraspinous region. There is positive straight leg raise testing on the right, negative on the left.

IMPRESSION:

1. Job related injury.
2. Facet arthropathy secondary to above.
3. Annular tear.
4. Neck pain.

PLAN:

A long discussion was had with Mr. Baker concerning his current situation. I suspect the pain in his back can be coming from his facet joints on his right side. It is common in acceleration/deceleration type injuries such as falling can lead to inflammation and trauma to the facet joints. This manifests itself as low back pain radiating down the legs stopping at the knee, with stiffness in the morning. Outside from his sensory change in the right L4 dermatomal pattern and straight leg raise testing, the remainder of his neurologic examination is unremarkable. he also has had a normal EMG nerve conduction study.

I would recommend performing right-sided L3-S1 diagnostic medial branch blocks at the next available time. By injecting Marcaine over his right L3-S1 medial branch nerves, I would expect a 50% or greater reduction in his symptoms lasting four or longer hours. If we achieve this milestone, he would indeed suffer from facet arthropathy, and would then be scheduled for radiofrequency ablation of the same nerves. Patients who undergo the radiofrequency ablation report six months to two years' worth of relief from their facet arthropathy. If successful on the right side, this procedure might need to be repeated on the left side and perhaps in his cervical region.

Conversely, if the procedure is ineffective in alleviating his symptoms, the pain can be coming from the annular tear in his disc. We might discuss provocative discography leading to possible IDET (intradermal electrothermal therapy) in order to treat his symptoms. We can discuss this and further options in the future as necessary.

Once his low back pain has abated, I would consider further treatment for his neck.

Thank you for allowing me to participate in his care.

CC:

MICHAEL MCCAFFREY, MD
JODY HUTSON, DO

JR:8000007

D: 09/21/2008 15:21:24 T: 09/22/2008 09:12:37 DOCUMENT: 96090

Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

copy: ROSENBERG, JASON C MD

Waccamaw Community Hospital

PAIN CENTER PROCEDURE NOTE

Rpt#: 1008-0252

Pt. Status: REG SDC

PT DOB:

PATIENT: BAKER, BOBBYMEDICAL RECORD #:ATTENDING PHYSICIAN:
ROSENBERG, JASON CACCOUNT #:PROCEDURE:

Right L3 through S1 diagnostic medial branch blocks under fluoroscopy with IV sedation.

INDICATIONS:

1. Job related injury.
2. Facet arthropathy.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw Pain Management Center on 10/08/08 for today's procedure. I would like to see if the pain is coming from his facet joints by performing today's diagnostic medial branch blocks. If he has 50% or greater reduction in his symptoms lasting four or longer hours, he would indeed suffer from facet arthropathy, and would then be scheduled for radiofrequency ablation of the same nerves in attempt to provide him with six months to two years' worth from his facet arthropathy.

SURGEON:

Jason Rosenberg, MD

ANESTHESIA:

Local.

DESCRIPTION OF PROCEDURE:

After the risks and benefits were explained to the patient, an informed consent was obtained. A peripheral IV was started. The patient was brought back to the fluoroscopic suite and placed in the prone position on the table.

The lumbosacral region was prepped and draped in a surgical, sterile fashion, using Betadine times three. The fluoroscopic C-arm was brought into anteroposterior view, and the right S1 neural foramen was brought to the center of the beam.

The skin overlying this area was anesthetized using 1% lidocaine via a 25-gauge needle. A 3.5-inch, 22-gauge needle was then advanced using intermittent fluoroscopic guidance, making bony contact superolateral to the right S1 neural foramen.

A lateral fluoroscopic view was obtained, revealing the needle tip posterior to the neural foramen at that level.

Our attention was then drawn to the L5 medial branch nerve, found at the intersection of the ala of the sacrum with the L5 vertebral body, inferior to the right transverse process.

The skin overlying this area was anesthetized using 1% lidocaine, via a 25-gauge needle. A 3.5-inch, 22-gauge needle was then advanced, using intermittent fluoroscopic guidance, making bony contact at the

ala of the sacrum.

A lateral fluoroscopic view revealed the needle tip posterior to the neural foramen at that level.

The L4 medial branch nerve was the following target. The L5 vertebral body was brought to the center of the beam, and the right pedicle was identified. The C-arm was brought to a 15-degree ipsilateral orientation, and the skin overlying the right L5 pedicle was anesthetized using 1% lidocaine.

A 3.5-inch, 22-gauge needle was then advanced using intermittent fluoroscopic guidance, making bony contact at the 2 o'clock position on the right L5 pedicle. A lateral view obtained revealed the needle tip in proper position, posterior to the neural foramen.

Finally, the L3 medial branch nerve was found on the L4 pedicle, with a 15-degree ipsilateral rotation of the C-arm. The skin overlying this pedicle was anesthetized using 1% lidocaine via a 25-gauge needle.

A 3.5-inch, 22-gauge needle was then advanced using intermittent fluoroscopic guidance, making bony contact at the 2 o'clock position on the L4 pedicle. A lateral fluoroscopic view revealed the needle tip posterior to the neural foramen.

Once all four needles were in place, a final anteroposterior view and lateral view was obtained, and placed in the patient's chart. All needle tips were in proper position, with the lateral view revealing all tips posterior to the neural foramina at all levels.

A solution containing 4 ml of 0.25% bupivacaine was divided among the four sites. There was negative aspiration for heme prior to injection.

Once all injections were completed, the needles were removed with tips intact. Bandages were applied.

Meaningful verbal communication was maintained throughout the entire procedure. The patient was brought back to the recovery area and convalesced for approximately 30 minutes' time, before being discharged in the care of a driver.

Thank you for allowing me to participate in his care.

CC:

MICHAEL MCCAFFREY, MD

JR:8000007

D: 10/08/2008 11:05:52 T: 10/08/2008 11:45:25 DOCUMENT: 101468

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND MARKED
<Electronically signed by>

Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

copy: ROSENBERG, JASON C

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PAIN CENTER PROCEDURE NOTE

Pt Status: REG SDC

Rpt#: 1015-0155

PT DOB:

PATIENT: BAKER, BOBBY**MEDICAL RECORD #:****ATTENDING PHYSICIAN:**
ROSENBERG, JASON C**ACCOUNT #:**
W00001458328**PROCEDURE:**

Radiofrequency ablation right L3-S1 medial branch nerves under fluoroscopy with IV sedation.

INDICATIONS:

1. Job related injury 05/05/08.
2. Facet arthropathy secondary to above.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw Pain Management Center on 10/15/08 for today's procedure. He had excellent results from his diagnostic medial branch blocks at last visit time with greater than 50% reduction in his symptoms lasting longer than four hours. As a result, he was scheduled for today's radiofrequency procedure. Hopefully, he will enjoy six months to two years' worth of relief from his facet arthropathy. I will see him back in two weeks' time for followup.

SURGEON:

Jason Rosenberg, M.D.

DESCRIPTION OF PROCEDURE:

After the risks and benefits were explained to the patient, an informed consent was obtained. A peripheral intravenous was started. Noninvasive hemodynamic monitors were applied. The patient was brought back to the fluoroscopic suite and placed in the prone position on the procedure table. Please see anesthesia record for complete details of all medications administered as well as hemodynamic variables throughout the procedure.

A time-out was undertaken.

The patient's lumbar and sacral regions were prepped and draped in the surgical sterile fashion using Betadine times three. A fluoroscopic C-arm was brought into anteroposterior orientation and the S1 neural foramen was identified. The skin overlying this area was anesthetized using 1% lidocaine via a 25-gauge needle. An SMK cannula with 5-mm active tip was advanced using intermittent fluoroscopic guidance making bony contact superolateral to the S1 neural foramen.

The right L5 medial branch nerve was found on the ala of the sacrum and the lateral border of the L5 vertebral body. The skin overlying this area was anesthetized in an identical fashion, and an SMK cannula was advanced making bony contact on the ala.

The L4 medial branch nerve was found over the L5 pedicle. The C-arm was adjusted 15 degrees ipsilaterally, and the skin overlying this pedicle was anesthetized. An SMK cannula was advanced making bony contact slightly lateral to the twelve o'clock position on the pedicle.

Finally, the L3 medial branch nerve was found over the L4 pedicle in an identical fashion.

A lateral view was obtained revealing all needle tips posterior to the neural foramina at all levels.

Sensory and motor stimulation were undertaken. Sensory stimulation was found to be positive at less than 1 volt at all levels with motor negative at 3 volts at all levels. Please see patient's chart for specific values.

A solution containing 3 mL 0.25% bupivacaine with 1 mL 40 mg of Depo-Medrol was created, and a 1 mL dose was administered at each site after negative aspiration for heme.

A conventional radiofrequency lesion was created at all levels using 80 degrees Celsius for 60 seconds.

The needles were removed with tips intact and bandages were applied.

The patient was brought to the recovery area and convalesced for approximately 30 minutes' time before being discharged to the care of a driver. I will see the patient back as detailed above.

Meaningful verbal communication was maintained at all times throughout the procedure.

Thank you for allowing me to participate in his care.

CC:
MICHAEL MCCAFFREY, MD

JR:8000007
D: 10/15/2008 07:56:02 T: 10/15/2008 08:26:43 DOCUMENT: 103717

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND MARKED
<Electronically signed by>

Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

copy: ROSENBERG, JASON C
ROSENBERG, JASON C

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MARKED <Electronically signed by.....>

Waccamaw Community Hospital

PAIN CENTER FOLLOW UP NOTE

Pt. Status: REG SDC

Rpt#: 1102-0209

PT DOB:

PATIENT: BAKER, BOBBYMEDICAL RECORD #:ADMITTING PHYSICIAN:ACCOUNT #:
W00001459746ATTENDING PHYSICIAN:
JASON C ROSENBERG

CHIEF COMPLAINT:

1. Job-related injury, May 5, 2008.
2. Back pain.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw pain management Center on 10/29/2008, for followup. I last saw him on 10/15/2008, and performed radiofrequency ablation of his right L3-S1 medial branch nerves. Overall, he is markedly reduced in his pain. His pain score is four out of ten on the visual analog scale on the right side. The remainder of his pain is coming from his left-sided back. He rates it is eight out of ten on the visual analog scale. He describes throbbing, shooting, burning, stabbing pain, which is present both day and night.

Upon further questioning, he has noticed a rash over the area that was treated. It has been present since the procedure.

REVIEW OF SYSTEMS:

Upon review of systems, he reports headaches, ringing in his ears, and the skin rash. All other systems were asked and were negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.7, blood pressure 151/84, pulse 61, respiratory rate 16. GENERAL: He is alert and oriented times four. Speech is clear. Language is normal. Attention and memory are normal. He ambulates with a slight antalgic gait. There is an area of erythema approximately five-inch square over his right lumbosacral region. There is tenderness to palpation over his left lumbar paraspinous region.

IMPRESSION:

Job-related injury, May 5, 2008, with resultant facet arthropathy.

PLAN:

A long discussion was had with Mr. Baker concerning his current situation. I am delighted he had excellent result from his right-sided radiofrequency procedure. The procedure should last between six months and two years' time.

With regards to his rash, I suspect it could be related to the lidocaine, Marcaine, steroid or adhesive tape. I would like him to take Benadryl in an attempt to provide him relief from his symptoms.

I will see him back in clinic pending worker's compensation approval for left-sided diagnostic medial branch blocks leading to radiofrequency ablation if positive. I will use only Marcaine for the next procedure and we will use a paper tape during the trial.

Hopefully, this will alleviate the remainder of his pain on left side and lessen his period of disability.

Thank you for allowing me to participate in his care.

CC:

MICHAEL M. MCCAFFREY, MD

JR:5655198

D: 11/02/2008 12:04:33 T: 11/02/2008 15:13:52 DOCUMENT: 109408

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND MARKED
<Electronically signed by>

Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

copy:

JASON C ROSENBERG
ROSENBERG, JASON C

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MARKED <Electronically signed by.....>

PAIN CENTER PROCEDURE NOTE

Pt. Status: REG SDC

Rpt#: 1117-0110

PT DOB:

PATIENT: BAKER,BOBBY

MEDICAL RECORD #:

ATTENDING PHYSICIAN:
ROSENBERG,JASON C

ACCOUNT #:
W00001467301

PROCEDURE:

Left L3 through S1 diagnostic medial branch blocks under fluoroscopy with intravenous sedation.

INDICATIONS:

Job related injury 05/05/08 with resultant facet arthropathy.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw Pain Management Center on 11/17/08 for today's left-sided L3-S1 diagnostic medial branch blocks. He had excellent relief from his right-sided radiofrequency procedure. We would like to see if the remainder of his pain is coming from his left-sided facet joints by performing today's diagnostic medial branch blocks. If he has 50% or greater reduction of his symptoms lasting four or longer hours, he would indeed suffer from facet arthropathy, and would then be scheduled for radiofrequency ablation of the same nerves in attempt to provide him with six months to two years' worth of relief from his facet arthropathy.

Mr. Baker was itching after his last procedure. We will use Hibiclens instead of Betadine to see if this cuts down on his discomfort after the procedure.

SURGEON:

Jason Rosenberg, MD

ANESTHESIA:

Local.

DESCRIPTION OF PROCEDURE:

After the risks and benefits were explained to the patient, an informed consent was obtained. A peripheral IV was started. The patient was brought back to the fluoroscopic suite and placed in the prone position on the table.

The lumbosacral region was prepped and draped in a surgical, sterile fashion, using Hibiclens times three. The fluoroscopic C-arm was brought into anteroposterior view, and the left S1 neural foramen was brought to the center of the beam.

The skin overlying this area was anesthetized using 1% lidocaine via a 25-gauge needle. A 3.5-inch, 22-gauge needle was then advanced using intermittent fluoroscopic guidance, making bony contact superolateral to the left S1 neural foramen.

A lateral fluoroscopic view was obtained, revealing the needle tip posterior to the neural foramen at that level.

Our attention was then drawn to the L5 medial branch nerve, found at the intersection of the ala of the sacrum with the L5 vertebral body,

inferior to the left transverse process.

The skin overlying this area was anesthetized using 1% lidocaine, via a 25-gauge needle. A 3.5-inch, 22-gauge needle was then advanced, using intermittent fluoroscopic guidance, making bony contact at the ala of the sacrum.

A lateral fluoroscopic view revealed the needle tip posterior to the neural foramen at that level.

The L4 medial branch nerve was the following target. The L5 vertebral body was brought to the center of the beam, and the left pedicle was identified. The C-arm was brought to a 15-degree ipsilateral orientation, and the skin overlying the left L5 pedicle was anesthetized using 1% lidocaine.

A 3.5-inch, 22-gauge needle was then advanced using intermittent fluoroscopic guidance, making bony contact at the 11 o'clock position on the left L5 pedicle. A lateral view obtained revealed the needle tip in proper position, posterior to the neural foramen.

Finally, the L3 medial branch nerve was found on the L4 pedicle, with a 15-degree ipsilateral rotation of the C-arm. The skin overlying this pedicle was anesthetized using 1% lidocaine via a 25-gauge needle.

A 3.5-inch, 22-gauge needle was then advanced using intermittent fluoroscopic guidance, making bony contact at the 11 o'clock position on the L4 pedicle. A lateral fluoroscopic view revealed the needle tip posterior to the neural foramen.

Once all four needles were in place, a final anteroposterior view and lateral view was obtained, and placed in the patient's chart. All needle tips were in proper position, with the lateral view revealing all tips posterior to the neural foramina at all levels.

A solution containing 4 ml of 0.25% bupivacaine was divided among the four sites. There was negative aspiration for heme prior to injection.

Once all injections were completed, the needles were removed with tips intact. Bandages were applied.

Meaningful verbal communication was maintained throughout the entire procedure. The patient was brought back to the recovery area and convalesced for approximately 30 minutes' time, before being discharged in the care of a driver.

Thank you for allowing me to participate in his care.

CC:
MICHAEL MCCAFFREY, MD

JR:8000007

D: 11/17/2008 07:59:07 T: 11/17/2008 08:49:50 DOCUMENT: 114333

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND MARKED
<Electronically signed by>

Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

copy: ROSENBERG,JASON C
ROSENBERG,JASON C

MARKED <Electronically signed by.....> THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND

PAIN CENTER PROCEDURE NOTE

Pt. Status: REG SDC

Rpt#: 1118-0166

PT DOB:

PATIENT: BAKER, BOBBYMEDICAL RECORD #:ATTENDING PHYSICIAN:
ROSENBERG, JASON CACCOUNT #:
W00001467753PROCEDURE:

Radiofrequency ablation left L3-S1 medial branch nerves under fluoroscopy with intravenous sedation.

INDICATIONS:

1. Facet arthropathy.
2. Job related injury 05/05/08.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw Pain Management Center on 11/18/08. He underwent left-sided L3-S1 diagnostic medial branch blocks at last visit time. He once again developed a rash at the site of the injections. Lidocaine and Marcaine were used. We did not use Betadine thinking it was a Betadine allergy at last visit time after some discussion. He had a headache and itching and globally felt uncomfortable. He noticed some improvement with mobility in his back.

We discussed how best to proceed today. In light of the fact that he had great improvement on his right side after his radiofrequency procedure, and had some benefit with regards to his back pain, but overall felt worse on the left side, I would attribute this overall malaise to probable allergy to either lidocaine or Marcaine. This is very rare, but certainly is possible. Instead of presenting additional challenge for his medial branch blocks on the left side, I would like to perform the radiofrequency procedure. I will perform the procedure without lidocaine or Marcaine, and use diluted Depo-Medrol as an injectate in preparation for the radiofrequency lesion. We will rely heavily on his intravenous sedation for the procedure. Hopefully, this will provide him with six months to two years' worth of relief from his facet arthropathy. I will see him back in clinic in two weeks' time.

We discussed this with Mr. Baker and he is interested in proceeding.

SURGEON:

Jason Rosenberg, M.D.

DESCRIPTION OF PROCEDURE:

After the risks and benefits were explained to the patient, an informed consent was obtained. A peripheral intravenous was started. Noninvasive hemodynamic monitors were applied. The patient was brought back to the fluoroscopic suite and placed in the prone position on the procedure table. Please see anesthesia record for complete details of all medications administered as well as hemodynamic variables throughout the procedure.

A time-out was undertaken.

The patient's lumbar and sacral regions were prepped and draped in the surgical sterile fashion using Hibiclens times three. A fluoroscopic

C-arm was brought into ant: posterior orientation and the neural foramen was identified. No skin wheal was created. The skin overlying this area was anesthetized using 1% lidocaine via a 25-gauge needle. An SMK cannula with 5-mm active tip was advanced using intermittent fluoroscopic guidance making bony contact superolateral to the S1 neural foramen.

The left L5 medial branch nerve was found on the ala of the sacrum and the lateral border of the L5 vertebral body. The skin overlying this area was anesthetized in an identical fashion, and an SMK cannula was advanced making bony contact on the ala.

The L4 medial branch nerve was found over the L5 pedicle. The C-arm was adjusted 15 degrees ipsilaterally, and the skin overlying this pedicle was anesthetized. An SMK cannula was advanced making bony contact slightly lateral to the twelve o'clock position on the pedicle.

Finally, the L3 medial branch nerve was found over the L4 pedicle in an identical fashion.

A lateral view was obtained revealing all needle tips posterior to the neural foramina at all levels.

Sensory stimulation were not undertaken due to patient's deep sedation. We did, however, performed motor stimulation that was negative at 3.0 volts at all levels.

A solution containing 1 cubic centimeters of 40 mg of Depo-Medrol, 3 cubic centimeters preservative free normal saline was created, and a 1 mL dose was administered at each site after negative aspiration for heme.

A conventional radiofrequency lesion was created at all levels using 80 degrees Celsius for 60 seconds.

The needles were removed with tips intact and bandages were applied.

The patient was brought to the recovery area and convalesced for approximately 30 minutes' time before being discharged to the care of a driver. I will see the patient back as detailed above.

Meaningful verbal communication was maintained at all times throughout the procedure.

Thank you for allowing me to participate in his care.

CC:
MICHAEL MCCAFFREY, MD

JR:8000007

D: 11/18/2008 09:11:27 T: 11/18/2008 12:02:03 DOCUMENT: 114807

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND MARKED
<Electronically signed by>

Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

copy: ROSENBERG,JASON C
ROSENBERG,JASON C

MARKED <Electronically signed by.....> THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND

Waccamaw Community Hospital

PAIN CENTER FOLLOW UP NOTE

Pt. Status: REG SDC

Rpt#: 1201-0148

PT DOB:

PATIENT: BAKER, BOBBYMEDICAL RECORD #:ADMITTING PHYSICIAN:ACCOUNT #:
W00001468083ATTENDING PHYSICIAN:
JASON C ROSENBERG

CHIEF COMPLAINT:

1. Job-related injury 05/05/08.
2. Low back pain secondary to above.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw Pain Management Center on 12/01/08 for followup. I last saw him on 11/18/08 and performed radiofrequency ablation of his left L3-S1 medial branch nerves after successful diagnostic medial branch blocks. Prior to that, we performed radiofrequency ablation of his right L3-S1 medial branch nerves.

Overall, he is markedly improved. He has no pain when he is inactive. Once he starts moving, he will have pain, which is as high as seven out of ten on the visual analog scale. His sharp pains, however, have decreased.

Mr. Baker developed a rash at the needle sites with his medial branch blocks. At the time of the radiofrequency procedure, we used Hibiclens as well as no lidocaine, only Marcaine. Once again he developed a rash at the site of the needles.

REVIEW OF SYSTEMS:

Upon review of systems, his rash has abated. He has itching and was taking liquid Benadryl, which again has since abated. He reports fatigue, heartburn, dizziness, headaches, ringing in his ears, swelling, and constipation. All other systems were asked and were negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.3, blood pressure 134/91, pulse 60, respiratory rate 20. GENERAL: He is alert and oriented x 4. Speech is clear. Language is normal. Attention and memory are normal. He ambulates with a slight antalgic gait and uses a cane. There is tenderness to palpation in his thoracolumbar junction. There is no tenderness to palpation over his lower lumbar region or over his gluteal region.

IMPRESSION:

1. Job-related injury 05/05/08 with resultant low back pain.
2. Facet arthropathy.
3. Skin rash with injections.

PLAN:

A long discussion was held with Mr. Baker concerning his current situation. I am delighted he had excellent results from his radiofrequency procedure. He is now hurting in the area higher than previously treated.

I would like to see if the pain is coming from his T12-L3 medial branch nerves by performing diagnostic medial branch blocks bilaterally at T12-L3. If he has 50% or greater reduction of his symptoms lasting four or longer hours, he would be scheduled for the radiofrequency ablation in this region as well.

Prior to starting the additional route of medial branch blocks and radiofrequency ablation, I would like him to see an allergist to determine the cause of his rash. The last procedures were performed with Hibiclens, Marcaine, and Depo-Medrol.

Thank you for allowing me to participate in his care.

CC:
MICHAEL MCCAFFREY, MD

JR:8000007
D: 12/01/2008 08:59:19 T: 12/01/2008 09:25:06 DOCUMENT: 118810

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND MARKED
<Electronically signed by>

Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

copy:
JASON C ROSENBERG
ROSENBERG, JASON C

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Waccamaw Community Hospital

PAIN CENTER FOLLOW UP NOTE

Pt. Status: REG SDC

Rpt#: 0409-0121

PT DOB:

PATIENT: BAKER, BOBBYMEDICAL RECORD #:ADMITTING PHYSICIAN:ACCOUNT #:
W00001501485ATTENDING PHYSICIAN:
JASON C ROSENBERG

CHIEF COMPLAINT:

1. Job-related injury 05/05/08.
2. Back pain.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw Pain Management Center on 04/08/09. I last saw him 12/01/08. He completed radiofrequency ablation of his left L3-S1 medial branch nerves on November 18, 2008. Prior to that, he had radiofrequency ablation of his right L3-S1 medial branch nerves on October 15, 2008.

His low back has greatly improved. He continues to have pain in the middle of his back and upper back.

Mr. Baker developed a rash after his procedures. He is still waiting to see an allergist.

Mr. Baker informs me there is controversy as to whether workers compensation versus private insurance will cover the visit to the allergist. The problem on the allergist's side is the allergist will not accept workers compensation as a form insurance.

Mr. Baker is here today complaining of pain, which is six out of ten on the visual analog scale. It is throbbing, shooting, stabbing, tender, sharp, and constant both day and night and it is unbearable at times.

REVIEW OF SYSTEMS:

Upon review of systems, he reports headaches, ringing in his ears, swelling and constipation, and skin rash across his low back. All other systems were asked and were negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.5, blood pressure is 147/94, pulse 62, respiratory rate 16. GENERAL: He is alert and oriented x 4. Speech is clear. Language is normal. He ambulates with a cane. There is no evidence of rash when looking on his trunk today. The remainder of his neurologic examination is unchanged.

IMPRESSION:

1. Job related injury 05/05/08.
2. Facet arthropathy secondary to above.
3. Unexplained rash after procedures.

PLAN:

A long discussion was had with Mr. Baker concerning his current situation. I once again would implore him to meet with one of the allergist to determine what is causing his rash. His last procedure

was performed with Hibicle, Marcaine and Depo-Medrol.

To determine the cause of his rash, I would continue by performing bilateral T12-L3 diagnostic medial branch blocks leading to radiofrequency ablation if positive. We can discuss this in the future.

Thank you for allowing me to participate in his care.

CC:

MICHAEL MCCAFFREY, MD

JODY HUTSON, MD

AYNOR, SC

JR:8000007

D: 04/09/2009 08:06:52 T: 04/09/2009 09:01:57 DOCUMENT: 161392

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND MARKED
<Electronically signed by>

Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

copy:

JASON C ROSENBERG

ROSENBERG, JASON C

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MARKED <Electronically signed by.....>

Waccamaw Community Hospital

PAIN CENTER PROCEDURE NOTE

Pt. Status: REG SDC

Rpt#: 0722-0135

PT DOB:

PATIENT: BAKER, BOBBYMEDICAL RECORD #:ATTENDING PHYSICIAN:
ROSENBERG, JASON CACCOUNT #:
W00001528638

PROCEDURE:

Right T12, right L1, right L2, and right L3 diagnostic medial branch blocks under fluoroscopy with intravenous sedation using lidocaine.

INDICATIONS:

1. Job related injury on 05/05/08.
2. Facet arthropathy secondary to above.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw Pain Management Center on 07/22/09 for today's procedure. He has been cleared by an allergist to have the procedure using lidocaine as well as Depo Medrol as needed for the radiofrequency procedure as he is not allergic to these medications.

If Mr. Baker has 75% or greater reduction in his symptoms lasting two or longer hours, he would indeed suffer from facet arthropathy in the above regions and will be scheduled for radiofrequency ablation of the same nerves in attempt to provide him with six months to two years' worth of relief from his facet arthropathy.

DESCRIPTION OF PROCEDURE:

After the risks and benefits were explained to the patient, an informed consent was obtained. A peripheral IV was started. The patient was administered 6 milligrams of Versed for the procedure to serve as sedation. He is placed in the prone position on the Jackson table and his thoracic and lumbar regions were prepped and draped in surgical sterile fashion using Hibiclens x 3 as he is allergic to Betadine. A fluoroscopic C arm was brought to AP orientation, and the patient's right T12 pedicle was identified. The skin overlying the pedicle was anesthetized using 1% lidocaine via 25 gauge 1 1/2 inch needle. A 3 1/2-inch 22 gauge needle was advanced using intermittent fluoroscopic guidance making bony contact at the 2 o'clock position on the pedicle. AP and lateral images revealed the needle tip in proper position. 1 cubic centimeter of 1% lidocaine was injected after negative aspiration for heme. The needles were removed with tip intact and a bandage was applied.

This procedure was repeated in identical fashion for the right L1, right L2, and right L3 pedicles. After the procedure, the patient was brought to the recovery area and convalesced approximately 30 minutes' time before being discharged to the care of a driver. I will see him back in clinic as described above.

Thank you for allowing me to participate in his care.

CC:

MICHAEL MCCAFFREY, MD

JODY HUTSON, MD

AYNOR, SC

JR:8000007

D: 07/22/2009 09:49:07 T: 07/22/2009 10:31:37 DOCUMENT: 197033

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<Electronically signed by>

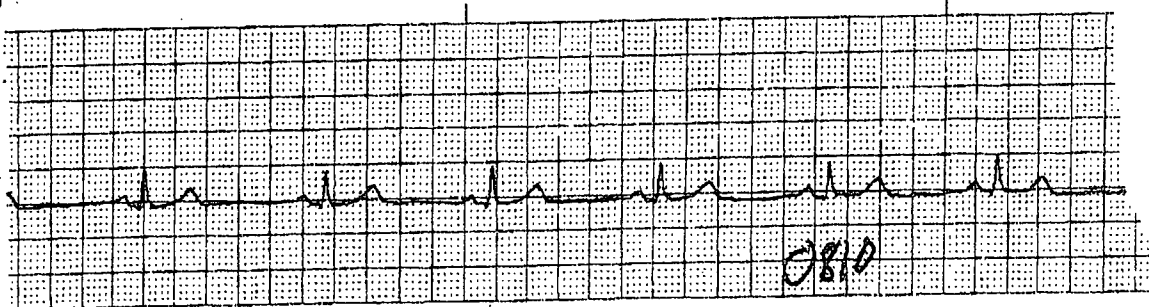
Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

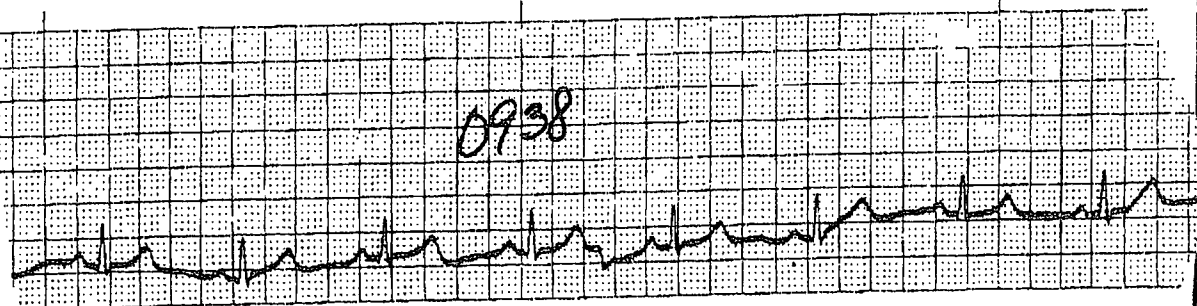
copy: ROSENBERG, JASON C
ROSENBERG, JASON C

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MARKED <Electronically signed by.....>

Pre Procedure



Procedure



(S(MIA)

22 Jul 09 9:48

PROCEDURE RM

Vital Signs Table

Group: VITAL SIGNS

	22 Jul	9:25	9:30	9:35	9:40	9:45
IR					71	67
Pulse					63	67
SpO2					96	94
Perf					3.6	5.8
HBP					135	135
HBPd					79	103
HBPm					93	108
RR					21	20

W00001528638 H000195964

BACHER, BOBBY

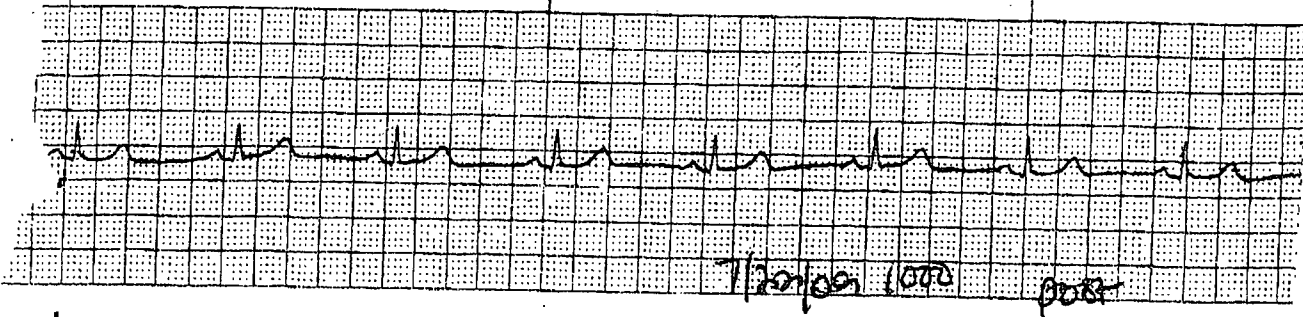
DOB: Age: 51 Sex: M

ROSENBERG, JASON C

ADM Date: 07/22/09



Post Procedure



(91MIA)
22 Jul 09 18:32

ROOM 5

Vital Signs Table
Group: VITAL SIGNS

	22 Jul	18:18	18:15	18:20	18:25	18:30
HR	65	-?-	-?-	64	53	
Pulse	764	65	62	762	54	
SpO2	797	95	94	798	99	
Perf	21.4	1.9	0.5	20.2	0.18	
NBP _s	155	-?-	149	146	131	139
NBP _d	93	-?-	93	81	85	76
NBP _m	108	108	107	98	95	91
RR	19	-?-	-?-	15	16	

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W00001528638 H000193964
BAKER, BORRY
DOB: Age: 51 Sex: M
ROSENBERG, JASON C
ADM Date: 07/22/09



Pain Management Center

00001928638 0000195964
 NAME: BOBBY
 DOB: Age: 51 Sex: M
 ROSENBERG, JASON C
 ADM Date: 07/22/09


P85

Date & Time	Physician's Medication Order's and Sign	
	Bupivacaine ml	0.25 0.50 Epidural Intra-articular Deep Tissue
	Depomedrol ml	40 mg 80 mg Intra-articular Deep Tissue
	Dexamethasone Sodium Phosphate	10mg
	Omnipaque ml	Intra-articular Deep Tissue
7/22/09 0930	Lidocaine 1% 20 ml 2% ml	Epidural Intra-articular Deep Tissue Locality <i>per Dr. Rosenberg</i>
7/22/09 08:10	Saline Lock with normal saline flush - 22 RFA i/c/o VORB Dr. Rosenberg / [Signature]	
	Normal Saline Solution IV @ KVO Total Amount Infused ml	
7/22/09 0936	Versed 6 mg (IVP) @ 0938 Wasted Amount mg	VORB Dr. Rosenberg / [Signature]
	Fentanyl mcg (IVP) @ Wasted Amount mcg	
	Ancef 1g/IVP	
	Azithromycin 500mg/IVPB	
	Toradol mg IM	
	Hyalagan mg (Intra-articular) Lot # Expiration Date	
	Synvisio mg (Intra-articular) Lot # Expiration Date	
	Botox 100u vials Lot # Expiration Date	
	Normal saline 20 ml vial	

Physicians Signature:

Allergies: *Codeine, Penicillin*

07-22-2009 09:49

Waccamaw Community Hospital

PAIN CENTER FOLLOW UP NOTE

Pt. Status: REG SDC

Rpt#: 0806-0203

PT DOB:

PATIENT: BAKER, BOBBYMEDICAL RECORD #:ADMITTING PHYSICIAN:ACCOUNT #:
W00001529212ATTENDING PHYSICIAN:
JASON C ROSENBERG

CHIEF COMPLAINT:

1. Job related injury 5/5/2008.
2. Back pain.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw Pain Management Center on 7/29/2009 with continued complaints of pain in his back. He underwent diagnostic medial nerve branch blocks on the right side at T12-L3 at last visit time.

Unfortunately, he was unable to determine the efficacy of the procedures. He went home and went to sleep. We were expecting a 75 percent reduction in his symptoms lasting up to four hours. We know that when he left the clinic, his pain went from six out of ten before the procedure, zero out of ten after the procedure, as we did not get a true determination of his response to the procedure. We do not know the efficacy of the procedure.

Mr. Baker continues to have pain in his low back. It is worse on the right side, it is at the thoracolumbar junction. It is six out of ten on the visual analog scale, it is stabbing in character. He has some relief when he takes his Dilaudid. His pain is intensifying with walking and sitting.

REVIEW OF SYSTEMS:

Upon review of systems, he denies any new numbness, any new weakness, any new rashes, lumps, or bumps. He denies any difficulty with bowel or bladder control. All other systems were asked and were negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 98.1, blood pressure is 137/93, pulse 52 respiratory rate 17. GENERAL: He is alert and oriented x4. Speech is clear. Language is normal. Attention and memory normal. He ambulates with a slight antalgic gait. He uses a cane to walk. There is tenderness to palpation over his right lumbar and thoracic paraspinal musculature.

IMPRESSION:

1. Job-related injury.
2. Facet arthropathy secondary to above.

PLAN:

I would like to repeat his right T12-L3 diagnostic medial branch blocks. I would recommend performing it without intravenous sedation

and make sure he stays awake up to four hours after the procedure.

If successful, I would proceed with the radiofrequency procedure. Conversely, if he has no relief, I would consider repeating radiofrequency ablation of his right L3-S1 medial branch nerves.

Thank you for allowing me to participate in his care.

CC:

MICHAEL M. MCCAFFREY, MD

JODY W. HUTSON, DO, AYNOR, SOUTH CAROLINA

JR:2

D: 08/06/2009 12:01:35 T: 08/06/2009 14:52:21 DOCUMENT: 202453

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<Electronically signed by>

Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

copy:

JASON C ROSENBERG
ROSENBERG, JASON C

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MARKED <Electronically signed by.....>

Waccamaw Community Hospital 4070 Highway 17 Bypass Murrells Inlet SC 295			
Service Date: 07/22/09 Service Time: 0736 Account Type: C	Physician Completed: _____ Nurse Completed: _____	EMR Number: 0179743 Unit Number: H000195944 Account Number: W00001528638	
Patient's Name: BAKER, BOBBY Patient's Address: _____	Birthdate: _____ Race: CA Sex: M Soc Sec #: _____	Age: 51 Last Inpatient Visit Date: _____ Last Outpatient Visit Date: 07/22/09	
Patient's Home Phone: _____ Patient's Local Phone: _____	ER Physician: _____ Attending Physician: ROSENBERG, JASON C Family Physician: MCCAFFREY, MICHAEL		
Reason For Visit: T12 L3 NBB			
Vital Signs: T _____ P _____ R _____ BP _____			
Time Seen By _____ Physician: _____			
PHYSICIAN'S REPORT			
ORDERS/TREATMENT LABS: ASG _____ X-RAYS: _____ CBC _____ CXR _____ CBC W/ DIFF _____ P-CXR _____ BMP _____ C-SPINE _____ CMP _____ KUB _____ AMYLASE/LIPASE ABD (FlatUp) _____ BLOOD CULTURES PELVIS _____ 1 OR 2 CT _____ HCG _____ PT/PTT _____ OTHER: _____ UA/U-C&S _____ GLUCOSE _____ EKG _____ LYTES _____ AEROSOL _____ HEART PROFILE TV _____ MONITOR: _____ CARDIAC _____ ULTRASOUND _____ B/P _____ EST/NIP. STIM/OCT _____ PULSE CX. _____ OBSERVE _____			
DIAGNOSIS			
Disposition of Patient: LWT _____ AMA _____ Treated And Discharged _____ Admitted _____ Room No. _____ Time Out _____ DOA _____ EXP _____ Transfer/Transport To Other Facility _____			
FOLLOW-UP INSTRUCTIONS: Waccamaw Community Hospital (843) 651-1000			
Instructions Given _____ Type _____		DATE: _____ I UNDERSTAND THESE INSTRUCTIONS	
		Patient or Responsible Party's Signature _____	
		Physician's Signature _____	
		Nurse's Signature _____	

*** MEDICAL RECORD ORIGINAL *** DO NOT REMOVE FROM CHART ***

NEXTSTEP PAIN MANAGEMENT
GEORGETOWN HOSPITAL SYSTEM
GEORGETOWN
MEMORIAL HOSPITAL
WACCAMAW
COMMUNITY HOSPITAL

WACCAMAW MEDICAL PARK
SUITE 108, HIGHWAY 17 BYPASS
MURRELLS INLET, SC 29576
(843) 652-0200

GEORGETOWN PAIN MANAGEMENT CENTER
219 CHURCH STREET
GEORGETOWN, SC 29440
(843) 545-5927

W00001528638 R000198964

BAKER, BOBBY

DOS: Age: 51 Sex: M

ROSENBERG, JASON C

ADM Date: 07/22/09



Pain Management Procedure Form

Short-Stay Record (Length of Stay 48 Hours or Less)

Referring Physician:	History / Reason for Admission:
Adverse Reactions to Medications? No ☐ Yes ☐ Specify _____ Allergies (other than medications) No ☐ Yes ☐ Specify _____ Rash, Wheezing? (other than medications) Current Medications? No ☐ Yes ☐ Specify _____ _____ _____ _____	Procedure: PT12 L3

Physical Examination

Temp	Pulse	Resp	BP	WT	HT	SaO2
Area	Norm	Abnormal	Explanation of Abnormal Findings			
General Appearance	/					
Head, Neck						
Ears, Nose, Throat						
Eyes						
Cardiovascular	/					
Lungs	/					
Breasts						
Abdomen	/					
Genitals/Rectum						
Extremities	/					
Skin						
Lymphatics						
Neurologic						
ADMITTING DIAGNOSIS			DISCHARGE DIAGNOSIS			
FA						
DATE		TIME	ATTENDING'S SIGNATURE			

07-22-2009 09:49



HP - PTSSR7701

Rev (10/08)

Pain Management Nursing Assessment

Date 7/22/09 Physician RosenbergProcedure (B) T2-L3 MBB

W00001528638 H000195964

BAKER, BOBBY

DOB: _____ Age: 61 Sex: M

ROSENBERG, JASON C

ADM Date: 07/22/09



PRE-SEDATION ANALGESIA ASSESSMENT/ PHYSICIAN'S ORDERS

Cardiovascular Status: Stable ☒ Unstable ☐ Admit for Procedure: _____

Level of consciousness: A&OX3 ☒

Respiratory / Airway: Normal ☒ Abnormal ☐

Saline Lock _____ or NS @KVO

IV Antibiotic _____

Physician's Signature _____

Plan for Anesthesia: None ☒ Local ☒ Moderate ☒

Time: _____

07-22-2009 09:49

PRE-PROCEDURE NURSING ASSESSMENT

Time 0805 Ride Home ☒ Recent Illness ☒

Pacemaker NO Blood Thinners NO

NPO p 7/24 ID Band ☒ Valuables Secured ☒

Current Medications Verified and Universal Medication Sheet Updated ☒

Med/History ☐ Hypertension ☐ Heart Disease ☐ DDD ☐ Depression ☐ Anxiety ☐ Renal Disease

☒ Gastric Reflux ☐ Sinus ☐ CHF ☐ Arthritis ☐ Diabetes ☐ SOB ☐ Stroke

Other USE Hibiclense

Allergies Codeine, betadine

Weight 192 Kg ☐ LMP ☐ Denies Pregnancy ☐ Menopause/Hysterectomy ☐

Alert/oriented ☒ Respirations Non-Labored ☒ Skin Warm/dry ☒

Color Normal ☒ Side Rails up ☒

Temp 97.4 BP 151/90 Pulse 61 Resp 14 O2 Sat 95%

Pre-Procedure Instructions: ☒ Pt Verbalized Understanding: ☒ Consent Signed ☒

PRE-OP PAIN ASSESSMENT

Response to Previous Procedure/Treatment 11/18/09 RF L4-L5 - reaction to it. Not very helpful

Pain on Admission 6 /10 Location of Pain low back

Duration of Pain: (hours, days, weeks, months, years) _____

Type of Pain: (Burns, throbs, sharp, stabbing, aching) _____

Numbness, Tingling tingling (worse on L)

Relieved by: (rest, heat, cold, medication) sitting

Intensified by: (activity, coughing) walking

Notes Radiates down both legs

Nurse Michelle Antrop

0 2 4 6 8 10

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Worst Possible

197033



HP - PTSSR7701

DO NOT WRITE IN THE MARGIN

W00001528638 H000158964
BOBBY Sex: M

W00001540
BAKER, BONNY
DOB: Age: 51 Sex: M
ROSENBERG, JASON C
ADM Date: 07/22/09

Procedure Assessment/Care	Time Out Verification
Correct Special Equipment <u>n/a</u>	Correct Patient ☒
Correct Implant <u>n/a</u>	Correct Consent ☒
Pt to Procedure room <u>0937</u>	Correct Procedure ☒
Safety Strap Applied <u>0937</u>	Correct Site and side ☒
Prepped/Draped <u>0938</u>	Correct Positioning ☒
Procedure began <u>0945</u>	Correct Antibiotics/IV Fluids <u>n/a</u>
Procedure complete <u>0949</u>	Correct Image ☒
C-arm Time <u>17 seconds</u>	Correct Safety Precautions ☒
Vitals Stable During Procedure <u>yes</u>	Nurse <u>Diane Warden</u>
Returned to Floor/Report Given to <u>Melissa</u> <u>0955</u>	Notes

POST-OPERATIVE ASSESSMENT

See Monitor/VS Flow sheet 14980, 59, 12, 9301/2
Alert/Oriented ☒ Skin warm dry ☒ Color/normal ☒ Voiding encouraged
Resp. Non-labored ☒ EKG unchanged ☒ PO fluids ☒ Family notified ☒
Nurse: M. Paulsen, R

PATIENT DISCHARGE

Pain Score 0 / 10 Location of pain 0
 Numbness/tingling 0
 Type of pain (sharp, dull, stabbing, aching, throbbing) 0
 Saline Lock / IV Fluid discontinued Site Swollen or edema in a 4cc cannula in back
 Understanding of discharge instructions verbalized Strong understanding
 Written discharge instructions given to patient/significant other
 Mode of transportation: Ambulatory WC Stretcher ✓
 Disposition: Home ✓ Other Accompanied by: wife
 Assisted to car by nurse: Reboul, R Discharge Time: 1035

Notes:



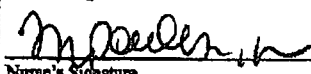
HP - PTSSR7701

W0000-628638 H000185964
 BAKER, BOBBY
 DOB: Age: 51 Sex: M
 ROSENBERG, JAMES C
 ADM Date: 07/22/09

Directions for scale: Score must be documented initially at least every 15 minutes until a score of 10 is reached. A score less than 10 will need the Sedation / Analgesia Discharge Section filled out by the Physician.

POST SEDATION / ANALGESIA RECOVERY SCORE		Initials	Time	Time	Time	Time
Activity		MP	0955			
Moves 4 Limbs Voluntarily on Command	+2		+2			
Moves 2 Limbs Voluntarily on Command	+1					
Moves 0 Limbs Voluntarily on Command	0					
Respiration						
Deep Breath and Cough Freely	+2		+2			
Shallow Breathing, Dyspnea, Splinting	+1					
Apnea (No Spontaneous Respiratory Effort)	0					
Circulation						
B/P + 20 % Pre Sedation / Analgesia Level	+2		+2			
B/P + 20 - 50 % Pre Sedation / Analgesia Level	+1					
B/P + 50 % Pre Sedation / Analgesia Level	0					
Level of Consciousness						
Fully Awake	+4		+4			
Sedated, But Follows Commands	+3					
Somnolent, But Arousable	+2					
Responds Only to Painful Stimuli	+1					
Obtunded	0					
O2 Saturation						
O2 Sat > 90% on Room Air	+2		+2			
Needs O2 Inhalation to Maintain O2 Sat > 90 %	+1					
O2 Sat < 90% even with O2 Supplement	0					
Total Score			(+12)			

DO NOT WRITE IN THE MARGIN

Discharge Criteria Met  Nurse's Signature	Discharge Criteria Not Met Nurse's Signature _____ Physician Notified _____ Physician's Name _____ Sedation / Analgesia Discharge Satisfactory Heart ☐ _____ Lungs ☐ _____ A/O X3 ☐ _____ Follow -Up Needed: ☐ Yes ☐ No Physician's Signature _____

LEVEL OF CONSCIOUSNESS		*** LOC MUST BE DOCUMENTED EVERY FIVE (5) MINUTES WITH VITAL SIGNS AND AFTER MEDICATION IS GIVEN.
FULLY AWAKE	+4	*** REGISTERED NURSES MAY NOT ADMINISTER MAJOR SEDATIVES, HYPNOTICS, OPIOIDS, IF THE LEVEL OF CONSCIOUSNESS IS BELOW A LEVEL 2
SEDATED, BUT FOLLOWS COMMANDS	+3	
SOMNOLENT, BUT AROUSABLE	+2	
RESPONDS ONLY TO PAINFUL STIMULI	+1	
OBTUNDED	0	

DISCHARGE SUMMARY (If applicable include diet, meds, activity, condition or patient and follow-up)

Final Diagnosis: _____

Date: _____ Time: _____ Attending Physician's Signature: 

07-22-2009 09:49



HP - PTSSR7701

Waccamaw Community Hospital

PAIN CENTER PROCEDURE NOTE

Pt. Status: REG SDC

Rpt#: 0730-0297

PT DOB: (

PATIENT: BAKER, BOBBY
H000195964

MEDICAL RECORD #:

ATTENDING PHYSICIAN:
ROSENBERG, JASON C

ACCOUNT #:
W00001530965

PROCEDURE:

Right T12 through L3 diagnostic medial branch blocks under fluoroscopy.

INDICATION:

1. Thoracic facet arthropathy.
2. Job-related injury.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw Pain Management Center on 07/30/2009 for today's repeat diagnostic medial branch block test. I will forego IV sedation with today's procedure. I will see him back in clinic for radiofrequency ablation of the same nerves if he has 75% or greater reduction in his symptoms lasting four or longer hours.

SURGEON:

Jason Rosenberg, MD

DESCRIPTION OF PROCEDURE:

After the risks and benefits were explained to the patient, an informed consent was obtained. The patient was brought back to the fluoroscopic suite and placed in prone position on the procedure table. His thoracic and lumbar regions were prepped and draped in surgical sterile fashion using Hibiclens.

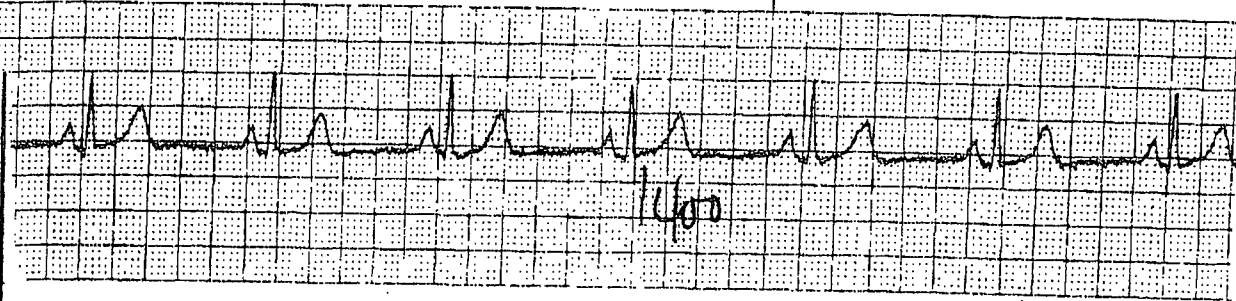
A fluoroscopic C-arm was brought in AP orientation, and the patient's right T12 pedicle was identified. The C-arm was adjusted approximately 5 degrees to the right. The skin overlying the pedicle was anesthetized using 1% lidocaine via 25-gauge 1 to 1-1/2-inch needle. A 3-1/2 inch 22-gauge needle was advanced using intermittent fluoroscopic guidance making bony contact at the 2 o'clock position on the pedicle. AP and lateral images revealed the needle tip in proper position. 1 milliliters of 0.25% bupivacaine was injected after negative aspiration for heme. The needle was removed with tip intact and the bandage was applied.

This procedure was repeated for the right L1, right L2, and right L3 medial branch nerves.

After the procedure, the patient was brought to the recovery area and convalesced approximately 30 minutes' time before being discharged to the care of a driver. I will see her back in clinic as described above.

Thank you for allowing me to participate in his care.

Post Procedure



(91MOA)

30 JUL 09 14:18

Vital Signs Table

	30 JUL	13:40	13:45	13:50	13:55	14:00	14:05	14:10	14:15
HR		62							
ST1							55	65	
PULSE		60					0.2	0.3	
NBP S		183					56	54	
NBP D		110				148		140	
NBP M		136				92		87	
		13:40				110		104	
SpO2		97				14:02		14:10	
RESP		14					94	91	
PERF		5.2					21	18	
							3.2	3.8	

[illegible]

W00001530965 H000195964

BAKER, BOBBY

DOB: Age: 51 Sex: M

ROSENBERG, JACOB C

ADM Date: 07/30/09



W00001530965 R00019596

BACHER, BOBBY

DOB: Age: 51 Sex: M

ROSENBERG, JASON C

ADM Date: 07/30/09



A member of the Georgetown Hospital Family

HOMEGOING INSTRUCTIONS

Activity: There is no restriction on activity following your block. **DO NOT** begin new strenuous activities immediately following your block, but continued any activities that you enjoyed before your block was performed.

Diet: You may eat or drink whatever you desire, except alcohol if you were sedated.

Medication: Continue taking your medications at the same time and the same dosage as before your block.

You may experience some soreness in your back where the needle was inserted. This may be relieved with an oral pain reliever such as Tylenol. Follow the directions on the medicine bottle.

~~If you were sedated for your procedure, do not drink alcohol, do not drive a vehicle, operate machinery or sign legal documents for 24 hours.~~

CALL THE PAIN THERAPY DOCTOR (843-652-0200 FROM 7:30 AM TILL 4:00 PM) OR (652-1000 AFTER HOURS) IF YOU HAVE ANY SIGNS OF INFECTIONS SUCH AS:

- Temperature above 100.4
- Redness at the site of the needle insertion
- Loss of sensation or numbness in your legs
- Loss of control of your bladder or bowels

IF YOUR PAIN CLINIC DOCTOR IS NOT AVAILABLE, GO TO THE EMERGENCY ROOM.

If you have any questions about your block, call the:

PAIN THERAPY CENTER (843-652-0200 FROM 7:30 AM - 4:00 PM)

IF YOU NEED TO SPEAK TO SOMEONE REGARDING YOUR PROCEDURE AT NIGHT OR ON THE WEEKEND: CALL 843-652-1000 and ask the hospital operator to page the personnel who is on-call for the Pain Therapy Center.

Your next appointment is See Card with Dr. Rosenberg

Instruction sheet given

If you are unable to have your block done on the date scheduled, please call the Pain Therapy Center 24 hours in advance, so your block can be rescheduled.

Patient or family member signature

J. Bobby Bacher

Nurse

M. Paulsen

W-7930 (4/28/06)

Pain Management Center M R

Date & Time	Physician's Medication Order's and Signature	Nurses Signature		
7/30/09	Bupivacaine _____ ml 0.25 0.50 Epidural Intra-articular Deep Tissue	} per Dr. Rosenberg noted J. Jankin		
	Depomedrol _____ ml		40 mg Intra-articular Deep Tissue	80 mg
	Dexamethasone Sodium Phosphate		10mg	
	Omnipaque _____ ml		Intra-articular Deep Tissue	
	Lidocaine 1% _____ ml 2% _____ ml		Epidural Intra-articular Deep Tissue Locally	
	Saline Lock with normal saline flush			
	Normal Saline Solution IV @ KVO			
	Total Amount Infused _____ ml			
	Versed _____ mg (IVP) @ Wasted Amount _____ mg			
	Fentanyl _____ mcg (IVP) @ Wasted Amount _____ mcg			
	Ancef 1g IVP			
	Azithromycin 500mg/ IVPB			
	Toradol _____ mg IM			
	Hyalagan _____ mg (Intra-articular) Lot # _____ Expiration Date _____			
	Synvisc _____ mg (Intra-articular) Lot # _____ Expiration Date _____			
	Botox 100u _____ vials Lot # _____ Expiration Date _____			
	Normal saline 20 ml vial			

07-30-2009 13:53

Physicians Signature: _____
 Allergies: Codeine, Betadine

W00001830965 N000195964
 ZAKER, BOBBY
 DOB: _____ Age: 51 Sex: M
 ROSENBERG, JASON C
 ADM Date: 07/30/09



Waccamaw Community Hospital
4070 Highway 17 Bypass Murrells Inlet SC 29

Service Date: 07/30/09
Service Time: 1311
Account Type: 0

Physician Completed: _____

EMR Number: 0179743
Unit Number: R000195964
Account Number: W00001530965

Patient's Name: BAKER, BOBBY
Patient's Address: _____

Birthdate: _____ Age: 51 Last Inpatient Visit Date: _____
Race: GA Sex: M Last Outpatient Visit Date: 07/30/09
Soc Sec #: _____

Patient's Home Phone: _____
Patient's Local Phone: _____

ER Physician: _____
Attending Physician: ROSENBERG, JASON C
Family Physician: MCCAFFREY, MICHAEL

Reason For Visit: FACET THORACIC

Vital Signs: T _____ P _____ R _____ BP _____

Time Seen By _____

PHYSICIAN'S REPORT

Physician: _____

ORDERS/TREATMENT

LABS:

ABG X-RAYS:

CBC CXR

CBC W/ DIFF P-CXR

BMP C-SPINE

CMP KUB

AMYLASE/LIPASE A&D (Flat&Up)

BLOOD CULTURES PELVIS

1 OR 2 CT _____

HCG

PT/PTT OTHER: _____

UA/U-C&S _____

GLUCOSE EKG

LYTES AEROSOL

HEART PROFILE IV _____

MONITOR: _____

CARDIAC ULTRASOUND

B/P NST/NIP STIM/OCT

PULSE OK. OBSERVE

DIAGNOSIS

Disposition of Patient: IAT _____ AMA _____ Treated And Discharged _____ Admitted _____ Room No. _____ Time Out _____
DOA _____ EXP _____ Transfer/Transport To Other Facility _____

FOLLOW-UP INSTRUCTIONS: Waccamaw Community Hospital
(843) 651-1000

DATE: _____

I UNDERSTAND THESE INSTRUCTIONS

Instructions Given _____ Type _____

Patient or Responsible Party's Signature

Physician's Signature

Nurse's Signature



*** MEDICAL RECORD ORIGINAL *** DO NOT REMOVE FROM CHART ***

NEXTSTEP PAIN MANAGEMENT
GEORGETOWN HOSPITAL SYSTEM
GEORGETOWN
MEMORIAL HOSPITAL
WACCAMAW
COMMUNITY HOSPITAL

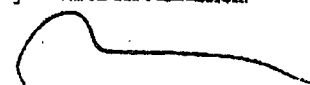
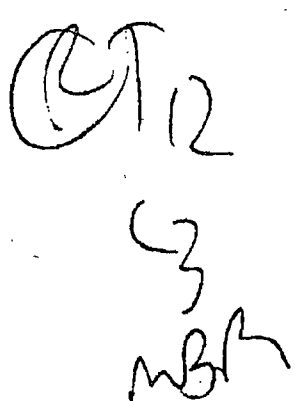
WACCAMAW MEDICAL PARK
SUITE 108, HIGHWAY 17 BYPASS
MURFIELLS INLET, SC 29576
(843) 652-0200

GEORGETOWN PAIN MANAGEMENT CENTER
219 CHURCH STREET
GEORGETOWN, SC 29440
(843) 645-5927

W00001530865 R000155964
BARKER, BOBBY
DOB: Age: 51 Sex: M
ROSENBERG, JASON C
ADM Date: 07/28/09

Pain Management Procedure Form

Short-Stay Record (Length of Stay 48 Hours or Less)

Referring Physician:	History / Reason for Admission:
Adverse Reactions to Medications? No ☐ Yes ☐ Specify _____ Allergies (other than medications) No ☐ Yes ☐ Specify _____ Rash, Wheezing? (other than medications) Current Medications? No ☐ Yes ☐ Specify _____ _____ _____ _____	Procedure:  

Physical Examination						
Temp	Pulse	Resp	BP	WT	HT	SaO2
Area	Norm	Abnormal	Explanation of Abnormal Findings			
General Appearance	/					
Head, Neck						
Ears, Nose, Throat						
Eyes						
Cardiovascular	/					
Lungs	/					
Breasts						
Abdomen	/					
Genitals/Rectum						
Extremities	/					
Skin						
Lymphatics						
Neurologic						
ADMITTING DIAGNOSIS			DISCHARGE DIAGNOSIS			
TIA						
DATE 07-30-2009 13:50			ATTENDING'S SIGNATURE			
						



HP - PTSSR7701

1

POST-OPERATIVE ASSESSMENT

PATIENT DISCHARGE

Notes:



D102

WOOD 130965 H000195964
 BAKER, ROBERT
 DOB: 98: 51 Sex: M
 BORN: JASON C
 ADM Date: 07/30/09

Directions for scale: Score must be documented initially at least every 15 minutes until a score of 10 is reached. A score less than 10 will need the Sedation / Analgesia Discharge Section filled out by the Physician.

POST SEDATION / ANALGESIA RECOVERY SCORE		Initials	Time	Time	Time	Time
Activity						
Moves 4 Limbs Voluntarily on Command	+2					
Moves 2 Limbs Voluntarily on Command	+1					
Moves 0 Limbs Voluntarily on Command	0					
Respiration						
Deep Breath and Cough Freely	+2					
Shallow Breathing, Dyspnea, Splinting	+1					
Apnea (No Spontaneous Respiratory Effort)	0					
Circulation						
B/P + 20 % Pre Sedation / Analgesia Level	+2					
B/P + 20 - 50 % Pre Sedation / Analgesia Level	+1					
B/P + 50 % Pre Sedation / Analgesia Level	0					
Level of Consciousness						
Fully Awake	+4					
Sedated, But Follows Commands	+3					
Somnolent, But Arousable	+2					
Responds Only to Painful Stimuli	+1					
Obtunded	0					
O2 Saturation						
O2 Sat > 90% on Room Air	+2					
Needs O2 Inhalation to Maintain O2 Sat > 90 %	+1					
O2 Sat < 90% even with O2 Supplement	0					
Total Score						

Discharge Criteria Met

[Signature]
 Nurse's Signature

Discharge Criteria Not Met

Nurse's Signature

Physician Notified

Physician's Name

Sedation / Analgesia Discharge

Satisfactory

Heart ☐Lungs ☐A/O X3 ☐Follow-Up Needed: ☐ Yes ☐ No

Physician's Signature

LEVEL OF CONSCIOUSNESS

FULLY AWAKE

+4

SEDATED, BUT FOLLOWS COMMANDS

+3

SOMNOLENT, BUT AROUSABLE

+2

RESPONDS ONLY TO PAINFUL STIMULI

+1

OBTUNDED

0

*** LOC MUST BE DOCUMENTED EVERY FIVE (5)

MINUTES WITH VITAL SIGNS AND AFTER

MEDICATION IS GIVEN.

*** REGISTERED NURSES MAY NOT ADMINISTER

MAJOR SEDATIVES, HYPNOTICS, OPIOIDS, IF THE

LEVEL OF CONSCIOUSNESS IS BELOW A LEVEL 2

DISCHARGE SUMMARY (If applicable include diet, meds, activity, condition or patient and follow-up)

Final Diagnosis:

Date:

Time:

Attending Physician's Signature:

07-30-2009 13:58

LD - DTSS87701

DO NOT WRITE IN THE MARGIN

Waccamaw Community Hospital

PAIN CENTER FOLLOW UP NOTE

Pt. Status: REG SDC

Rpt#: 0805-0300

PT DOB:

PATIENT: BAKER, BOBBYMEDICAL RECORD #:ADMITTING PHYSICIAN:ACCOUNT #:
W00001531429ATTENDING PHYSICIAN:
JASON C ROSENBERG

CHIEF COMPLAINT:

1. Back pain.
2. Date of injury 05/05/2008.

HISTORY OF PRESENT ILLNESS:

Mr. Baker returns to Waccamaw Pain Management Center on 08/04/2009. He underwent diagnostic medial branch blocks in the right-sided T12 through L3 on 07/30/2009.

Unfortunately, he had no relief from the diagnostic medial branch blocks.

Several hours later, he complained of a choking-type sensation. He did not seek medical attention but felt his "throat was closing over."

Mr. Baker continues to have pain in his low back on his right side greater than left side. It is burning and stabbing. There is tingling sensation in his buttocks. It is relieved when he is lying down and better with activity.

REVIEW OF SYSTEMS:

Upon review of systems, he denies any fevers, chills, weight gain, weight loss, new numbness, new weakness, or any new difficulties with bowel or bladder control. He did have the episode of choking sensation in his throat, which is since resolved. All other systems were asked and were negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.6, blood pressure 146/89, pulse 62, and respiratory rate 20. MENTAL STATUS: He is alert and oriented times four. Speech is clear. Language is normal. Attention and memory are normal. GAIT: He ambulates with a slight antalgic gait.

IMPRESSION:

1. Job-related injury.
2. Radiculopathy secondary to above.

PLAN:

A long discussion was held with Mr. Baker concerning his current situation. Unfortunately, he had no benefit after his repeat diagnostic medial branch blocks. As a result, he will not be a candidate for the radiofrequency procedure on the right side from T12 through L3.

We discussed spinal cord stimulation in great detail.

By implanting 1 or 2 leads in the thoracic epidural space, I can create a paresthesia encompassing the painful areas. The paresthesia is reportedly more pleasing than the sensation of pain.

If the patient wishes to proceed with further workup for a spinal cord stimulator implant, they will need to undergo a psychological evaluation. Once cleared, we would make arrangements to bring the patient back for a 1 or 2 lead trial. During the trial, the leads are placed percutaneously into the thoracic epidural space, and connected to an external generator. The device is trialed for up to 1 week. At the conclusion of the trial, the leads are removed. If the trial is successful, we would make arrangements several weeks later to go to the operative suite to implant the leads, as well as an internal rechargeable battery pack/generator. The device is ultimately controlled with a wireless remote control.

Mr. Baker will contact me after watching the video to see if he wished to proceed down this path. I think it is reasonable to see if he might improve from his chronic pain of his trunk and right lower extremity.

Thank you for allowing me to participate in his care.

CC:

MICHAEL M. MCCAFFREY, MD
JODY W. HUTSON, DO, AYNOR, SOUTH CAROLINA

JR:5655229

D: 08/05/2009 14:01:49 T: 08/05/2009 17:35:47 DOCUMENT: 202080

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND MARKED
<Electronically signed by>

Dictated by: JASON C ROSENBERG MD

<Electronically signed by JASON C ROSENBERG MD>

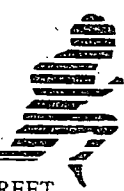
copy:

JASON C ROSENBERG
ROSENBERG, JASON C

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND
MARKED <Electronically signed by.....>

LOWE'S THERAPY

PHYSICAL THERAPY
OCCUPATIONAL THERAPY



507 W. CHEVES STREET
FLORENCE, S.C. 29501-4494
TELEPHONE 843-662-1234
FAX NO. 843-669-7144

May 18, 2009

Patient: Bobby Baker
DOB:

Impairment Rating

Bobby was seen on May 18, 2009 for a functional capacity evaluation followed by an impairment rating. The Guides to the Evaluation of Permanent Impairment, 5th Edition was used to estimate impairment. The estimates were for injuries he sustained while performing maintenance duties at the Hilton Hotel on May 5, 2008.

He has received pain management and appears to be at maximum medical healing. It was suggested in the functional capacity evaluation that he could benefit from a work conditioning program. His diagnosis is a lumbar facet arthropathy and an annular tear of the lumbar disc. His cervical pain has mostly subsided and is not rated at this time.

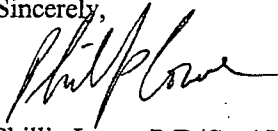
The lumbar estimates for impairment is best represented by the range of motion method of the guides. The instructions are found on page 402-403. Table 15-17 provides for a level 2-C which allows for a 7% whole person impairment due to the lumbar spine with the annular tear of his lumbar disc.

His impairment for loss of motion is found on page 407-409. He receives a 4% whole person impairment for loss of flexion and a 2% for a loss of extension. This totals a 6% whole person impairment.

The 7% whole person impairment for his diagnosis is combined with his 6% whole person impairment for loss of motion using the combined values chart on page 604 producing a 13% whole person impairment. The whole person impairment may be converted to a regional spine impairment using the range of motion method by dividing the 13% by .9 to equal a 14% impairment of the lumbosacral spine. The directions for this are found on page 427.

Should you have any questions, please do not hesitate to call. Thank you for the referral to Lowe's Physical Therapy.

Sincerely,

A handwritten signature in cursive script, appearing to read "Phillip Lowe".

Phillip Lowe, P.T./Certified Disability Examiner Level II

PL/ab

LOWE'S THERAPY

PHYSICAL THERAPY
OCCUPATIONAL THERAPY

507 W. CHEVES STREET
FLORENCE, S.C. 29501-4494
TELEPHONE 843-662-1234
FAX NO. 843-669-7144

Functional Capacity Evaluation

Examinee Information

Examinee: Bobby Baker

Date: May 18, 2009

Summary

The examinee was able to complete all test activities. Management of symptoms were controlled to an acceptable level. Overall, the examinee was consistent in effort. The optimal work capacity at present was demonstrated to be at a light physical demand level. Examinee did not demonstrate the necessary physical demands to perform usual and customary job duties as a maintenance man. The specific previous job tasks cannot be safely performed. Performance of the previous job would require modification of technique or equipment.

Examinee's activities of daily living are significantly affected. A determination if the employee is capable of returning to his previous job is based on information provided by the examinee. Potential for improvement of physical condition is unexpected. He may benefit from work conditioning.

Age: 51 **DOB:** **Sex:** M **Height:** 68" **Weight:** 193 lbs.

Occupation: Maintenance man **Employer:** Hilton Hotel for 4 years

Primary job duties: Standing: 90% Sitting: 10% Maximum lift: 50 lbs.
Multiple postures and use of tools. Lifting.

Date of injury: May 5, 2008 **Last date of work:** May 5, 2008

Medical history since injury: Pain management.

Medical records reviewed: Yes

Intake Interview

Diagnosis: Lumbar facet arthropathy, annular tear of lumbar disc and cervical pain.

Surgeries: Medial branch blocks and radio frequency ablation of right and left lumbar spine.

Special tests: Nerve conduction studies and MRI.

Past medical history: Examinee reports no previous injuries or medical conditions which would alter the outcome of the FCE. Inguinal hernia with no residual problems and fractured right hand- ORIF with no problems.

Education level: 10th grade

Economic situation: Workman's compensation

Job attitude: Examinee would like to return to his previous employer if physically able. Examinee believes his employer is interested in continuing employment.

Medication taken today: None

Chief complaint: Low back pain

Secondary problems: Tingling in bilateral legs and intermittent neck pain with increased activity.

Examinee Discomfort Rating: (Scale of 0 to 10)

Pretest: 6 **Post test:** 8

Resting BP: 160/99

Heart rate per minute: 72

Examinee complained of pain upon arrival from the 1 hour drive. He also had bilateral leg tingling. He arrived with a cane for ambulation. Testing was performed without the use of his cane.

Testing Protocol

The examination protocol used to determine examinee's capacity to perform work was the NADEP* protocol which is research-based out of Southern Illinois University. Scheduled components consist of intake screening, examinee profiling, physical range tolerance to specific work related postures, grip strength, materials handling and domain tests. Effort is made to stimulate work related activities when possible during testing.

*NADEP-National Association of Disability Evaluating Professionals, P.O. Box 35407, Richmond, Virginia, 23235-0407.

Patient Profiling

Examinee was asked to fill out 3 forms which describe his symptoms and changes in function since their injury. Poor correlation for the forms may indicate further psychological evaluation. The 3 forms are enclosed.

The first form asked the examinee to rate his ability to perform 18 sensory and physical activities on an 11 point performance scale with "10" indicating impossible to perform and "0" meaning no limitations, problems or changes in performance since the injury.

The subjective activity change form allows the examinee to narratively indicate changes in function since the injury and describe where and what type of pain they have. The third form completed is a pain drawing describing his symptoms. The three subjective reports did generally remain consistent and are included in this report. The subjective did accurately reflect the measured ability and are consistent with diagnosis.

The Ransford pain drawing[^] scores pain using a penalty point system. It is generally accepted that 2 points is considered the upper limit of normality. Therefore, any scores of 3 or greater could indicate poor psychometrics. The patient scored 0 points.

Non-organic Physical Signs by Waddell: (used to help identify patients with low back pain who requires a more detailed psychological assessment.)

The patient showed non-organic signs in 1 of the 5 categories tested. A score of 3 or greater indicates poor psychometrics.

- (1.) Distraction - Flip Test SLR - Positive.
- (2.) Simulation - Hip and Shoulder Rotation - Negative. Axial Loading - Negative.
- (3.) Tenderness - Superficial - Negative. Non-anatomic - Negative.
- (4.) Regional disturbances - Weakness - Negative. Sensory - Negative.
- (5.) Over reaction - Negative.

[^]Ransford AO, Cairns D. Mooney, The Pain Drawing as an Aide to the Psychological Evaluation of Patients with Low Back Pain; 1 (2): 1976.

Materials Handling- Maximum Effort Tests

Weights were gradually added until examinee could not complete the lift. Examinee's body mechanics were average.

VERTICAL HEIGHT	DEMONSTRATED	REASON FOR STOPPING
Floor to Knuckle	39 lbs	Low back/leg pain
12" to Knuckle	39 lbs	Low back pain
Waist to Shoulder	25 lbs	Low back pain
Shoulder to Overhead	26 lbs	Low back pain/neck burning
Pushing 15 Feet	48 lbs	Low back pain
Pulling 15 Feet	48 lbs	Low back pain
Carrying 15 Feet	36 lbs	Low back pain

Heart Rate Results

The examinee's heart rate was monitored during one or more of the maximum effort tests in order to determine if the examinee was performing at a maximal effort. Population studies* indicate that an appropriate elevation in heart rate should follow a maximum whole-body exertion. The table below shows pre and post exertion heart rates, the actual changes, and the expected minimum acceptable increase. If examinee demonstrated at least the minimum increase, a valid effort is reported.

Heart Rate Results	Measured Heart Rates			Comparison to Norms		
Task Name	Pre-	Post	Change	Expected increase	Minimum Acceptable Increase	Valid?
12" to Knuckle	72	100	28	17.5	7.4	yes

As an additional means of determining if the examinee gave a full and consistent effort, certain tests were repeated with examinee being asked to move 10 inches farther away from the object lifted. Population studies^ indicate that such a change should produce a 33% or greater decrease in strength when moving farther away. When the expected change of at least 33% is not observed it is reported by assigning a Fail status to indicate inconsistent performance.

Task Name	Force	Repeated Test	Force	Expected Decrease	Actual Decrease	Status
12" to Knuckle	39 lbs	10" farther	29 lbs	0.33	26%	Fail

* "Assessing Reliability of Performance in the Functional Capacity Assessment", Journal of Disability, Vol.3, No.1-4, July 93.

^ "Horizontal strength changes: An Ergonomic measure for Determining Validity of Effort in Impairment Evaluations", Journal of Disability, Vol.3, No.1-4, July 93.

A gross mobility course was designed to include the following activities and are rated as unable, restricted, or no restrictions.

Activity	Rating	Minutes	Activity	Rating	Minutes	Activity	Rating	Minutes
Stand	no restr.		Bend	restr.	1	Squat	restr.	1
Sit	restr.	60	Reach	no restr.		Kneel	no restr.	
Walk	restr.	7	Ladder	no restr.		Crawl	no restr.	
			Stairs	no restr.				

Examinee walked 7 minutes and stopped stating everything added up made him, "scared he would fall from pain."

Hand Strength Testing:

Isometric hand strength was evaluated in 5 positions using the Jamar Dynamometer. Position #2 is compared to population norms.^e

The examinee falls within the 50th percentile for the right hand and falls within the 75th percentile for the left. (Note: Right hand dominant subjects are assumed 10% stronger on the right while left hand dominant are assumed to have equal strength on both sides.~)

A greater than 14% coefficient of variance cannot be considered valid.^e

TEST RESULTS	AVERAGE FORCE		Coefficient of Variance		WEAKER HAND
	Right	Left	Right	Left	
Position 1	75.0	75.0	4.0%	12.7%	100%
Position 2	117.3	118.3	5.2%	6.5%	99%
Position 3	106.3	111.0	7.7%	0.9%	96%
Position 4	90.7	97.7	6.6%	12.8%	93%
Position 5	83.0	83.3	5.3%	9.2%	100%

Fine Motor Skills: The Purdue Pegboard was used to measure fine motor skills of each upper extremity. Results were compared to normative data. The examinee performed 12 tasks with right upper extremity and 12 with left upper extremity. Results are within normal limits for both upper extremities.

^e J.A.Preston Corp, 60 page Road, Clifton, New Jersey, 07012.

~ Virgil Mathiowetz, MS, OTR, et al; "Grip and Pinch Strength: Normative Data for Adults", OT Program Arch Phys Med Rehab 66:69-72, Feb 85.

* NIOSH., work practices Guide for manual lifting., US Dept HHS., Cincinnati, OH, 1981.

Spine Range of Motion

The following data was measured with inclinometers under protocols established by the AMA Guides.* True angles need to be within $\pm 10\%$ or 5 degrees. The straight leg raising angle on the tightest side should be within 15 degrees of total hip motion = sacral flexion + sacral extension. If it exceeds 15 degrees, the lumbosacral test is invalid. The validity test should not be used if the total sacral flexion plus extension exceeds 55 degrees for men and 65 degrees for women.

SPINE RANGE OF MOTION	TRIALS	BEST TRUE	LIMITED	VALID ?
SLR (R)	50			
SLR (L)	50			
Lumbar Flexion (T12)	50,50,50	30	Yes	Yes
Lumbar Flexion (sacral)	20,20,20			
Lumbar Extension (T12)	30,30,30	20	Yes	Yes
Lumbar Extension (sacral)	10,10,10			
Right Lateral (T12)	30,30,30	25	No	Yes
Right Lateral (sacral)	5,5,5			
Left Lateral (T12)	30,30,30	25	No	Yes
Left Lateral (sacral)	5,5,5			

Neurological Testing: (Lumbar Spine)

Sensation

Ant. thigh (L 1,2,3): Equal Medial leg (L4): Equal Heel (S2): Equal

Dorsum of Foot (L5): Equal Lateral mal (S1): Equal

Reflexes

Patellar (L4): 2+ bil. Achilles (S1): 2+ bil.

Strength

Iliopsoas (L2-3): 5/5 Quad (L3): 5/5 Heel walking (L4): 5/5

Ext Hal longus (L5): 5/5 Peroneals (L5, S1): 5/5 Tiptoes (S1, S2): 5/5

Palpation: Bilateral low back.

* AMA Guides to Permanent Impairment, 4th Edition; AMA, Chicago, Illinois: 1994. e NIOSH standard for validity.

Inconsistencies: 10 inch further test.

Recommendations

Gross Mobility	Avoid 0% of day	Occasional 1-33% of day	Frequent 34-66% of day	Constant 67-100% of day
Stand			X	
Sit			X	
Walk			X	
Bend		X		
Reach				X
Climb			X	
Squat		X		
Kneel			X	
Crawl		X		

Physical Demand Classification: (Maximum capacity at which patient can perform)

	Sedentary	Seden/ Light	<i>Light</i>	Light/ Medium	Medium	Medium/ Heavy	Heavy	Very Heavy
Occasional (1-33%)	10 lbs	15 lbs	20 lbs	35 lbs	50 lbs	75 lbs	100 lbs	>100 lbs
Frequent (34-66%)		8 lbs	10 lbs	15 lbs	25 lbs	35 lbs	50 lbs	>50 lbs
Constant (67-100%)				6 lbs	10 lbs	15 lbs	20 lbs	>20 lbs
	Sit	Sit/ Stand	Stand/ Walk	Stand/ Walk	Stand/ Walk	Stand/ Walk	Stand/ Walk	Stand/ Walk
METS	1.5	2.0	2.5	3.0	3.5	4.5	6.0	7.5-12.0

Should you have any questions regarding Bobby Baker or this test, please feel free to contact me.

Thank you for the referral to Lowe's Therapy.

Sincerely,

A handwritten signature in cursive script that reads "Phillip Lowe".

Phillip Lowe, P.T./Certified Disability Examiner II

PL/ab

**FUNCTIONAL CAPACITY EVALUATION**

NAME: Bobby Baker
 EMPLOYER: Hilton Hotels Corp
 DATE OF INJURY: 05/05/2008
 DATE OF EVALUATION: 5/10/2010
 DATE OF REPORT: 5/10/2010
 I.D. NO.:

REFERRED BY: Physician
 PHYSICIAN: Dr. Kang
 INSURANCE CARRIER: Intracorp
 INSURANCE REP: Branda Zitz
 INSURANCE I.D. NO.: YTEC01212
 DATE OF BIRTH:
 SEX: MALE
 SURGERY STATUS (Y/N) SURGERY DATE
 N

DIAGNOSIS
 1: LUMBAGO

VITAL SIGNS

HEIGHT: 68 inches WEIGHT: 173 lbs.
 RESTING HEART RATE: 61 bpm HAND DOMINANCE: RIGHT
 STARTING TIME: 5/10/2010 13:45:05 ENDING TIME: 17:10
 RESTING BLOOD PRESSURE: 142/82 (B/P) mm/Hg

PURPOSE OF ASSESSMENT:

FCE Type: Work Related; Return to work, any occupation

SUMMARY

The results of this evaluation indicate that Bobby Baker is functionally capable of work within the Light classification for an 8 hour work day according to U.S. Department of Labor Standards. Within the Light Physical demand level special considerations must be given in reaching/lifting to the floor level, carrying, crouching, and climbing ladders due to exacerbation of low back pain. The client demonstrated an ability to occasionally lift up to 15 lbs. floor to waist, 20 lbs. waist to shoulder, 15 lbs. floor to shoulder, 15 lbs. shoulder to overhead, occasionally carry up to 25 lbs., push 57.5 lbs. of force, and pull 60 lbs. of force. Mr. Baker was able to demonstrate constant levels of standing and sitting with occasional levels of walking. He demonstrated occasional levels of climbing stairs, stooping, kneeling, and crawling. Frequent levels of reaching overhead, reaching to the floor level, and balancing were performed. Along with these he was able to demonstrate constant levels of reaching forward, object handling, feeling, simple/firm hand grasp, and fine/gross manipulation. The client attempted but was unable to tolerate crouching and ladder climbing. Overall the client did demonstrate consistency of performance when both aware and unaware of observation with appropriate physiologic and biomechanical responses. He was consistent in 19 of 20 consistency tests. Increased respirations, heart rate, and facial grimacing along with a minimal amount of accessory muscle use were observed. He was inconsistent in floor to waist and overhead lifting in that he was able to achieve the same or greater amount of weight with the frequent trial when compared to the occasional trial. As a result an accurate performance in these was not likely assessed. Deficits identified in this evaluation included: Limited lumbosacral and hip range of motion and strength preventing crouching and climbing activities and limiting reaching and lifting to/from the ground level an material handling in general due to pain increase. Mr. Baker was able to complete testing with a peak observed heart rate of 81 beats per minute and no abnormal physiological responses

PHYSICAL DEMAND LEVEL**LIGHT**

Thank you for referring Bobby Baker to Select Physical Therapy. If you have any further questions regarding this evaluation, please do not hesitate to contact us.

Professionally,

Evaluator: Kevin Bullard
 Title: Physical Therapist, Center Manager

cc:

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FUNCTIONAL CAPACITY EVALUATION

Re: Bobby Baker

DOB: 0

INSURANCE I.D. NO.: YTE001212

PHYSICAL ABILITIES ASSESSMENT (PAA)

LIGHT

	Occasional (0 - 33%)	Frequent (33% - 66%)	Constant (66% - 100%)	Job Position	Comments
Material Handling :					
Lift - Floor to Waist	15	15	N/A lbs.		
Lift - Waist to Shoulder	20	15	N/A lbs.		
Lift - Floor to Shoulder	15	10	N/A lbs.		
Carry - Bimanual	25	5	N/A lbs.		
Push	57.5	40	N/A lbs.		
Pull	60	40	N/A lbs.		

Postural Tolerance :	Frequency	Job Position	Comments
Sit	Constant		
Stand	Constant		
Walk	Occasional		
Climb Stairs	Occasional		
Climb Ladders	Unable		
Reach Forward	Constant		
Reach Overhead	Frequent		
Reach Floor Level	Occasional		
Balance	Frequent		
Sit	Unable		
Kneel - Half Kneel	Occasional		
Crouch	Unable		
Crawl	Occasional		

Manipulative Ability:	Frequency	Job Position	Comments
Object Handling	Right: Constant Left: Constant		R/L:
Fingering	Right: N/A Left: N/A		R/L:
Simple Hand Grasp	Right: Constant Left: Constant		R/L:
Firm Hand Grasp	Right: Constant Left: Constant		R/L:
Fine/Gross Manipulation	Right: Constant Left: Constant		R/L:

Consistency Profile:	Consistent Test Performance
Maximal Voluntary Effort	Consistent 10 of 10 CV Scores < 15%; 2 of 2 of Bell Shapes Curve Distributions
Pinch Strength Testing	Consistent 4 of 6 CV Scores < 15%
Isometric Push / Pull	Consistent 2 of 2 CV Scores < 15%
Dynamic Lift Test	Consistent Expected Linear Heart Rate Increase
Observed Movement Patterns	Consistent
Waddell's Testing	Consistent The test is negative

Evaluator: Kevin Bullard
Title: Physical Therapist Center Manager

Date: 5/10/2010

Kevin Bullard, MPT
Evaluator Signature

Physician:
Title:

Date: 5/10/2010

[Signature]
Physician Signature

FUNCTIONAL CAPACITY EVALUATION

SELECT PT CT WAY

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Re: Bobby Baker

DOB:

INSURANCE I.D. NO.: YTEC01212

SUBJECTIVE HISTORY:

Bobby Baker is a 52 year old male with the current diagnosis of LUMBAGO, onset 05/05/2008. Bobby Baker reports that the injury occurred when a ceiling fell in on him while at work. He reports that this injured his back and head. Present symptoms include: low back pain with pain into the right greater than left leg. He reports that he has a lot of hip pain as well.

Current medication includes: Roxycodone, Neurontin, Ambien. He reports that he took the Roxycodone and Neurontin in the last 24 hours

Bobby Baker reports the following relevant past medical history: Hypertension.

Previous testing and treatment for this injury/illness (as reported by Bobby Baker) includes: MRI indicated multilevel degenerative changes of the lumbar spine. He reports that he has received multiple nerve blocks and Epidural injections. He reports that he has been told that he is a good candidate for a nerve stimulator. He states that he attempted PT but could not tolerate it.

Bobby Baker reported severe pain at an intensity of 8/10 (0 = no pain; 1,2,3 = low; 4,5,6 = moderate; 7,8,9 = severe; 10 = emergency pain). He reported that the pain ranges from 5/10 at best to 10/10 at its worst. He states that walking or riding aggravates his symptoms, and that resting and medications provides relief. Perceived abilities include: sitting 20 minutes, standing 30 minutes, walking 15 minutes, riding 30 minutes, lifting up to 20 lbs, and carrying 20 lbs.

Bobby Baker is independent with activities of daily living (ADLs) including: dressing, grooming, bathing, hygiene, cooking, laundry, etc. He reports that he attempted doing some yard raking but could only tolerate 5 minutes due to pain.

He describes a typical day as: sitting at home with occasional walking outside and helping get the horses watered with the water hose. He reports that he performs some light house hold tasks but very little. He reports that he walks around the yard for exercise for short bouts. Bobby Baker was driven to/from the FCE appointment today.

NA

VOCATIONAL/JOB HISTORY:

Bobby Baker is currently not working. Bobby Baker was employed as a mechanic and as a maintenance person for the Hilton Hotel. He reports that he attempted returning to work for a few days after the injury but that he was not able to tolerate this due to pain.

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FUNCTIONAL CAPACITY EVALUATION

Re: Bobby Baker

DOB:

INSURANCE ID. NO.: YTEC01212

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MUSCULOSKELETAL SCREENING SUMMARY

Gait: The patient ambulates with antalgic gait on the right and utilizes a straight cane in the right hand. He demonstrates increased step width and decreased stride length.

Posture: The patient demonstrates a forward flexed posture at the low back.

Soft Tissues: Point tenderness reported at bilateral SI joints and the L5-S1 region bilaterally but right more than left.

Flexibility: The patient is able to reach fully overhead bilaterally.

Range of Motion: Refer to Active Range of Motion / Strength Measurements Form. The patient demonstrated limited lumbosacral range of motion and hip range of motion with pain at end ranges.

Strength: Refer to Active Range of Motion / Strength Measurements Form. The patient is limited in all active lumbosacral and hip range of motion.

Neurological: All reflexive testing is 2+ with normal latency.

Additional Testing: NA

ENDURANCE / AEROBIC CAPACITY

Not Tested	Completed Test	Incomplete Test	Not Tested
Classification: N/A	m/kg/min	METS	
HR Increase: N/A	Respiration Increase: N/A	Blood Pressure: N/A	

Comments:

The patient was not stable enough upon observation to attempt treadmill walking so no sub-maximal treadmill testing was not performed.

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FUNCTIONAL CAPACITY EVALUATION

Re: Bobby Baker

DOB

SELECT PT C 141

PAGE 06

MATERIAL HANDLING

INSURANCE I.D. NO.

Waist to Shoulder Dynamic Lift Test

Occasional Lift	Heart Rate	RPL	RFT	Frequent	Lift	Heart Rate	RPL	RFT
20 lbs.	70 bpm	6	Max Lift	15 lbs.	70 bpm	5	Pain	YES
Start Heart Rate	60 bpm	HR Increase?	YES	Start Heart Rate	66 bpm	HR Increase?	YES	

Comments: The patient was able to perform waist to shoulder lifting with good mechanics. He attempted 25 lbs with the occasional trial but was not able to complete due to pain per report. The frequent trial was terminated by the patient due to indicating that he did not safe with greater weight.

Floor to Waist Dynamic Lift Test

Occasional Lift	Heart Rate	RPL	RFT	Frequent	Lift	Heart Rate	RPL	RFT
15 lbs.	73 bpm	5	Pain	15 lbs.	60 bpm	6	Pain	YES
Start Heart Rate	70 bpm	HR Increase?	YES	Start Heart Rate	57 bpm	HR Increase?	YES	

Comments: The patient demonstrated good mechanics with floor to waist with the exception of a slight increase in thoracic kyphosis at the lowest portion of the lift. He self terminated both floor to waist lifts due to reports of increased low back pain reaching 8/10.

Floor to Shoulder Dynamic Lift Test

Occasional Lift	Heart Rate	RPL	RFT	Frequent	Lift	Heart Rate	RPL	RFT
15 lbs.	74 bpm	7	Pain	10 lbs.	81 bpm	8	Pain	YES
Start Heart Rate	66 bpm	HR Increase?	YES	Start Heart Rate	67 bpm	HR Increase?	YES	

Comments: Floor to shoulder lifting was performed with good mechanics at the lumbosacral spine but with increased thoracic kyphosis noted at the bottom of the lift. He self terminated both trials due to reports of increased low back pain reaching 9/10. He also reported 9/10 interscapular pain in the mid thor.

Lift Capacity Performance:

Consistent

Carry Testing

Occasional Carry	Heart Rate	RPL	RFT	Frequent	Carry	Heart Rate	RPL	RFT
25 lbs. Bimanual	68 bpm	8	Pain	6 lbs.	85 bpm	2	Pain	YES
N/A lbs Right	N/A bpm	N/A		N/A lbs.	N/A bpm	N/A		
N/A lbs Left	N/A bpm	N/A		N/A lbs.	N/A bpm	N/A		
Start Heart Rate	63 bpm	HR Increase?	YES	Start Heart Rate	65 bpm	HR Increase?	YES	

Comments: The patient demonstrated an antalgic pattern on the right with all carrying tasks. He self terminated each task due to reports of pain in the low back reaching 8/10.

Push / Pull Testing

Occasional Push	Occasional Pull	Frequent Push/Pull	Heart Rate	RPL	RFT
57.5 lbs.	80 lbs.	40 lbs.	71 bpm	7	Pain
Peak Heart Rate: 70 bpm	Peak Heart Rate: 68 bpm	Start Heart Rate:	60 bpm	HR Increase?	YES

Comments: Occasional push/pull was assessed utilizing a isometric force gauge. Frequent push/pull was performed utilizing a weighted sled. The patient demonstrated an antalgic pattern on the right while pushing and pulling. The frequent trial was self terminated due to reports 9/10 increased low back pain.

Additional Testing

Occasional	Heart Rate	RPL	RFT	Frequent	Heart Rate	RPL	RFT
Shoulder to overhead	15 lbs.	67 bpm	5	Shoulder to overhead	15 lbs.	71 bpm	8
Start Heart Rate	60 bpm	Max Lift	HR Increase?	Start Heart Rate	63 bpm	HR Increase?	YES

Comments: The patient demonstrated good mechanics with shoulder to overhead lifting. The occasional trial was attempted with up to 20 lbs but was not able to be completed due to reports of increased low back pain. The frequent trial was self terminated due to reports of increased low back pain to 8-9/10.

* RPL - Rate of Perceived Load

* RFT - Reason For Termination

Post Material Handling Blood Pressure:

144/90
mmHg

FUNCTIONAL CAPACITY EVALUATION

Re: Bobby Baker

DOB:

INSURANCE I.D. NO.:

POSITIONAL TOLERANCE

	Frequency	Comments
Sitting	Constant	Positional Change Observed The patient achieved a constant level of sitting but frequently shifted his weight right to left and leaned forward or reclined to varying degrees due to reports of low back pain increasing with sitting. A peak hear rate of 62 beats per minute was observed in sitting.
Standing	Constant	Elevated pain level Standing was performed at a constant level with a peak hear rate of 87 beats per minute observed. The patient was noted to frequently lean on surrounding structures for support and reported increased pain during prolonged standing.
Walking	Occasional	Terminated due to pain complaint The patient ambulated for up to 14 minutes with a peak hear rate of 81 beats per minute. He demonstrated an antalgic pattern on the right greater than left. He began walking without an assistive device but after 9 minutes began to use a straight cane due to reports of increased low back pain.
Stair Climbing	Occasional	Terminated due to pain complaint The patient ambulated up/down steps with a step through gait pattern and hand hold assist. He self terminated stair climbing due to reports of increased low back, hip, and leg pain.
Climb Ladders	Unable	Attempted activity but unable to perform The patient attempted ladder climbing but was only able to perform up/down three steps for a single repetition before terminating due to reports of increased pain.
Reach Forward	Constant	No Deficit Observed
Reach Overhead	Frequent	Terminated due to pain complaint The patient performed the equivalent of 5 cycles of 5 repetitions of overhead reaching before terminating due to reports of increased low back pain.
Reach Floor Level	Occasional	No Deficit Observed
Balance	Frequent	Positional Change Observed The patient was able to maintain constant levels of standing but frequently used surrounding structures for balance and support resulting in only an occasional level single interval of balance.
Stoop	Unable	Terminated due to pain complaint The patient was only able to tolerate 3 stoops before self terminating stooping due to reports of increased low back pain.
Kneel - Half Kneel	Occasional	Terminated due to pain complaint
Crouch	Unable	Refuse to attempt activity or position The patient reported that he was sure he could not tolerate crouching and did not feel comfortable attempting due to elevated low back pain.
Crawl	Occasional	Terminated due to pain complaint The patient performed a single interval of crawling before self terminating due to increased low back pain
	N/A	N/A

MANIPULATIVE ABILITY

	Frequency	Comments
R Object Handling	Constant	No Deficit Observed
L Object Handling	Constant	No Deficit Observed
R Fingering	N/A	
L Fingering	N/A	
R Simple Hand Grasp	Constant	No Deficit Observed
L Simple Hand Grasp	Constant	No Deficit Observed
R Firm Hand Grasp	Constant	No Deficit Observed
L Firm Hand Grasp	Constant	No Deficit Observed
R Fine/Gross Manipulation	Constant	No Deficit Observed
L Fine/Gross Manipulation	Constant	No Deficit Observed

Observed Movement Patterns: Constant

Additional Positional and Postural Tolerance Comments:

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FUNCTIONAL CAPACITY EVALUATION

Re: Bobby Baker

DOB:

INSURANCE I.D. NO.:

POST TEST VITAL SIGNS:

Heart Rate: 60 bpm

Blood Pressure: 144/90 mmHg

POST TEST PAIN LEVEL

9/10

MUSCULOSKELETON SCREENING POST-TEST SUMMARY**Gait Analysis:**

Antalgic on the right with pain reported in the low back.

Posture Analysis:

The patient maintained an increased forward flexed posture during sitting and standing post test due to reports of increased low back pain.

Soft Tissue Assessment:

The patient reported that the point tenderness in his low back remained about the same after testing compared to pretest levels.

Flexibility:

The patient demonstrated increased sensitivity to knee extension in sitting upon completion of testing with pain reported in the low back and hip and on the right greater than left.

Range Of Motion:

The patient reported increased pain with all movements. A formal ROM was not performed post test due

Strength:

Consistent with pretest findings of limited hip strength in all planes of motion.

Neurological:

Not assessed post test due to the patient having difficulty relaxing due to reports of increased pain.

Additional Tests:

NA

ADDITIONAL INFORMATION

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FUNCTIONAL CAPACITY EVALUATION

Re: Bobby Baker

DOB:

INSURANCE I.D. NO.:

PERFORMANCE CONSISTENCY

Maximal Voluntary Effort

Grip Test

	1			2			3			4			5		
	45	50	60	100	104	100	104	109	94	83	87	80	60	50	70
Right Hand	Average			51.67			101.33			86.67			63.33		
Coefficient of Variation *	12%			2%			6%			6%			20%		
Left Hand	Average			53.67			76.67			75.67			63.33		
Coefficient of Variation *	13%			3%			3%			4%			7%		

10 of 10 CV Scores < 15% Consistent Test Performance

2 of 2 of Bell Shapes Curve Distributions

HR(s): 61,65

Comments:

Pinch Strength Testing

Pinch Test

	Tip Pinch			Palmar Pinch			Key Pinch		
	8	9	11	13	15	15	18	19	19
Right Hand	Average			9.33			14.33		
Coefficient of Variation *	13%			7%			3%		
Left Hand	Average			8.67			15.33		
Coefficient of Variation *	20%			16%			8%		

4 of 6 CV Scores < 15% Consistent Test Performance

HR(s): 56, 62

Comments:

Isometric Push / Pull

Test

Test	Heart Rate	Trials (Pounds of Force)			Average	Standard Deviation	Coefficient of Variation *
		Trial 1	Trial 2	Trial 3			
Isometric Push	70	57.5	57.5	55	58.67	1.18	2%
Isometric Pull	66	60	60	60	60.00	0.00	0%

2 of 2 CV Scores < 15% Consistent Test Performance

Comments:

Initial heart rate of 61 beats per minute noted.

Performance Consistency Summary: Consistent Test Performance

Additional Performance Consistency Testing

N/A

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FUNCTIONAL CAPACITY EVALUATION

Re: Bobby Baker

DOB:

INSURANCE I.D. NO:

ACTIVE RANGE OF MOTION / STRENGTH

SPINE		NORM	AROM (Degrees)	N/A	
Cervical	Flexion	50°	WNL		
	Extension	60°	WNL		
	Right Lateral Flexion	45°	WNL		
	Left Lateral Flexion	45°	WNL		
	Right Rotation	80°	WNL		
	Left Rotation	80°	WNL		
Thoracic	Flexion	60°	WNL		
	Right Rotation	30°	WNL		
	Left Rotation	30°	WNL		
Lumbar	Flexion	60°	20		
	Extension	25°	5		
	Right Lateral Flexion	25°	10		
	Left Lateral Flexion	25°	10		
	Right SLR	80°	35		
	Left SLR	80°	35		

UPPER EXTREMITY		NORM	Right AROM	Left AROM	Right Strength	Left Strength
Shoulder	Flexion	180°	WNL	WNL	5/5	5/5
	Extension	50°	WNL	WNL	5/5	5/5
	Abduction	180°	WNL	WNL	5/5	5/5
	Adduction	40°	WNL	WNL	5/5	5/5
	Internal Rotation	80°	WNL	WNL	5/5	5/5
	External Rotation	90°	WNL	WNL	5/5	5/5
Elbow	Flexion	140°	WNL	WNL	5/5	5/5
	Extension	0°	WNL	WNL	5/5	5/5
	Supination	80°	WNL	WNL	5/5	5/5
	Pronation	80°	WNL	WNL	5/5	5/5
Wrist	Flexion	80°	WNL	WNL	5/5	5/5
	Extension	70°	WNL	WNL	5/5	5/5
	Radial Deviation	20°	WNL	WNL	5/5	5/5
	Ulnar Deviation	30°	WNL	WNL	5/5	5/5

LOWER EXTREMITY		NORM	Right AROM	Left AROM	Right Strength	Left Strength
Hip	Flexion	120° **	45	60	3/5	3/5
	Extension	30° **	5	5	3/5	3/5
	Abduction	45° **	WNL	WNL	3/5	3/5
	Adduction	30° **	WNL	WNL	5/5	5/5
	Internal Rotation	45° **	20	20	4/5	4/5
	External Rotation	45° **	20	25	4/5	4/5
Knee	Flexion	135° **	WNL	WNL	5/5	5/5
	Extension	0° **	WNL	WNL	5/5	5/5
Ankle	Plantar Flexion	50° **	WNL	WNL	5/5	5/5
	Dorsiflexion	20° **	WNL	WNL	5/5	5/5
	Inversion	35° **	WNL	WNL	5/5	5/5
	Eversion	15° **	WNL	WNL	5/5	5/5

Normative Data - AMA Guides to the Evaluation of Permanent Impairment, 8th Edition* Normative Data - Rehabilitation of the Hand: Surgery and Therapy, 4th Edition** Normative Data - American Academy of Orthopedic Surgeons

FUNCTIONAL CAPACITY EVALUATION

Re: Bobby Baker

DOB

INSURANCE I.D. NO.

ACTIVE RANGE OF MOTION / STRENGTH (continued)

HAND		NORM *	Right AROM (Degrees)	Left AROM (Degrees)	Right Strength	Left Strength
Thumb	CMC Flexion	15°	WNL	WNL	5/5	5/5
	CMC Extension	20°	WNL	WNL	5/5	5/5
	CMC Abduction	70°	WNL	WNL	5/5	5/5
	MCP Flexion	50°	WNL	WNL	5/5	5/5
	MCP Extension	0°	WNL	WNL	5/5	5/5
	IP Flexion	80°	WNL	WNL	5/5	5/5
Index	IP Extension	0°	WNL	WNL	5/5	5/5
	MCP Flexion	90°	WNL	WNL	5/5	5/5
	MCP Extension	Up to 45°	WNL	WNL	5/5	5/5
	PIP Flexion	110°	WNL	WNL	5/5	5/5
	PIP Extension	0°	WNL	WNL	5/5	5/5
	DIP Flexion	80°	WNL	WNL	5/5	5/5
Long	DIP Extension	0°	WNL	WNL	5/5	5/5
	MCP Flexion	90°	WNL	WNL	5/5	5/5
	MCP Extension	Up to 45°	WNL	WNL	5/5	5/5
	PIP Flexion	110°	WNL	WNL	5/5	5/5
	PIP Extension	0°	WNL	WNL	5/5	5/5
	DIP Flexion	80°	WNL	WNL	5/5	5/5
Ring	DIP Extension	0°	WNL	WNL	5/5	5/5
	MCP Flexion	90°	WNL	WNL	5/5	5/5
	MCP Extension	Up to 45°	WNL	WNL	5/5	5/5
	PIP Flexion	110°	WNL	WNL	5/5	5/5
	PIP Extension	0°	WNL	WNL	5/5	5/5
	DIP Flexion	80°	WNL	WNL	5/5	5/5
Small	DIP Extension	0°	WNL	WNL	5/5	5/5
	MCP Flexion	90°	WNL	WNL	5/5	5/5
	MCP Extension	Up to 45°	WNL	WNL	5/5	5/5
	PIP Flexion	110°	WNL	WNL	5/5	5/5
	PIP Extension	0°	WNL	WNL	5/5	5/5
	DIP Flexion	80°	WNL	WNL	5/5	5/5
	DIP Extension	0°	WNL	WNL	5/5	5/5

Normative Data - American Academy of Orthopedic Surgeons, *Rehabilitation of the Hand: Surgery and Therapy, 4th Edition*

Hand Volume

	Right	Left
Pretest	n/a ml	n/a ml
Post Test	n/a ml	n/a ml
Difference	n/a ml	n/a ml

* *Rehabilitation of the Hand: Surgery and Therapy, 4th Edition*

- Fluid volume changes are often 30 to 50 ml or more between one measurement and the next if swelling is present.

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FUNCTIONAL CAPACITY EVALUATION

Re: Bobby Baker

DOB:

INSURANCE I.D. NO.:

ACTIVE RANGE OF MOTION / STRENGTH (continued)

Circumference		Right		Left	
n/a	Pretest	n/a cm	Pretest	n/a cm	N/A
	Post Test	n/a cm	Post Test	n/a cm	
	Difference	n/a cm	Difference	n/a cm	
n/a	*R (Pretest)	n/a cm	Pretest	n/a cm	
*R - Right	*R (Post Test)	n/a cm	Post Test	n/a cm	
	*R (Difference)	n/a cm	Difference	n/a cm	
n/a	Pretest	n/a cm	Pretest	n/a cm	
	Post Test	n/a cm	Post Test	n/a cm	
	Difference	n/a cm	Difference	n/a cm	

* Rehabilitation of the Hand: Survey and Therapy, 4th Edition - Circumference measurements of the hand and fingers or arcs of swelling.

Opposition	Right	Index - n/a	Long - n/a	Ring - n/a	Small - n/a
	Left	Index - n/a	Long - n/a	Ring - n/a	Small - n/a

* American Academy of Orthopedic Surgeons - Tip of thumb to base or tip of small digit

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FUNCTIONAL CAPACITY EVALUATION

Re: Bobby Baker

DOB:

INSURANCE I.D. NO.:

PHYSICAL DEMAND CATEGORY (U.S. Department of Labor, Dictionary of Occupational Titles)

- Sedentary** Exerting up to 10 lbs. of force occasionally (Occasionally: activity or condition exists up to 1/3 of the time) and/or a negligible amount of force frequently (Frequently: activity or condition exists from 1/3 to 2/3 of the time) to lift, carry, push, pull or otherwise move objects, including human body.
- Light** Exerting up to 20 lbs. of force occasionally, and/or up to 10 lbs. force frequently, and/or a negligible amount of force constantly (Constantly: activity or condition exists from 2/3 or more of the time) to move objects. Physical demand requirements are in excess of those for Sedentary Work.
- Medium** Exerting 20 lbs. to 50 lbs. of force occasionally, and/or 10 lbs. to 25 lbs. of force frequently, and/or greater than negligible up to 10 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.
- Heavy** Exerting 50 lbs. to 100 lbs. of force occasionally, and/or 25 lbs to 50 lbs. of force frequently, and/or 10 lbs. to 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.
- Very Heavy** Exerting in excess of 100 lbs. of force occasionally, and/or in excess of 50 lbs. of force frequently, and/or in excess of 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.

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Community Rehab
Physical Therapy

117 Waccamaw Medical Park Dr. Phone: 843-347-2970
Conway, SC 29526 Fax: 843-347-2975

Physical Therapy Evaluation

Patient Name: Baker, Bobby
Chart Number: 575A
Date of Service: 9/29/09
Referring Provider: Jeffrey C. Wilkins, MD

Reason for Referral: This 51 y/o male has been referred to physical therapy with a Dx of LBP. Pt reports pain started in May 5, 2008. He states a ceiling fell on top of him while he was at work. He reports having 13 staples placed in his scalp and has had problems with his back since that time. He denies any prior back problems. He reports the present Sx as stabbing pain at intrascap area, stabbing pain across LB and numbness in R buttocks and burning sensation at L calf and numbness at R leg. At times he feels like the R leg is going to give out on him and he uses a cane held in R hand at present time for this reason. He reports he has had nerve blocks, which helped approximately 10 months ago but recurrence of pain now. He states his tol for walking is probably 500 feet and then he has to sit down because of pain. He cannot stand sitting longer than 10 min. He avoids weight bearing on R buttocks due to pain.

Current Medications: Does not recall any of the pain medicine he is taking, he is taking new meds but does not know name.

PMH/PSEH/Contradictions: Significant for HTN secondary to elevated pain, arthritis pain. He reports HAs, history of smoking. The last MRI he had was at Long Bay and was in June of this year.

Patient Goals: To eliminate his pain and improve his tol for walking and weight bearing on his RLE.

Objective:

Observations: Pt stands stooped over in a post pelvic tilt and forward trunk flex. He stands c L leg ER. L hip is retracted and R crest is higher than L in standing. Moderately kyphotic.

ROM:

L-spine: Flex 36° c central LBP.
Ext 12° c central LBP.
ROT 25% B c reports of pulling pain going to R and L.
SB R 12° c pain into L buttocks and stabbing sensation, L 12° c pain.

SLRs: R 31° Pt unable to relax L 40°.
SKEs: R lacks 50° of full knee ext 2° stabbing pain at back, L 40°.
PKBs: R 53° c muscle guarding L 45°.

Neurological: DTRs at BLE are grossly 3+.

Functional Mobility/Observation: motion testing, Pt exhibits a R ant innom., R inflair.

Rx today consisted of:

1. Met to correct above mentioned mech dysfunction.
2. Proprioceptive taping of B shoulders to improve postural awareness.
3. Attempted Tx prone over pillow. Stopped after 1 min 2° to Pt stating could not tol positioning. Repositioned Pt sup, again stopped Tx after 1 1/2 min again. Pt states he could not take the pulling sensation. Stopped therapy and no other Rx were performed 2° ↑ in elevation in pain.
4. Reinstructed Pt in proper gait, gait training for walking c cane held in L hand versus R to support RLE c walking.

ASSESSMENT: This patient presents to the department with signs and symptoms consistent with a Dx of acute LBP.

PROBLEM LIST:

1. Painful and limited ROM.
2. Deconditioned.
3. Muscle Guarding.
4. Poor tol for weight bearing on R hip.
5. Poor tol for walking.

STG's: To be met within 2 weeks:

1. Pt will be compliant with HEP.
2. Pt will walk utilizing cane in L hand for 100 ft.
3. Pt will perform positional changes with difficulty level a 4 on optimal scale.

LTG's: To establish after 3 weeks of therapy if pt can tol therapy.

The above goals have been discussed with patient. Patient in agreement with established goals.

PROGNOSIS: Rehab potential to reach above goals is fair.

PLAN: This patient is to be seen 2-3 times a week. Treatments to include, but not be limited to, IHEP, ongoing education, manual therapy, STM, MFR, E-stim, possible US, gentle stretching ex, try Tx at later date but hold at this present time, proprioceptive taping. Reassess in 3 weeks time. If Pt has no change, refer back to MD.

Thank you for the opportunity of working with your patient.

Sincerely,

L. Pearce, PT
Louise Pearce, RPT

LP/SB

Jeffrey C. Wilkins, MD

Progress Note

Patient Name: Baker, Bobby
 Chart Number: 575A
 Date of Service: 9/30/09

S: Pt arrived today utilizing cane held in L hand and walking c < difficulties than he did yesterday.

O: MFR and STM to L/S area in L SL. E-stim to B Lumbar region, R sciatic notch and piriformis X20 min in SL.

A: Good response. Pt had < difficulties c coming to stand and amb c better control.

P: Cont conservative Rx.

L Pearce

Louise Pearce, RPT

LP/SB

Progress Note

Patient Name: Baker, Bobby
Chart Number: 575A
Date of Service: 10/2/09

S: Pt reports status quo.

O: E-stim to LB, R sciatic notch and piriformis X20 min, man ther of STM/MFR to B L/S area X30 min.

A: Pt exhibited less difficulties c positional changes. Pt walking c better control c cane held in L hand. Pt still exhibiting muscle guarding @ R QL and piriformis but responded to MFR.

P: Cont.

L Pearce

Louise Pearce, RPT

LP/ACS



PATIENT: BOBBY BAKER
DATE: 11/04/09
REFERRING:

CHIEF COMPLAINT:

Second opinion regarding back injury.

HISTORY OF PRESENT ILLNESS:

Mr. Baker is a 51-year-old gentleman who suffered a work related back injury on 05/05/08 when the ceiling fell on his head and lower back. He initially had some neck pain associated with headaches but that has really gotten better over time. His main problem has been his lower back. He has pain that radiates into the right leg and sometimes into the calf. He has occasional numbness in the right calf but it doesn't seem to be constant. Occasionally his legs will turn cool, sometimes the left side, sometimes the right side. He regularly rates his back pain to be a 7 out of 10. He has back pain far more than leg pain. He has had at least two epidural injections with Dr. Sarb. He has had bilateral lumbar radio frequency ablation procedures with Dr. Rosenberg, which gave him far more than 50% pain reduction in the lower back for at least nine months and closer to a year. He had excellent relief during that time. He did have a course of physical therapy but he had some traction, which seemed to aggravate his symptoms. He currently has no bowel or bladder dysfunction. He uses a cane because at times, the right leg will give out due to back pain. In fact, he recently had a fall about two weeks ago when his right leg gave out.

PAST MEDICAL HISTORY:

Negative.

PAST SURGICAL HISTORY:

Remarkable for right inguinal hernia repair and right wrist fracture requiring surgery.

ALLERGIES:

None.

SOCIAL HISTORY:

Positive for tobacco. Negative for alcohol. He denies drug use. He used to work at Kingston Plantation. He lives in Conway.

MEDICATIONS:

Xodol, Motrin.

REVIEW OF SYSTEMS:

Currently negative for chest pain, shortness of breath, nausea, vomiting, fevers, chills or night sweats.

PHYSICAL EXAMINATION

General: He has a normal body habitus. No acute distress.

HEENT: Normocephalic, head atraumatic. Neck is supple.

PATIENT:
DATE:
PAGE 2

BOBBY BAKER
11/04/09

Cardiovascular: Regular rate and rhythm. Lungs are clear, no rales or wheezes.

GI: Soft and non-tender.

Skin: Bruising in the lumbar spine and into the gluteal region. Otherwise, no rashes or cyanosis.

Musculoskeletal exam: Reveals pain with back extension. Minimal extension is present. Lumbar flexion is also markedly restricted. Straight leg testing aggravates lower back pain bilaterally.

Neurological: Alert and oriented x 3. Cranial nerves II through XII intact. Biceps, triceps, hand intrinsic strength are 5/5. Quadriceps, plantar, and dorsiflexors strength are 5/5. Sensation is intact to light touch in all four extremities and all dermatomes except the right medial calf which is slightly altered to light touch. Reflexes are 2+ patella, 2+ Achilles. No clonus or spasticity present.

His MRI reveals evidence of degenerative changes primarily at the L4-5 level.

DIAGNOSTIC IMPRESSION:

1. Lumbar degenerative disc disease with lumbar facet syndrome.

RECOMMENDATIONS:

1. The treatment modalities that seemed to have had the most success for the patient in the past were the radio frequency ablation as well as medical management. I think he is deserving of repeat radio frequency ablation in the lumbar spine through Dr. Rosenberg. He will also need continued medical management with his pain medications including Xodol.
2. With regards to the spinal cord stimulator, I don't think he is a candidate at this point. If all previous modalities had failed in the past, then I think it would be reasonable for him to undergo a spinal cord stimulation trial to see if he would be a good candidate. But as I have mentioned before, the previous treatments have been effective in controlling the patient's pain and that should be utilized prior to any thoughts about proceeding with a spinal cord stimulator.
3. Of note, I do think that if he does get a radio frequency ablation procedure in the future and he does get pain reduction, this should be followed-up by a physical rehabilitation program to increase his lower back flexibility and strength.

Pain, Spine and Sports Medicine

C. Gregory Kang, M.D.

Date: 11-18-09 Patient Name: Bobby Baker

Today's Procedure: _____

PRE-PROCEDURE ASSESSMENT

True Allergies (i.e. Anaphalactic): ~~None~~

• Sensitivities? Reactions?

Shellfish? ☐ YES ☒ NO Dyes? ☐ YES ☒ NO Iodine? ☐ YES ☒ NO Adhesive? NO Latex? NO

Are you currently taking any OTC Meds? ☐ YES ☒ NO If so, what? _____

Are your Diabetic? ☐ YES ☒ NO BG checked? _____ If so have you eaten? ☐ YES ☒ NO

Any infections? ☐ YES ☒ NO If so, what? _____

• Any antibiotics? _____

Have you ever fainted? ☐ YES ☒ NO

☐ PACEMAKER (IF STIM. TRIAL)

Women: Is there a possibility of pregnancy? ☐ YES ☒ NO

☐ BLOOD THINNERS (Plavix, Coumadin, Warfarin, etc.)

Pain Level Today (0-10) 8 L. Low

NO

INTRAPROCEDURE/POST-PROCEDURE

Medication / Treatment	Route	Time/Initial Dose	Time/Initial Dose	Time/Initial Dose	Total Given Dose

VITAL SIGNS

Time	Loc	Pulse	Res	BP	Sa O2	Comments:
909		64		141/88	100	PRE-PROCEDURE
						Hematoma middle
930		62		137/90	98	POST-PROCEDURE

DISCHARGE EVALUATION

Discharge Instructions Given ☐ Verbally ☐ Written		Discharge to: ☐ Home ☐ Other Discharged Via ☐ Walked Out ☐ Other	
Minimal or No Pain		RF:	
Minimal or No Nausea		1. Sensory _____ Motor _____	
Dressing dry and intact (if applicable)		2. Sensory _____ Motor _____	
Ambulates with minimal assistance		3. Sensory _____ Motor _____	
Responsible adult present to accompany patient home		Follow up RF Therapy? ☐ Yes ☒ No	

Nurse Signature _____

Physician Signature _____

PATIENT: BOBBY BAKER
DATE: 11/18/09

Preoperative Diagnosis:

1. Recurrent lumbar facet syndrome.

Postoperative Diagnosis:

1. Recurrent lumbar facet syndrome.

Procedure:

1. Diagnostic right L3, L4, L5 medial branch block.

Brief History:

Mr. Baker is a 51-year-old man with lumbar spondylosis and facet pain. He has had a previous radio frequency ablation with good results. The effects have long since worn off. He is now here for confirmatory medial branch block to see if he is a candidate for repeat denervation.

Procedure in Detail:

After informed consent was obtained, Mr. Baker was placed in the prone position and Betadine was used to sterilely prep the back in the usual fashion. 1% Xylocaine was used for local anesthesia. C-arm fluoroscopy was used to identify the right L3 medial branch location. A 3½-inch, 22-gauge spinal needle was used to approach the most medial aspect of the L4 transverse process. The needle tip was placed at the base of L4 SAP. In the lateral view, it was seen to be at the L3-4 facet joint line. Then 0.5 cc of 0.5% Marcaine was injected. The needle was then directed towards the right L4 medial branch location in a similar fashion. Again it was placed at the base of the L5 SAP. Then after a negative aspirate, 0.5 cc of 0.5% Marcaine was injected. The needle was then directed towards the right sacral ala where the L5 dorsal ramus lies. AP and oblique views revealed the needle tip to be at the base of the S1 SAP. Then after a negative aspirate, 0.5 cc of 0.5% Marcaine was injected. 40 mg of Depo-Medrol was also equally divided among the three sites.

Post Injection:

He had more than 75% reduction in pain. We will therefore proceed with a radio frequency ablation procedure.

C. Gregory Kang, M.D.
Physiatrist

CGK:dh

cc: Worker's Compensation carrier



C. Gregory Kang, M.D. • Phone: (843) 215-8868 • Fax: (843) 215-9555

3029 Newcastle Loop • Myrtle Beach, SC 29588

NEURAXIAL MEDIAL BRANCH NERVE BLOCK

TARGET ANATOMY:

(12) L3, L4, L5

1. I fully acknowledge that the procedure has been explained to and discussed with me in lay terms to my full understanding as the placement of a needle(s) in close proximity to the nerve(s) of the spine for injection of a drug(s) for the relief of pain.
2. I fully understand that no guarantee or warranty has been implied or made to me concerning the outcome of the procedure.
3. I voluntarily request Dr. Kang as my physician, and such healthcare provider(s), technical assistant(s), and other designee(s) as may be necessary to perform the procedure.
4. I fully understand that just as there may be risks in not treating my present medical condition, there are significant risks of potential complications associated with the procedure, to include but not limited to, increased pain; headache; infection; bleeding; permanent nerve damage causing paresthesia, numbness, weakness, paralysis, bowel/bladder incontinence, or sexual dysfunction; drug reaction causing loss of consciousness, generalized seizure, cardiopulmonary failure, or even death.
5. I fully acknowledge that alternative therapy(s) to the procedure has been explained to, discussed with, and considered by me, resulting in my voluntary decision to proceed with the procedure as my best choice of care for my present medical condition.
6. I fully understand that abnormal anatomy may require a modification in the approach or technique of the procedure. I voluntarily authorize such potential modification during the procedure.
7. I voluntarily consent to the use of fluoroscopy during the procedure.
8. I voluntarily consent to the presence of an observer(s), and photography/videography during my procedure.
9. I voluntarily consent to the withdrawal of a sample of my blood for testing of communicable diseases should a healthcare provider be exposed to my blood or body fluid.
10. I voluntarily accept full financial responsibility for all charges related to the procedure. I voluntarily accept full financial responsibility for all charges related to the procedure that are determined to be either not covered or denied by my insurance carrier.

PARENT/LEGAL GUARDIAN/LEGAL HEALTHCARE PROXY: A parent or legal guardian must sign voluntary informed consent for the procedure for either a patient who is a minor, or a patient who is physically or mentally incompetent.

PATIENT/LEGAL GUARDIAN/LEGAL HEALTHCARE PROXY DECLARATION: I voluntarily certify that I have read this form in full, or I have had this form in full read to me. I fully acknowledge that the procedure with significant risks of potential complications has been explained to, discussed with, and considered by me, resulting in my voluntary decision to proceed with the procedure as my best choice of care for my present medical condition. I voluntarily certify that I have been given ample opportunity to ask any and all questions regarding the procedure; and, that I fully understand the procedure with significant risks of potential complications, benefit(s), and alternative therapy(s). In short, I voluntarily certify that I have sufficient information to voluntarily give my informed consent to proceed with the procedure.

Bobby Baker
Patient/Legal Guardian/Legal Healthcare Proxy Signature

MB
Nurse Witness Signature

11.18.09
Date

PHYSICIAN DECLARATION: I certify that a full understanding of the procedure with associated risks of potential complications, benefit(s), and alternative therapy(s) has been articulated by the patient, legal guardian, and/or legal healthcare proxy. I certify that any and all questions regarding the procedure with associated risks of potential complications, benefit(s), and alternative therapy(s) have been answered to the verbalized satisfaction of the patient, legal guardian, and/or legal healthcare proxy.

C. Gregory Kang MD PA

11.18.09
Date

**Pain,
Spine & Sports
Medicine**

C. Gregory Kang, M.D. • Phone: (843) 215-8868 • Fax: (843) 215-9555

3029 Newcastle Loop • Myrtle Beach, SC 29588

RADIO FREQUENCY NEUROTOMY

TARGET ANATOMY: R C3, L4, L5 (Lumbar; Cervical)

1. I fully acknowledge that the procedure has been explained to and discussed with me in lay terms and I understand the placement of a canula in close proximity to the nerve(s) of the spine.
2. I fully understand that no guarantee or warranty has been implied.
3. I voluntarily request Dr. Kang as my physician, and such healthcare may be necessary to perform the procedure.
4. I fully understand that just as there may be risks in not treating my complications associated with the procedure, to include but not limited to nerve damage causing paresthesia, numbness, weakness, paraesthesia causing loss of consciousness, generalized seizure, cardiac arrest.
5. I fully acknowledge that alternative therapy(s) to the procedure have been discussed and I am resulting in my voluntary decision to proceed with the procedure as discussed.
6. I fully understand that abnormal anatomy may require a modification of the procedure and I authorize such potential modification during the procedure.
7. I voluntarily consent to the use of fluoroscopy during the procedure.
8. I voluntarily consent to the presence of an observer(s), and photographs.
9. I voluntarily consent to the withdrawal of a sample of my blood for testing of communicable diseases should a healthcare provider be exposed to my blood or body fluid.
10. I voluntarily accept full financial responsibility for all charges related to the procedure. I voluntarily accept full financial responsibility for all charges related to the procedure that are determined to be either not covered or denied by my insurance carrier.

LYRICA
PREGABALIN

Bobby Baker 12-1-09

1) .26

2) .24

3) .24

PARENT/LEGAL GUARDIAN/LEGAL HEALTHCARE PROXY: A parent or legal guardian must sign voluntary informed consent for the procedure for either a patient who is a minor, or a patient who is physically or mentally incompetent.

PATIENT/LEGAL GUARDIAN/LEGAL HEALTHCARE PROXY DECLARATION: I voluntarily certify that I have read this form in full, or I have had this form read to me in full. I fully acknowledge that the procedure with significant risks of potential complications has been explained to, discussed with, and considered by me, resulting in my voluntary decision to proceed with the procedure as my best choice of care for my present medical condition. I voluntarily certify that I have been given ample opportunity to ask any and all questions regarding the procedure; and, that I fully understand the procedure with significant risks of potential complications, benefit(s), and alternative therapy(s). In short, I voluntarily certify that I have sufficient information to voluntarily give my informed consent to proceed with the procedure.

Bobby Baker
Patient/Legal Guardian/Legal Healthcare Proxy Signature

Nurse Witness Signature

12.1.09
Date

PHYSICIAN DECLARATION: I certify that a full understanding of the procedure with associated risks of potential complications, benefit(s), and alternative therapy(s) has been articulated by the patient, legal guardian, and/or legal healthcare proxy. I certify that any and all questions regarding the procedure with associated risks of potential complications, benefit(s), and alternative therapy(s) have been answered to the verbalized satisfaction of the patient, legal guardian, and/or legal healthcare proxy.

C. Gregory Kang, MD PA

12.1.09
Date

PATIENT: BOBBY BAKER
DATE: 12/01/09

Preoperative Diagnosis:

1. Recurrent right lumbar facet syndrome.

Postoperative Diagnosis:

1. Recurrent right lumbar facet syndrome.

Procedure:

1. Radio frequency neurotomy of the right L3, L4 medial branch nerve.
2. Radio frequency neurotomy of the right L5 dorsal ramus.

Brief History:

Mr. Baker is a 51-year-old man with lumbar spondylosis and facet syndrome. He had a successful medial branch block on the right side. He is now here for denervation of the right lower lumbar facet joints.

Procedure in Detail:

After informed consent was obtained, Mr. Baker was placed in the prone position and Betadine was used to sterilely prep the back in the usual fashion. 1% Xylocaine was used for local anesthesia. C-arm fluoroscopy was used to identify the right L3 medial branch location. A 6-inch, 20-gauge cannula with a 10 mm active tip was used to approach the most medial aspect of the L4 transverse process. The cannula tip was placed at the base of the L4 SAP. Then in the lateral view it was seen to be at the L3-4 facet joint line. Sensory testing at this level revealed a response at 0.26 volts. Motor testing at 3 volts revealed no activity in the leg. Denervation is performed at 80° Celsius for 90 seconds. The cannula was then directed towards the right L4 medial branch location in a similar fashion. Again, it was placed at the base of the L5 SAP. In the lateral view, it was seen to be at the L4-5 facet joint line. Sensory testing revealed a response at 0.24 volts. Motor testing at 3 volts revealed no activity in the leg. Denervation is performed at 80° Celsius for 90 seconds. The cannula was then directed towards the right sacral ala where the L5 dorsal ramus lies. AP and oblique views revealed the cannula tip to be at the base of S1 SAP. In the lateral view, it was seen to be at the L5-S1 facet joint line. Sensory testing revealed a response at 0.24 volts. Motor testing at 3 volts revealed no activity in the leg. Denervation is performed twice at this level at 80° Celsius for 90 seconds. He was observed in the office for twenty-five minutes prior to discharge. There were no apparent complications.

C. Gregory Kang, M.D.
Physiatrist

CGK:dh

cc: Worker's Compensation carrier

Pain, Spine and Sports Medicine

C. Gregory Kang, M.D.

Date: 12-1-09 Patient Name: Bob Baker

Today's Procedure: RF

PRE-PROCEDURE ASSESSMENT

True Allergies (i.e. Anaphalactic): Iodine

• Sensitivities? Reactions? _____

Shellfish? ☐ YES ☒ NO Dyes? ☐ YES ☒ NO Iodine? ☐ YES ☒ NO Adhesive? _____ Latex? _____

Are you currently taking any OTC Meds? ☐ YES ☒ NO If so, what? _____

Are your Diabetic? ☐ YES ☒ NO BG checked? _____ If so have you eaten? ☐ YES ☒ NO

Any infections? ☐ YES ☒ NO If so, what? _____

• Any antibiotics? _____

Have you ever fainted? ☐ YES ☒ NO ☐ PACEMAKER (IF STIM. TRIAL)

Women: Is there a possibility of pregnancy? ☐ YES ☒ NO ☐ BLOOD THINNERS (Plavix, Coumadin, Warfarin, etc.)

Pain Level Today (0-10) 7 R-L limb NO

INTRAPROCEDURE/POST-PROCEDURE

Medication / Treatment	Route	Time/Initial Dose	Time/Initial Dose	Time/Initial Dose	Total Given Dose

VITAL SIGNS

Time	Loc	Pulse	Res	BP	Sa O2	Comments:
1024		63		130/84	99	PRE-PROCEDURE
1104		66		141/90	99	POST-PROCEDURE

DISCHARGE EVALUATION

Discharge Instructions Given ☐ Verbally ☒ Written		Discharge to: ☐ Home ☐ Other Discharged Via ☐ Walked Out ☐ Other	
☒ Minimal or No Pain	RF: 1. Sensory _____ Motor _____ 2. Sensory _____ Motor _____ 3. Sensory _____ Motor _____ Follow up RF Therapy? ☐ Yes ☒ No		
☒ Minimal or No Nausea			
☒ Dressing dry and intact (if applicable)			
☒ Ambulates with minimal assistance			
☒ Responsible adult present to accompany patient home			

Nurse Signature

Physician Signature

Pain, Spine and Sports Medicine

3029 Newcastle Loop

Myrtle Beach, SC 29588

Office: (843) 215-8868 FAX: (843) 215-9555

Patient Name: Bobby Baker

Date of visit: 12/31/09

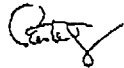
Subjective: Mr. Baker returns to the clinic for evaluation of chronic low back pain. He reports that the last radiofrequency rhizotomy has not helped, but he realized he is still only 4 weeks into a 6-8 week healing process. He has developed severe itching since then and has had this problem in the past after injections. He has been using topical benedryl which helps, but it is not doing the job adequately. He also reports that the Percocet is not working very well and he would like an increase if possible. He continues to have pain radiating down his right leg which significantly interferes with his sleep.

Objective: He is a well-developed, well-nourished, slightly overweight white male in no acute distress. He continues to ambulate with the aid of a cane. He shows no signs of cognitive impairment and cranial nerves II through XII remain grossly intact. He continues to have lumbar paraspinal tenderness with limited range of motion to include flexion and extension. There no new neurologic deficits noted. He has a very mild rash on his right forearm that looks more like dry skin. He has no rash at the site of the injection.

Assessment: Lumbar degenerative disc disease with radicular pain

Plan:

- Since he demonstrates compliance with medications and no aberrant behavior, refilled the Percocet without changes.
- Started Gabapentin 100mg 1-2 po qhs for the neuropathic pain. He has been on this medication at significantly higher doses and did not tolerate it. Hopefully, this will help his pain and sleep and at this dose, he should have no difficulty tolerating it.
- Gave him Atarax 25mg 1 po bid prn itching. He was instructed that this may cause drowsiness and to not drive with this medication. If it causes too much drowsiness, he may resume the topical Benedryl. He verbalized understanding.
- He is to return to the clinic in one month or p.r.n.



Constance Alger, FNP-BC
Electronically Signed

C. Gregory Kang, MD

cc: Workman's Compensation

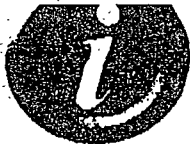
Percocet 10/325 1 po q6hrs prn pain (#120/ /)

Gabapentin 100mg 1-2 po qhs (#60/ /)

Atarax 25mg 1 po bid prn itching (#60/ /)

Last UDS: Not done - Collect next visit

Allergies: NKDA



Instant Technologies Inc.

Initial Drug Screen Result Form

Specimen ID Number 7026099

Collection Test Date _____

Company _____

Address _____

Suite _____

City _____

State _____

Postal Code _____

Collector's Name _____

Phone _____

Specimen Temperature: (90-100 F.) In Range ☐ Other ☐ _____

Fax _____

Donor's Name _____

Employee ID# or Last Name: _____

ID # or SSN _____

Identification Type _____

Expiration _____

Notes _____

I hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites and/or alcohol.

Donor's Signature Bobby BakerDate 1-2-2010

I hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge. The specimen temperature and color were acceptable.

Collector's Signature [Signature]Date 1-23-10

Drug Name	Device Code	Negative	Confirm	Not Tested	Adulteration Panel Results
Cocaine	COC	☒	☐	☐	Oxidant ☐ In Range ☐ Other _____ OX
Marijuana	THC	☒	☐	☐	
Opiates/Morphine	OPI/MOR	☒	☐	☐	
Amphetamines	AMP	☒	☐	☐	
Methamphetamine	mAMP	☒	☐	☐	Specific Gravity ☐ In Range ☐ Other _____ S.G.
Phencyclidine	PCP	☒	☐	☐	
Benzodiazepine	BZO	☒	☐	☐	
Barbiturates	BAR	☒	☐	☐	
Methodone	MTD	☒	☐	☐	pH ☐ In Range ☐ Other _____ pH
Tricyclic Antidepressants	TCA	☒	☐	☐	
Oxycodone	OXY <u>(Y)</u>	☒	☒	☐	
Propoxyphene	PPX	☒	☐	☐	
Methylenedioxymethamphetamine	MDMA	☒	☐	☐	
ALCOHOL SCREEN	ALC	☐		Level _____	

OFFICE

Last Name

First Name

Pain, Spine and Sports Medicine

3029 Newcastle Loop
Myrtle Beach, SC 29588
Office: (843) 215-8868 FAX: (843) 215-9555

Patient Name: Bobby Baker

Date of visit: 01/28/10

Subjective: Mr. Baker returns to the clinic for evaluation of chronic low back pain. He reports that the last radiofrequency rhizotomy has continued to be ineffective and he has significant back and leg pain. This still interferes with his sleep. The gabapentin is not very effective, but it remains at a very low dose. He has not had any negative effects. The itching from the RF resolved last week. He is having erectile dysfunction and is wondering if it could be related to his back or medications.

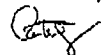
Objective: He is a well-developed, well-nourished, slightly overweight white male in no acute distress. He continues to ambulate with the aid of a cane. He shows no signs of cognitive impairment and cranial nerves II through XII remain grossly intact. He continues to have lumbar paraspinal tenderness with limited range of motion to include flexion and extension. There no new neurologic deficits noted.

Assessment:

- Lumbar degenerative disc disease with radicular pain
- Probable opiate induced hypogonadism and erectile dysfunction

Plan:

- Since he demonstrates compliance with medications and no aberrant behavior, refilled the Percocet without changes.
- Increased the Gabapentin to 300mg qhs. Hopefully, he will have improvement of his leg pain.
- Started Klonopin 0.5mg 1 po qhs for his sleep and leg movement at night (RLS).
- Discontinued the Atarax.
- Administered the "Adam Test" which was significantly positive for low testosterone levels. As a result, ordered a morning serum testosterone level and PSA. If this is low, will start testosterone replacement and repeat the labs in two months to evaluate the effectiveness and ensure any dormant prostate cancer is not activated.
- Will write Cialis if desired. He is concerned about the price since it is expensive. He hopes that WC will pay for it since the problem is most likely due to his injury and medications.
- Did an 11 panel urine drug screen with passing results. It is being sent to Aegis laboratories for confirmation.
- Completed a Handicapped placard application.
- Will complete the life insurance form.
- He is to return to the clinic in one month or p.r.n. He is scheduled to see Dr. Kang for evaluation of permanent work restrictions, MMI status and palliative care needs.



Constance Alger, FNP-BC
Electronically Signed

C. Gregory Kang, MD

cc: Workman's Compensation

Percocet 10/325 1 po q6hrs prn pain (#120/____/____)
Gabapentin 300mg 1 po qhs (#30/____/____)
Klonopin 0.5mg 1 po qhs (#30/____/____)
Last UDS: 01/28/10 Allergies: NKDA

File 15



Laboratory Report

Laboratory Director: David L. Black, Ph.D., DABFT • CLIA Number 44D1083455
615 Great Circle Rd, Nashville TN 37228 • (615) 255-2400 • fax (615) 255-3030

Client: Pain, Spine, & Sports Medicine
3029 Newcastle Loop
Myrtle Beach, SC 29588
Practitioner: C. Gregory Kang

Patient Name: Bobby Baker
Date of Birth:
Male/Female: Male

Patient ID:
Laboratory ID: 30104802
Collected: 1/28/2010
Received: 1/29/2010
Reported: 2/3/2010

Pain Medication Prescribed: Oxycodone PRN

Test(s) Requested: #00188U Quant. Metabolite Profile

- # 04410 Amphetamine
- # 04420 Barbiturates
- # 04440 Marijuana
- # 04450 Cocaine
- # 04496 Buprenorphine (Suboxone)
- # 04497 Cotinine

Result / Interpretation			
Drug	Result Interpretation	Normalized Result	Comment
Oxycodone	PRN - Present	1,840 ng/mL	Test result is consistent and expected with prescribed drug.
Cotinine	Present	1,220 ng/mL	Test result indicates active use of tobacco product.

Specimen Validity Testing	Normal Range	Result	Comment
Creatinine	20 mg/dL	231 mg/dL	Normal
Specific Gravity	1.0020	1.0200	Normal
pH	3.5 - 9.0	5.5	Normal
Nitrites	< 200 mcg/mL	< 200 mcg/mL	Normal
Chromates	< 50 mcg/mL	< 50 mcg/mL	Normal

Additional Comments

All other tests requested were negative.

Description of PainComp™ Quantitative Metabolite Profile

Specimen Validity Testing includes: Specific Gravity, Creatinine, pH, Nitrites, Chromates
Specimen was tested for the following drugs and metabolites (Bold = parent drug):

Benzodiazepines		Barbitic Analgesics		Miscellaneous	
Alprazolam	Diazepam (Valium®)	Codaine	Meperidine	Carisoprodol/Misoprobamate	
Alphahydroxy-Alprazolam	Nordiazepam	Morphine	Normeperidine	Quazepam	
Chlordiazepoxide	Oxazepam	Hydrocodone*	Methadone	Nexen	
Nordiazepam	Temazepam	Norcodeine	EDDP (Methadone Metabolite)	6-monoacetylmorphine	
Oxazepam	Flurazepam	Dihydrocodeine	Morphine	6-acetylcodaine	
Clonazepam	2-hydroxy-ethyl-Surazepam	Pentobarbital	Hydromorphone*	Morphine	
7-amino-clonazepam	Lorazepam (Ativan®)	Norlansyl	Oxycodone	Progabalin	
Clonazepam	Oxazepam (Serax®)	Hydrocodone	Noroxycodone	Tramadol	
Nordiazepam	Temazepam	Dihydrocodeine	Oxymorphone	o-desmethyl-tramadol	
Oxazepam	Oxazepam	Hydromorphone	Oxycodone	n-desmethyl-tramadol	
		Norhydrocodone	Propoxyphene		
		Hydromorphone	Norpropoxyphene		

Note: Urine drug metabolite concentrations do not correlate with blood drug concentrations or medication dosage. Aegis PainComp® does not compare urine drug metabolite concentrations to the dose of drug prescribed or administered to the patient.

End of Report

Please call 1.800.533.7052 if you require additional information.

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PATIENT: BOBBY BAKER
DATE: 02/25/10

BRIEF HISTORY:

Mr. Baker returns in follow-up. He reports that his symptoms are worse. The lower back pain is worse. The pain is worse in the right leg and is also starting to develop in the left leg. He reports the radio frequency ablation didn't help at all. They have become less / and less effective. He is taking Percocet, which is not relieving his pain to a significant degree. He is not sleeping at nighttime. His wife is complaining about that as well. He has no bowel or bladder dysfunction. He has not been able to return to work.

PHYSICAL EXAMINATION

Examination today reveals that he is in some distress. He has pain with back extension bilaterally. Lumbar flexion is markedly restricted. Neurologically, reflexes are intact. There is no clonus or spasticity. He walks with a straight cane.

DIAGNOSTIC IMPRESSION:

1. Lumbar degenerative disc disease with chronic lower back and leg pain.

RECOMMENDATIONS:

1. He pretty much has failed radio frequency ablation as well as physical therapy. I think it would be reasonable for him to have a spinal cord stimulation trial and if successful, permanent implantation.
2. I also think that it is reasonable to check serum testosterone and PSA to see if he has opioid induced hypogonadism.
3. He is not at maximal medical improvement at this time. I have asked him not to return to work.

C. Gregory Kang, M.D.
Physiatrist

CGK/dh

cc: Worker's Compensation carrier

AL
RTW

PATIENT: BOBBY BAKER
DATE: 03/25/10

BRIEF HISTORY:

Mr. Baker returns in follow-up. He still has chronic back pain radiating down both lower extremities. He has failed radio frequency denervation. His spinal cord stimulator was just denied. He is getting some relief with Oxycodone, Ambien, and Neurontin. He reports no significant side effects from it. He currently rates his pain to be a 7 out of 10 on the VAS scale.

PHYSICAL EXAMINATION

Examination today reveals minimal lumbar flexion and extension. Both activities aggravate pain. Neurologically, no new changes.

DIAGNOSTIC IMPRESSION:

1. Multiple level lumbar degenerative disc disease with chronic back and leg pain.

RECOMMENDATIONS:

1. I don't have much more to offer Mr. Baker other than palliative care.
2. I am going to refill his medications.
3. I have made an order for a functional capacity evaluation to see what his physical limitations are. Once that is complete, we will go ahead and give him an impairment rating.

C. Gregory Kang, M.D.
Physiatrist

CGK/dh

cc: Worker's Compensation carrier

7/10
Pain

LabCorp
Laboratory Corporation of America

LabCorp Burlington
1447 York Court
Burlington, NC 27215-3361

Phone: 800-762-4344

Specimen Number		Patient ID		Control Number	Account Number	Account Phone Number	Results
				20044291551	39713620	843-215-8868	**
Patient Last Name		Account Address					
BAKER		Pain Spine and Sports Medicine					
Patient First Name		Patient Middle Name					
BOBBY							
Patient SSN	Patient Phone	Total Volume					
Age (Y/M/D)	Date of Birth	Sex	Fasting				
52/00/19		M	No				
Patient Address				Additional Information			
				UPIN: G32310			
Date and Time Collected	Date Received	Date and Time Reported	Physician Name	NH	Physician ID		
03/25/10 10:54	03/25/10	03/26/10 08:36ET	KANG, C	1275560419			

Test Ordered
Prostate-Specific Ag, Serum; Testosterone, Serum; Drawing Fee

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Prostate-Specific Ag, Serum	0.5		ng/mL	0.0 - 4.0	01
Prostate Specific Ag, Serum Roche ECLIA methodology.					

According to the American Urological Association, Serum PSA should decrease and remain at undetectable levels after radical prostatectomy. The AUA defines biochemical recurrence as an initial PSA value 0.2 ng/mL or greater followed by a subsequent confirmatory PSA value 0.2 ng/mL or greater. Values obtained with different assay methods or kits cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

Testosterone, Serum 112 Low ng/dL 280 - 800 01

01 BN LabCorp Burlington Dir: William F Hancock, MD
1447 York Court, Burlington, NC 27215-3361
For inquiries, the physician may contact Branch: 800-762-4344 Lab: 800-762-4344

*Needs to
Start
Thyroid*

BAKER, BOBBY	084-277-4456-0	Seq # 0160

FINAL REPORT

Page 1 of 1

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Pain, Spine and Sports Medicine

3029 Newcastle Loop
Myrtle Beach, SC 29588
Office: (843) 215-8868 FAX: (843) 215-9555

Patient Name: Bobby Baker

Date of visit: 04/22/10

Subjective: Mr. Baker returns to the clinic for evaluation of chronic low back pain. He reports that his medications are adequate most of the time. He has no desire for an increase in his medications at this time. He has not heard anything about the FCE nor the neurostimulator. He is very interested in the results of his lab work. He continues to rate his pain as 7/10 on the VAS.

Objective: He is a well-developed, well-nourished, slightly overweight white male in no acute distress. He continues to ambulate with the aid of a cane. He shows no signs of cognitive impairment and cranial nerves II through XII remain grossly intact. He continues to have lumbar paraspinal tenderness with limited range of motion to include flexion and extension. There no new neurologic deficits noted.

Assessment:

- Lumbar degenerative disc disease with radicular pain
- Opiate induced hypogonadism and erectile dysfunction

Plan:

- Since he demonstrates compliance with medications and no aberrant behavior, refilled the Oxycodone without changes.
- Refilled the Gabapentin and Ambien without changes +5 refills.
- Reviewed the serum testosterone PSA results. His PSA is within normal limits at 0.5 (0-4) serum testosterone was low at 112 (280-800). As a result started him on Testim 1% 5 g q. day and gave him 2 weeks of samples and a prescription with one refill. At the end of this prescription, we'll repeat the PSA and serum testosterone levels.
- He is to return to the clinic in one month or p.r.n.

Gregory

Constance Alger, FNP-BC
Electronically Signed

C. Gregory Kang, MD

cc: Workman's Compensation

Oxycodone 15 mg one p.o. q.i.d. p.r.n. pain (#120/ 1121 /)
Gabapentin 300mg 2 po qhs (#60/ 5 RF/ ✓)
Ambien 10 mg one p.o. q.h.s. p.r.n. sleep (#30/ 5 RF/ ✓)
Testim 1% 5 g q. day (#30+14 samples/ 1 RF/)
Last UDS: 01/28/10 Allergies: NKDA

Pain, Spine and Sports Medicine

3029 Newcastle Loop
Myrtle Beach, SC 29588

Office: (843) 215-8868 FAX: (843) 215-9555

Patient Name: Bobby Baker

Date of visit: 05/20/10

Subjective: Mr. Baker returns to the clinic for evaluation of chronic low back pain. He reports that his medications are not working properly and he has constant significant lower back pain. He had the FCE done and is interested in the results. He continues to have significant leg pain at night interfering with his sleep. He continues to use the Testim as ordered.

Objective: He is a well-developed, well-nourished, slightly overweight white male in significant distress. He continues to ambulate with the aid of a cane. He shows no signs of cognitive impairment and cranial nerves II through XII remain grossly intact. He continues to have lumbar paraspinal tenderness with limited range of motion to include flexion and extension. There no new neurologic deficits noted.

Assessment:

- Lumbar degenerative disc disease with radicular pain
- Opiate induced hypogonadism and erectile dysfunction

Plan:

- Since he demonstrates compliance with medications and no aberrant behavior, but he is not having pain control as desired, increased the Oxycodone to 30mg tid prn pain.
- He continues to have 5 refills on the Gabapentin and Ambien.
- Wrote a prescription for a repeat serum testosterone and PSA levels to be done before the next visit.
- He is to discuss the FCE results with Dr. Kang.
- He is to return to the clinic in one month or p.r.n.

Constance
Constance Alger, FNP-BC
Electronically Signed

C. Gregory Kang, MD

cc: Workman's Compensation

Oxycodone 30mg one p.o. t.i.d. p.r.n. pain (#90/___/___)
Gabapentin 300mg 2 po qhs (#60/ 4 RF/___)
Ambien 10 mg one p.o. q.h.s. p.r.n. sleep (#30/ 4 RF/___)
Testim 1% 5 g q. day (#30+14 samples/ 0RF/___)
Last UDS: 01/28/10 Allergies: NKDA

C. GREGORY KANG, M.D.

DEA #BK4979641
LIC #19925

CONSTANCE M. ALGER, FNP

DEA #MA1176850
LIC #APN-2092
UPIN: Q33861

PAIN, SPINE & SPORTS MEDICINE
3029 NEWCASTLE LOOP • MYRTLE BEACH, SC 29588
PH. (843) 215-8868 • FAX (843) 215-9555

NAME Bobby Baker AGE _____

ADDRESS _____ DATE 05/20/10

R Serum Testosterone + PSA Levels

Am Specimen

Dr: Hypogonadism
V58.69

Please See
Referral
Sheet

Dispense As Written

Substitution Permitted

C. GREGORY KANG, M.D.

DEA #BK4979641
LIC #19925

CONSTANCE M. ALGER, FNP

DEA #MA1176850
LIC #APN-2092
UPIN: Q33861

PAIN, SPINE & SPORTS MEDICINE
3029 NEWCASTLE LOOP • MYRTLE BEACH, SC 29588
PH. (843) 215-8868 • FAX (843) 215-9555

NAME Bobby Baker AGE _____

ADDRESS _____ DATE 05/20/10

R Oxycodone 30 mg $\dot{\bar{r}}$ po TID

per pain (4905 QNR)

Dispense As Written

Substitution Permitted

TO:

ATTN: Pain Spine and Sports Medicine

LABORATORY BILL BLK

Page 1 of 1

A

LabCorp
Laboratory Corporation of AmericaLabCorp Burlington
1447 York Court
Burlington, NC 27215-3361

Phone: 800-762-4344

Accession Number		Patient ID		Control Number	Account Number	Account Phone Number	Branch
				20044293955	39713620	843-215-8868	**
Patient Last Name				Account Address			
BAKER				Pain Spine and Sports Medicine			
Patient First Name		Patient Middle Name					
BOBBY							
Patient SSN	Patient Phone	Total Volume					
Age (Y/M/D)	Date of Birth	Sex	Parking				
52/02/29		M	No	3029 Newcastle Loop MYRTLE BEACH SC 29588			
Patient Address				Additional Information			
				UPIN: Q33861			
Date and Time Collected	Date Entered	Date and Time Reported	Physician Name	NPI	Physician ID		
06/04/10 09:42	06/04/10	06/05/10 08:35ET	ALGER, C	1073727525			
Test Ordered							
Prostate-Specific Ag, Serum; Testosterone, Serum; Drawing Fee							
General Comments							
A courtesy copy of this report has been sent to 843-215-9555.							
TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB		

Prostate-Specific Ag, Serum

Prostate Specific Ag, Serum	0.4	ng/mL	0.0 - 4.0	01
Roche ECLIA methodology.				

According to the American Urological Association, Serum PSA should decrease and remain at undetectable levels after radical prostatectomy. The AUA defines biochemical recurrence as an initial PSA value 0.2 ng/mL or greater followed by a subsequent confirmatory PSA value 0.2 ng/mL or greater.

Values obtained with different assay methods or kits cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

Testosterone, Serum	431	ng/dL	280 - 800	01

01	BN	LabCorp Burlington	Dir: William F Hancock, MD
		1447 York Court, Burlington, NC 27215-3361	
For inquiries, the physician may contact Branch: 800-762-4344 Lab: 800-762-4344			

BAKER, BOBBY	155-277-4167-0	Seq # 0165

FINAL REPORT

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06/05/2010 8:35:03 AM
TO: DR ALGER

FROM: LABCORP LCLS BLK TO: 0432109000
ATTN: Pain Spine and Sports Medicine

LABCORP LCLS BLK

Page 1 of 1

A ***

LabCorp
Laboratory Corporation of America

LabCorp Burlington
1447 York Court
Burlington, NC 27215-3361

Phone: 800-762-4344

Specimen Number 15	Patient ID	Control Number 20044293955	Account Number 39713620	Account Phone Number 843-215-8868	Route **
Patient Last Name BAKER		Account Address Pain Spine and Sports Medicine			
Patient First Name BOBBY	Patient Middle Name	3029 Newcastle Loop			
Patient SSN	Patient Phone	Total Volume	MYRTLE BEACH SC 29588		
Age (Y/M/D) 52/02/29	Date of Birth	Sex M	Fasting No		
Patient Address			Additional Information UPIN: Q33861		
Date and Time Collected 06/04/10 09:42	Date Entered 06/04/10	Date and Time Reported 06/05/10 08:35ET	Physician Name ALGER, C	NPI 1073727525	Physician ID

Tests Ordered
Prostate-Specific Ag, Serum; Testosterone, Serum; Drawing Fee

General Comments
This is a courtesy copy of a laboratory report.

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Prostate-Specific Ag, Serum					
Prostate Specific Ag, Serum	0.4		ng/mL	0.0 - 4.0	01
Roche ECLIA methodology.					

According to the American Urological Association, Serum PSA should decrease and remain at undetectable levels after radical prostatectomy. The AUA defines biochemical recurrence as an initial PSA value 0.2 ng/mL or greater followed by a subsequent confirmatory PSA value 0.2 ng/mL or greater.

Values obtained with different assay methods or kits cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

Testosterone, Serum	431	ng/dL	280 - 800	01

01	BN	LabCorp Burlington 1447 York Court, Burlington, NC 27215-3361	Dir: William F Hancock, MD
For inquiries, the physician may contact Branch: 800-762-4344 Lab: 800-762-4344			

BAKER, BOBBY	Seq # 0165

FINAL REPORT

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0150

PATIENT: BOBBY BAKER
DATE: 06/08/10

BRIEF HISTORY:

Mr. Baker returns in follow-up. He continues to have lower back pain radiating into the leg. He rates his pain to be a consistent 7-8 out of 10 on the VAS scale. He did have his functional capacity evaluation, which showed consistent effort. He was occasionally able to lift about 15 pounds. The therapist basically rated him at the light duty level. He has CNS side effects and light-headedness on occasion when he takes the Oxycodone. It is giving him some pain relief where he can at least function on a day-to-day basis.

PHYSICAL EXAMINATION

Examination today reveals limited lumbar flexion and extension. He walks with a straight cane. Neurologically, he has no new focal deficits in the lower extremities. He does have some give-away weakness due to pain.

DIAGNOSTIC IMPRESSION:

1. Multiple level lumbar degenerative disc disease with probable discogenic pain.

RECOMMENDATIONS:

1. From my standpoint, he is at maximal medical improvement. I don't think he is capable of working at the light duty level, however I do think he is capable of sedentary type activity. Based on the AMA guides, 5th edition, he gets an 18% lumbar spine impairment. He will continue to require palliative care including testosterone gel, Gabapentin, Oxycodone, and Ambien.
2. I would also suggest that he at least get a spinal cord stimulator trial to see if this would be an acceptable alternative for pain control in the lower back and legs.

C. Gregory Kang, M.D.
Physiatrist

CGK/dh

cc: Worker's Compensation carrier

Pain, Spine and Sports Medicine

3029 Newcastle Loop
Myrtle Beach, SC 29588
Office: (843) 215-8868 FAX: (843) 215-9555

Patient Name: Bobby Baker DOB:

Claim # YTEC 01212

Date of visit: 07/15/10

Subjective: Mr. Baker returns to the clinic for evaluation of chronic low back pain. He reports that his medications are working adequately, and he has no desire for changes. He continues to have lower back pain and episodic swelling and bruising on the lower coccyx and right buttocks. This area is extremely painful and causes a burning discomfort. At this point, he was unable to determine the cause. He is planning to see his family doctor who has evaluated this in the past for reevaluation.

Objective: He is a well-developed, well-nourished, slightly overweight white male in significant distress. He continues to ambulate with the aid of a cane. He shows no signs of cognitive impairment and cranial nerves II through XII remain grossly intact. He continues to have lumbar paraspinal tenderness with limited range of motion to include flexion and extension. There no new neurologic deficits noted. He does not have any edema or bruising at this time.

Assessment:

- Lumbar degenerative disc disease with radicular pain
- Opiate induced hypogonadism and erectile dysfunction

Plan:

- Since he demonstrates compliance with medications and no aberrant behavior, refilled the Oxycodone without changes.
- Refilled the Testim without changes for one month.
- He continues to have 3 refills on the Gabapentin and Ambien.
- He is to return to the clinic in one month or p.r.n.

Gregory

Constance Alger, FNP-BC
Electronically Signed

C. Gregory Kang, MD

cc: Workman's Compensation

Oxycodone 30mg one p.o. t.i.d. p.r.n. pain (#90/7/1/✓)

Gabapentin 300mg 2 po q.h.s (#60/2 RF/✓)

Ambien 10 mg one p.o. q.h.s. p.r.n. sleep (#30/3 RF/7/13)

Testim 1% 5 g q. day (#30/0 RF/)

Last UDS: 01/28/10 Allergies: NKDA

ain, Spine and Sports Medicine
3029 Newcastle Loop
Myrtle Beach, SC 29588
Office: (843) 215-8868 FAX: (843) 215-9555

Patient Name: Bobby Baker

DOB:

Claim # YTEC 01212

Date of visit: 08/11/10

Subjective: Mr. Baker returns to the clinic for evaluation of chronic low back pain. He reports that his medications are not working adequately and he is hoping to have it increased to 4 times a day. He continues to have significant lower back pain preventing him from doing many "normal" activities of daily living. Any prolonged walking significantly aggravates his pain.

Objective: He is a well-developed, well-nourished, slightly overweight white male in significant distress. He continues to ambulate with the aid of a cane. He shows no signs of cognitive impairment and cranial nerves II through XII remain grossly intact. He continues to have lumbar paraspinal tenderness with limited range of motion to include flexion and extension. There no new neurologic deficits noted. He does not have any edema or bruising at this time.

Assessment:

- Lumbar degenerative disc disease with radicular pain
- Opiate induced hypogonadism and erectile dysfunction

Plan:

- Since he demonstrates compliance with medications and no aberrant behavior, he is not having adequate pain control at this time on a regular basis, increased the Oxycodone to 30 mg one p.o. 3-4 times per day p.r.n. pain and for a total of 100 tablets. He was instructed that this is not an authorization for him to take one q.i.d. every day. He verbalized understanding.
- He did not bring, nor did we discuss the Testim. I will call this into the pharmacy. Therefore we will refill his Testim for another month.
- Refilled the Oxycodone without changes for one month.
- He continues to have 2 refills on the Gabapentin and 3 on the Ambien.
- He is to return to the clinic in one month or p.r.n.

Constance Alger, FNP-BC
Electronically Signed

C. Gregory Kang, MD

cc: Workman's Compensation

Rite Aid: 248-5731

Oxycodone 30mg one p.o. 3-4 times per day p.r.n. pain (#100/___/___)

Gabapentin 300mg 2 po q.h.s (#60/2 RF/___)

Ambien 10 mg one p.o. q.h.s. p.r.n. sleep (#30/2 RF/___)

Testim 1% 5 g q. day (#30/0 RF/___)

Last UDS: 01/28/10 Allergies: NKDA

Pain, Spine and Sports Medicine

3029 Newcastle Loop
Myrtle Beach, SC 29588
Office: (843) 215-8868 FAX: (843) 215-9555

Patient Name: Bobby Baker

DOB

Claim # YTEC 01212

Date of Visit: 09/08/10

Subjective: Mr. Baker returns to the clinic for evaluation of chronic low back pain. He reports that his medications are working adequately. His biggest complaint is that he continues to have the negative effects of low testosterone to include hot flashes, decreased energy and decreased sexual function despite taking the Testim every day. He would like some help in this regard. His wife is requesting this too.

Objective: He is a well-developed, well-nourished, slightly overweight white male in significant distress. He continues to ambulate with the aid of a cane. He shows no signs of cognitive impairment and cranial nerves II through XII remain grossly intact. He continues to have lumbar paraspinal tenderness with limited range of motion to include flexion and extension. There no new neurologic deficits noted. He does not have any edema or bruising at this time.

Assessment:

- Lumbar degenerative disc disease with radicular pain
- Opiate induced hypogonadism and erectile dysfunction

Plan:

- Since he demonstrates compliance with medications and no aberrant behavior, refilled the Oxycodone without changes.
- He continues to have 2 refills on the Gabapentin. I recommended he start taking one twice a day instead of 2 p.o. q.h.s.
- He continues to have 2 refills remaining on the Ambien.
- Increased the Testim to 7.5 g per day. Next month, I will order repeat serum testosterone levels.
- Started Cialis 2.5 mg one p.o. q. day.
- He is to return to the clinic in one month or p.r.n.

Constance Alger, FNP-BC
Electronically Signed

C. Gregory Kang, MD

cc: Workman's Compensation

Rite Aid: 248-5731

Oxycodone 30mg one p.o. 3-4 times per day p.r.n. pain (#100/ /)

Gabapentin 300mg 2 po q.h.s (#60/ 1 RF/) take one p.o. b.i.d.

Ambien 10 mg one p.o. q.h.s. p.r.n. sleep (#30/ 1 RF/)

Testim 1% 7.5 g q. day (\$45 5 gm tubes / 0 RF/)

Cialis 2.5 mg one p.o. q. day (#30/ 0 RF/)

Last UDS: 01/28/10 Allergies: NKDA Repeat Serum Testosterone Next Month

PATIENT: BOBBY BAKER
DATE: 10/07/10

BRIEF HISTORY:

Mr. Baker returns in follow-up. He reports fair pain control. His pain is a 6-7 out of 10 on the VAS scale. It is mainly in the lower back and hips. It radiates down the legs. He wasn't able to tolerate the Testim. It seemed to cause a lot of nausea and sweats. It could be the formulation. He also reports the Gabapentin doesn't seem to be working as well as before for the radicular component of the pain.

PHYSICAL EXAMINATION

Examination today reveals that he is alert. His speech is fluent. He has limited lumbar flexion and extension secondary to pain. Straight leg testing is negative. Neurologically, no new changes.

DIAGNOSTIC IMPRESSION:

1. Lumbar degenerative disc disease.
2. Opioid induced hypogonadism.
3. Chronic pain.

RECOMMENDATIONS:

1. Refilled Oxycodone. —
2. Discontinue Testim.
3. We will try Androgel 5 grams daily.
4. We will repeat urine drug test today.
5. Increase Gabapentin to 300 mg three times daily.

C. Gregory Kang, M.D.
Physiatrist

CGK/dh

cc: Worker's Compensation carrier

Cxg 30 Q100 - 10/18
Ambien 10 HS - Q100
TRILETID - 248-5731

Pain, Spine and Sports Medicine

3029 Newcastle Loop
Myrtle Beach, SC 29588
Office: (843) 215-8868 FAX: (843) 215-9555

Patient Name: Bobby Baker

DOB:

Claim # YTEC 01212

Date of visit: 11/04/10

Subjective: Mr. Baker returns to the clinic for evaluation of chronic low back pain. He reports that his medications continue to work adequately and he has no desire for changes. He reports his lower back pain continues to radiate into his hips bilaterally and he rates it at a 6-7/10 on VAS. He also reports that he went to Florence for a surgical consultation as arranged by the patient. He is awaiting the results of that meeting. He also reports that the Testim was discontinued and he started the AndroGel.

Objective: He is a well-developed, well-nourished, slightly overweight white male in significant distress. He continues to ambulate with the aid of a cane. He shows no signs of cognitive impairment and cranial nerves II through XII remain grossly intact. He continues to have lumbar paraspinal tenderness with limited range of motion to include flexion and extension. There no new neurologic deficits noted. He does not have any edema or bruising at this time.

Assessment:

- Lumbar degenerative disc disease with radicular pain
- Opiate induced hypogonadism and erectile dysfunction

Plan:

- Since he demonstrates compliance with medications and no aberrant behavior, refilled the Oxycodone without changes.
- Continues to have one refill remaining on the Gabapentin and wrote Ambien without changes +5 refills, and the AndroGel and Cialis without changes +3 refills.
- He is to return to the clinic in one month or p.r.n.

C. Kang

Constance Alger, FNP-BC
Electronically Signed

C. Gregory Kang, MD

cc: Workman's Compensation

Rite Aid: 248-5731

Oxycodone 30mg one p.o. q.i.d. p.r.n. pain (#120/____/____)

Gabapentin 300mg one p.o. t.i.d. (#90/____/____)

Ambien 10 mg one p.o. q.h.s. p.r.n. sleep (#30/ 5 RF/____)

AndroGel 5 g q. day (\$#2/ 3 RF/____)

Cialis 2.5 mg one p.o. q. day (#30/ 3 RF/____)

Last UDS: 01/28/10 Allergies: NKDA Repeat Serum Testosterone Next Month
11/6/10

30104802

Quantitative Metabolite Profile Contents:

Benzodiazepines, Gabapentin (Neurontin), Heroin, Meperidine, Oxycodone, Opioid Analgesics (including Codeine, Fentanyl, Morphine, Hydrocodone, Hydromorphone, Dihydrocodeine, Oxycodone, Oxymorphone, Meprobamate, Methadone, Propoxyphene), Pregabalin (Lyrica), Tramadol, Specimen Validity Testing (including Nitrites, Chromates, Specific Gravity, pH, Creatinine).

VERSION 08/01/08

PROGRESS NOTES

Name _____ Birthdate _____ File # _____ Page _____

style w/ 5/5/08.

cent. Fell on head not needed.

Neck → better

8 weeks

AMH

① can

① as

① h/w

PSH

RH

ch LBP, rotate @ leg (all)

① w/ S

Silly is worse than stork

SH - N/A

No rubens.

o.c. coll. n.d.g.

① B+B.

7/10/08

SH

① w/

① zll

① long

(Kingsht)

conny

ESS + 2 DR. Sorens phelp.

Mod

Xo Sol

Abstr

① data pt → helped →

worried for ~ 1 year.

75% P. redut

PSO

Name: **BAKER, BOBBY**
Chart: **10016**
Date: **8/19/2009**



PATIENT DATA FORM

LAST NAME: **BAKER**
FIRST NAME: **BOBBY**
MIDDLE NAME: **E**
STREET ADDRESS: _____
MAILING (If different): _____
CITY, STATE, ZIP: _____
PHONE (HOME): _____ (CELL) _____

DATE OF BIRTH: _____ AGE: **51 Yr** RACE: _____
SOCIAL SECURITY #: _____ SEX: **M F**
EMAIL: _____
REFERRING PHYSICIAN: **NONE**
DATE OF INJURY: **5/5/08**
DATE CONDITION OCCURRED: **5/5/08**

INSURANCE INFORMATION

Please give receptionist your insurance cards!

PRIMARY #: **BECK FORD LINCOLN NATIONAL**
SECONDARY #: **Work Compensation**

CREDIT HISTORY

PLEASE CIRCLE ONE OF THE FOLLOWING.
Do you OWN or RENT your residence?

PLEASE CIRCLE ALL THAT YOU OWN.
VISA MASTERCARD DISCOVER

I AUTHORIZE COASTAL ORTHOPAEDIC ASSOCIATES, P.A. TO RELEASE MY INFORMATION TO THE FOLLOWING:
SPOUSE: **Peggy Baker** CHILD(REN): _____ OTHER: _____

I authorize release of information to any and all insurance carriers or Department of Social Services to allow processing of an insurance claim. A copy of this authorization may be used in place of the original.

COASTAL ORTHOPAEDIC ASSOCIATES PARTICIPATES WITH
BLUE CROSS BLUE SHEILD OF SOUTH CAROLINA (STATE BLUE CROSS BLUE SHEILD OF SC), MEDICARE,
MEDICAID WITH REFERRAL, SELECT HEALTH MEDICAID WITH REFERRAL, MEDCOST, HEALTH CARE SAVINGS,
PREMIER, BEECHSTREET, AETNA, BENEFIT ADMINISTRATORS, AND UNITED HEALTHCARE. WE WILL FILE CLAIMS
FOR THESE COMPANIES.

I fully understand that I am responsible for payment of professional fees to Coastal Orthopaedic Associates, P.A.

FULL PAYMENT IS EXPECTED WHEN SERVICES RENDERED. We will provide you with the appropriate forms and are happy to assist you with your insurance claims. If you anticipate a problem with payment, you must discuss this with our business staff prior to your visit. TELEPHONE (843) 347-7222. Any account balance 60 days old may be charged 1.5% interest PER MONTH.

I HAVE BEEN OFFERED A COPY OF THE PRIVACY POLICY!

I authorize the physicians and staff of Coastal Orthopaedic Associates, P.A. to perform indicated medical care.

Bobby Baker
Signature Patient or Legal Guardian

DATE: **8/18/09**

Please provide employer information for you and your spouse. If the patient is a minor, please provide employer for patient's mother and father.

NAME OF SPOUSE(PARENT): **Peggy Baker**

PATIENT'S EMPLOYER

(IF MINOR FATHER'S EMPLOYER)

OCCUPATION: **Maintenance**
COMPANY NAME: **Hilton Corp/Kingston Plantation**
ADDRESS: **9100 Queensway Blvd**
CITY, STATE, ZIP: **Murrell Beach**
PHONE #: **843-788-0006**
DATE OF BIRTH: _____
SOCIAL SECURITY #: _____

SPOUSE EMPLOYER

(IF MINOR MOTHER'S EMPLOYER)

OCCUPATION: _____
COMPANY NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE #: _____
DATE OF BIRTH: _____
SOCIAL SECURITY #: _____

Reviewed By: _____ Chart#: _____

Name: BAKER, BOBBY
Chart: 10016
Date: 8/19/2009



NEW PATIENT ENCOUNTER FORM
COASTAL ORTHOPAEDIC ASSOCIATES, PA
ORTHOPAEDIC SURGERY

PATIENT NAME: BAKER, BOBBY

☒ MALE

☐ FEMALE

AGE: 51 Years

☒ WHITE

☐ BLACK

☐ HISPANIC

☐ OTHER:

REFERRED BY (PHYSICIAN):

Brenda Zitu RN Case Manager
(FIRST AND LAST NAME)

PRIMARY CARE DOCTOR:

Jason C. Rosenberg M.D.
(FIRST AND LAST NAME)

BRIEFLY DESCRIBE INJURY/ACCIDENT/PROBLEM:

Head, Neck, Back
Ceil Fell hit me in (head, neck, back) knock me down
in Floor.

DATE OF INJURY/WHEN PROBLEM BEGAN:

5-5-08

LIST ALL SIGNIFICANT MEDICAL PROBLEMS (high blood pressure, diabetes, high cholesterol, etc.):

cholesterol

and sci nerve
? taken
↓
again?

→ ESI - 5/15

→ RIF - 5/15

Back pain

stimulation

OPT

MRT
Hwy 101

Name: **BAKER, BOBBY**
Chart: **10016**
Date: **8/19/2009**



LIST ALL PAST SURGICAL PROCEDURES, INCLUDING DATES:

Lower Right Hemis July 1997
August 2001-02 Right Hand

LIST ALL CURRENT MEDICATIONS, INCLUDING DOSAGE:

Nucynta 100 mg ✓
take 1 by mouth
3 times a day as
needed for chronic pain

LIST ALL DRUG ALLERGIES:

Codine
Banadine

LIST FAMILY MEMBERS WITH SIGNIFICANT MEDICAL PROBLEMS:

(cancer, heart attack, or stroke at young age, etc.)

Kyle mother - 4y

WHAT DO YOU DO FOR A LIVING? _____

IF A STUDENT, WHAT SCHOOL AND GRADE: _____

DO YOU SMOKE? ☒ YES ☐ NO IF SO, HOW LONG? Quit 1995
Started Back 2005

DO YOU DRINK? ☐ YES ☒ NO IF SO, HOW LONG? _____

Name: **BAKER, BOBBY**
Chart: **10016**
Date: **8/19/2009**



REVIEW OF MEDICAL SYSTEMS:

Check any of the following symptoms that you have now or have had in the past several months.

CONSTITUTIONAL

- ☐ ~~Significant weight loss~~
- ☒ Significant weight gain
- ☐ Difficulty sleeping
- ☐ Unexplained high fever
- ☐ Other: _____
- ☐ None

EARS, NOSE & THROAT

- ☐ Difficulty hearing (hearing aid, etc.)
- ☐ Chronic ear infections
- ☐ Difficulty with smelling
- ☐ Difficulty swallowing
- ☐ Other: _____
- ☐ None

GASTROINTESTINAL

- ☐ Heartburn
- ☐ Diarrhea
- ☒ Constipation
- ☐ Persistent abdominal pain
- ☐ Other: _____
- ☐ None

SKIN

- ☒ Discoloration of skin
- ☐ Enlarging mass
- ☐ Irregular moles
- ☐ Breast lump/mass
- ☐ Other: _____
- ☐ None

MUSCULOSKELETAL

- ☒ Joint pain
- ☐ Joint stiffness
- ☐ Swelling
- ☒ Loss of strength
- ☐ Other: _____
- ☐ None

EYES

- ☐ Blurry Vision
- ☐ Corrected Vision
(Contacts or Glasses)
- ☐ Other: _____
- ☐ None

CARDIOVASCULAR

- ☐ Chest palpitations
- ☐ Chest pain
- ☐ Other: _____
- ☐ None

HEMATOLOGY/ENDOCRINOLOGY

- ☒ Easy bruising
- ☐ Uncontrollable bleeding
- ☐ Persistent warmth/coolness
- ☐ Other: _____
- ☐ None

ALLERGY/IMMUNOLOGY

- ☒ Rash
- ☒ Itching
- ☐ Persistent sinus infection
- ☐ Other: _____
- ☐ None

NEUROLOGICAL

- ☒ Numbness
- ☒ Tingling
- ☒ Persistent/Frequent headaches
- ☐ Other: Stuttering
- ☐ None

Name: **BAKER, BOBBY**

Chart: **10016**

Date: **8/19/2009**



* 1 0 0 1 6 - 1 *

PSYCHOLOGICAL

- ☐ Significant mood changes
☐ Memory loss
☐ Anxiety
☐ Other: _____
☐ None

RESPIRATORY

- ☐ Persistent cough
☐ Shortness of breath
☐ Other: _____
☐ None

UROLOGICAL

- ☐ Blood in urine
☐ Difficulty starting urine
☐ Difficulty maintaining stream
☐ Other: _____
☐ None

OSTEOPOROSIS

SINCE AGE 45 HAVE YOU EXPERIENCED A FRACTURE (BROKEN BONE), AT ANY OF THE FOLLOWING SITES?

- ☐ Hip
☐ Rib
☐ Wrist
☐ Spine
☒ None

HAVE YOU EVER BEEN TREATED OR TOLD YOU HAVE OSTEOPOROSIS OR OSTEOPENIA?

- ☐ Yes
☒ No

HAVE YOU HAD A BONE DENSITY TEST (DEXA) PERFORMED IN THE PAST TWO YEARS?

- ☐ Yes
☒ No

Where: _____ When: _____

HAVE YOU EVER BEEN DIAGNOSED WITH MENOPAUSE (CHANGE OF LIFE)?

- ☐ Yes
☒ No

Bobby Baker
Signature (Patient or Legal Guardian)

Date: 9-5-09

BOBBY BAKER

Date: 09/08/2009
Case No. 10016
AGE/SEX:

Referred By:

CHIEF COMPLAINT: Evaluation for further treatment related to his chronic back pain.

PRESENT ILLNESS: Worker's comp. The patient had a work related injury 05/05/2008. He said a ceiling fell and hit him in the neck, head, and back and knocked him to the floor. He has had epidurals by Dr. Sarb, RF by Dr. Rosenburg. He is now being evaluated for a stimulator. He has had an MRI which is unavailable today. He has not had any physical therapy. Current medications include Nucynta which does help. Please see gray sheet for past family, social history, medications, medical problems, and review of systems. He has worked in maintenance at Kingston Plantation for approximately 4 years. He has prominent low back pain. He says his right leg occasionally gives way and he has some left calf cramping.

PHYSICAL EXAMINATION:

VITAL SIGNS: HT 5 feet 8 inches, WT 196 pound male, Respirations 18.
NEUROLOGIC/LOWER: Strength, sensory, reflex exam of lower extremity including patellar, Achilles, medial hamstring reflexes within normal limits. Plantar responses downgoing. No ankle clonus or increased tone/cogwheeling noted.
VASCULAR: Distal pulses intact. No skin changes consistent with vascular insufficiency.
HIP: Patrick's sign negative. Passive range of motion with internal/external rotation without pain. Log rolling negative. No significant trochanteric tenderness.
KNEE: No effusion, erythema or increased warmth noted. Lachman's normal. Varus/valgus stress at 0 and 30 degrees without abnormal laxity/instability. Joint line without tenderness. Patellar movement symmetric without tenderness of patellar facets. Apprehension sign

Initial Visit Report for BAKER, BOBBY
 Case No. 10016
 09/08/2009
 Page 2

negative. Anterior/posterior drawer within normal limits.

SHOULDER: Active/passive range of motion within normal limits without pain. No tenderness to palpation of AC joint, subdeltoid bursa or biceps tendon. Negative impingement or apprehension sign. No instability noted.

LUMBAR SPINE: No SI or facet dysfunction. Negative straight leg raise in seated and supine position. He has moderate restriction of extension greater than flexion.

IMPRESSION: Chronic back pain.

PLAN: We have gone over the various options today. One, we think prior to stimulator, which we think _____ low yield subjective only treatment in this milieu. We think a formal course of physical therapy would be more likely to benefit. We will defer this, however, until we are able to see either or both the report and the actual films, to get an evaluation for true extent of underlying pathology, which is likely degenerative disk disease based on the patient's complaints and findings. In addition, prior to any stimulator, we think a Functional Capacity Evaluation would also be reasonable to get a determination of the patient's vocational abilities.

Jeffrey C. Wilkins, M.D.
 6598

/5154

PATIENT PAIN DRAWING

Name Bobby Baker

Date 9-5-09

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

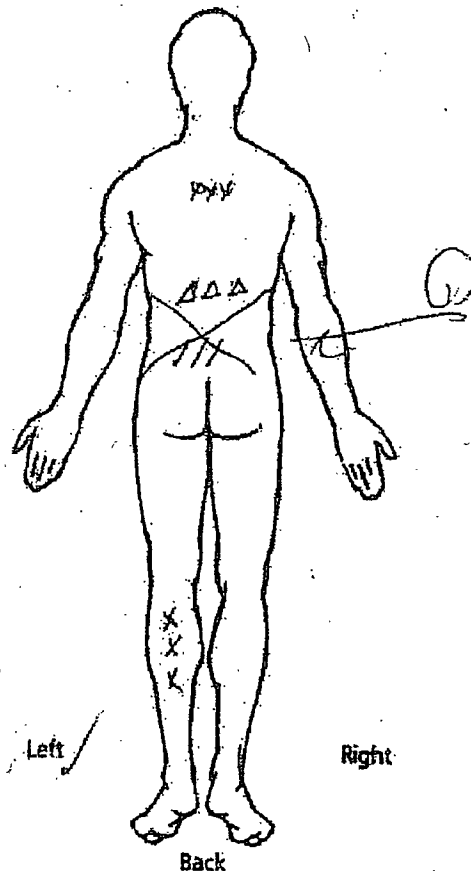
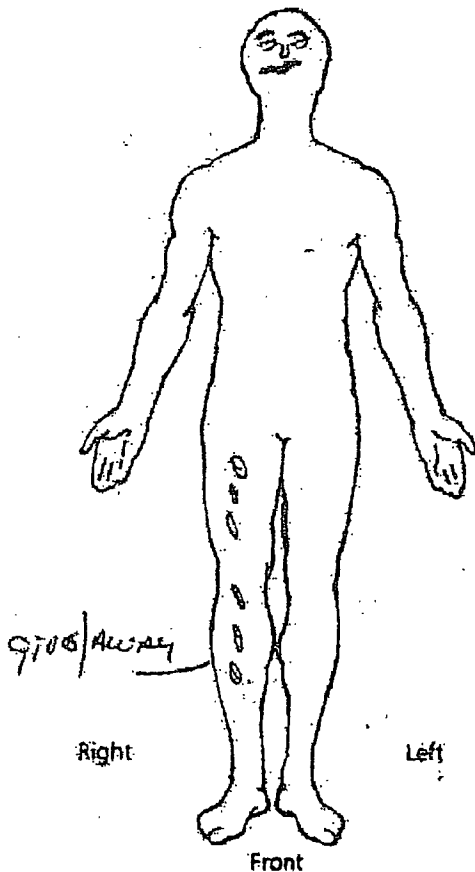
Aching
△ △ △

Numbness
= = =

Pins and needles
○ ○ ○

Burning
x x x

Stabbing
/ / /



How bad is your pain now?

Please mark with an X on the body form where the pain is worst now.

Please mark on the line how bad your pain is now:

No pain _____ X _____ Worst possible pain

THE JOURNAL OF
MUSCULOSKELETAL MEDICINE

THE JOURNAL OF MUSCULOSKELETAL MEDICINE
Volume 6, Number 9 • September 1989

BOBBY BAKER

REF:

10016

10/05/2009

He returns today with terrible incapacitating pain for two days after 10 pounds of traction. He notes _____ single point cane. We discussed with the patient's wife and his rehab nurse, we have no neuromusculoskeletal pathology to explain how one can walk with a cane, whose purpose would be to unload your spine would be fine but 10 pounds of traction which would basically cause no demonstrable affect on the lumbar spine be so painful. He says he is doing well on the Xodol, although it causes sedation. I cannot recommend any further physical therapy or other interventional techniques for such a non-physiologic response and we recommend a Functional Capacity Evaluation. Apparently Luke Rankin, the patient's attorney, wants to continue to push the spinal cord stimulator. He has asked for an additional opinion. We have recommended Dr. John _____. Dr. _____ is the physician that I think has the longest period of expertise in our area. He would be a different speciality than that obtained before and I think he would give a cogent treatment as he _____ performs these procedures. I cannot strongly enough recommend against the stimulator. I think that, again, two days of incapacitation from 10 pounds of traction does not strike me as the profile of someone likely to have dramatic improvements in their quality of life, and more importantly ability to function with a spinal cord stimulator.

Jeffrey C. Wilkins, M.D.

/5154

6811

Chart Copy

Wilkins

PSYCHOLOGICAL AND TRAINING SERVICES, P.A.

926 St. Andrews Rd., Columbia, SC 29210

bobnorabrabham@bellsouth.net

PH: 803-731-0588 FAX: 803-731-0589

ROBERT E. BRABHAM, PH.D.

LICENSED PSYCHOLOGIST
MASTER'S IN REHABILITATION COUNSELING
CERTIFIED BRAIN INJURY SPECIALIST
LIFE CARE PLANNER

ROB BRABHAM, MRC, CRC

NORA HEAPE, RN, BA

BETH BURNETT, BA, ED.

TO: Mr. Luke Rankin, Attorney

FROM: Robert E. Brabham, Ph.D. *Robert E. Brabham*

DATE: October 12, 2010

RE: Bobby Baker

Background and History: On 07-21-10, I prepared a vocational and psychological evaluation regarding Mr. Baker. Based on a combination of factors, medical conditions, limitations and restrictions, it was my opinion that Mr. Baker has experienced a (Physical) Traumatic Brain Injury and must be expected to permanently remain unable to engage in full-time gainful, competitive employment as a result of his medical conditions resulting from his on-the-job injuries in May 2008.

Your office has provided me with additional medical records from Dr. Michael McCaffrey and Dr. Randolph Waid which were not available to me at the time of my evaluation. The purpose of this report is to provide a brief addendum to my 2008 report.

Records Reviewed: On 09-29-10, Dr. Randolph Waid indicated, "...status post head injury sustained work related capacities on May 5th, 2008...the current neuropsychological evaluation was revealing of an individual who has a history of educational deficiencies...intellectual functioning was assessed as borderline...compromise in his capacity to sustain attention/concentration with slow mentation and significant compromise in anterograde memory...continues to be compromised in his motor functioning, particularly with regard to weakness and spasms affecting the lower extremities...individual is most encumbered by pain, somatic symptoms and physical limitations...comorbid depression, sleep disturbance that is assisted by the use of medication, as well as increased irritability/impatience...easy fatigueability..."

Dr. Waid concluded, "...I am in agreement with previous opinions that Mr. Baker is not capable of returning to employment capacities...it is also evident that Mr. Baker is experiencing neurocognitive impairments affecting his capacity for attention, concentration, memory and other brain behavior functions...causal factors for neurocognitive impairments involve the interfering effects of chronic pain/somatic symptoms, psychological disruption, fatigue, use of a regiment of medications, and residuals of a mild traumatic brain injury...I believe it evident that the primary obstacle to Mr. Baker's ability to return successfully to role functioning are the residuals from the orthopedic injury with resultant chronic pain, somatic symptoms, and balance/dyscoordination difficulties...Cognitive Disorder secondary to the interfering effects of chronic pain/somatic symptoms, psychological disruption, fatigue, use of medications, and residuals of a mild head injury...Mood Disorder with depressive features secondary to chronic pain syndrome...status post mild traumatic brain injury, chronic low back pain with radiation

down the legs, disequilibrium/poor balance, head pain/neuralgia, tinnitus affecting the left ear...need for continuing pain management intervention, disability/unemployment, Workers' Compensation.."

On 10-12-10, Dr. Michael McCaffrey noted, "...I concur with the opinion of Dr. Randolph Waid that Bobby Baker has sustained a permanent physical brain injury..."

Review of Vocational Evaluation and Labor Market Survey: Also requested by your office, I have reviewed the Vocational Evaluation and Labor Market Survey regarding Mr. Baker as prepared by James R. Myers, MA on October 2, 2010. I respectfully disagree with the conclusion that he reached in his report. It is my opinion that he has failed to give proper weight to the numerous medical reports describing his continued pain over an extended period of time dating back to his injuries in 2008.

Mr. Myers correctly noted that Mr. Baker continues to be prescribed narcotic pain medications, requires the use of a cane for mobility and stability, and is receiving other pain treatment. He failed to consider Mr. Baker's need to rest/recline for nearly 50% of every day due to his continued pain with nearly any activity. He also failed to take note of my report wherein it notes Mr. Baker's need for assistance in dressing occasionally due to his inability to bend without experiencing significant pain. Finally, he also failed to take into consideration his inability to be present at any potential job for far more days than the average job permits. Mr. Meyers has also misrepresented Mr. Baker's attempts to continue as many activities as possible around his home. He described those activities, but failed to also describe his marked limitations following any efforts at activity and his inability to sustain even those household activities for more than a few minutes at a time.

Mr. Myers also failed to take into consideration Mr. Baker's ongoing difficulty with sustaining concentration and attention to complete any task, which he attributes to side-effects of prescription narcotic medication, as well as symptoms of depression and anxiety. As noted in my 07-21-10 report, Mr. Baker is suffering from a Pain Disorder, Depressive Disorder, Generalized Anxiety Disorder, and Cognitive Disorder, Secondary to a Traumatic Brain Injury, all of which contributes to an inability to sustain concentration and attention, as well as process and organize information.

It is also worth noting that while Mr. Myers correctly noted Dr. Kang's opinion that he believes Mr. Baker is capable of sedentary type activity, he failed to also indicate that Dr. Kang suggested that MR. Baker get a spinal cord stimulator trial to see if that would be an acceptable alternative for pain control in the lower back and legs. This indication by Dr. Kang clearly supports the reports of continued pain by Mr. Baker, which clearly affect his ability to work in any gainful employment.

Specifically, my reaction to his suggested alternative vocational options are as follows:

Generally his "Labor Market Surveys" concludes that he is able to provide a variety of physical activities on a sustained basis. Obviously, his analysis ignores physical limitations in that he suggested a variety of jobs which would require that Mr. Baker be on his feet throughout a workday. It is also noted that his efforts at describing available jobs in the Myrtle Beach area is now more than a year old. The high unemployment rate in that area has continued during that

period and further deterioration in Mr. Baker's employability has resulted. It should also be noted that Mr. Myers cited out-of-state jobs as available options for employment, which suggestions completely ignore Mr. Baker's inability to travel for insignificant periods of time without experiencing significant pain when seated in a relatively fixed position as driving/traveling requires.

Mr. Myers clearly identified within his report Mr. Baker's ongoing low back pain which radiates down both legs. He also suggested several possible alternative employment settings which would require a combination of sitting, standing and walking throughout a workday. As noted in my 07-21-10 report, Mr. Baker's primary daily exercise is to walk out to the horse barn, only about 400 feet, but then requires a break to recover before returning to the house. Mr. Myers had to have been aware of Mr. Baker's report that after sitting or standing for even a brief period of time, he then requires an even greater period of time resting or reclining to "recover" from sitting. Therefore, all of the jobs he suggested are inappropriate, incorrect, and fail to take into consideration the full range of information available to Mr. Myers. Specifically, the suggestions that he could be an Assembler, Greeter, Order Clerk, Collection Clerk, Escort Driver, Sorter, etc. are totally bogus suggestions.

He also suggested several possibilities that are equally inappropriate due to his total lack of a high school education/GED. With numerous qualified applicants available for all openings, it is unreasonable to suggest that any potential employer would need to make accommodations to Mr. Baker. Specifically, this would include his suggestion that he could become a Greeter, an Assembler, Industrial Order Clerk, or Collection Clerk. Mr. Myers surely knows, for example, that these positions either require a high school diploma/GED or excellent customer service, and written and verbal communication skills, which qualifications Mr. Baker does not possess as a high school dropout. As indicated in my 07-21-10 report, Mr. Baker has a history of failing the 1st grade and barely passing all others, an inability to handle the paperwork or financial aspects of his auto mechanics business in the past, a current borderline IQ and ability to function at only elementary grade levels.

He also suggested he could work on a full-time basis as some type of Escort Driver. However, he also ignored Mr. Baker's report that driving in his own vehicle creates considerable low back pain. If he is unable to drive for extended periods of time, it is totally inappropriate to suggest that he could become a full-time driver. It is also unreasonable to suggest that someone taking narcotic pain medication would be an appropriate driver. Surely Mr. Myers forgot that Mr. Baker is taking these medications.

Summary and Conclusions: In summary, it is unfortunate that none of the suggestive alternative employment settings Mr. Meyers noted are actually appropriate or reasonable. Mr. Baker would be delighted if he were able to return to gainful employment, as correctly indicated by Mr. Myers within his report, and would no doubt be pleased to be able to perform any of the suggested jobs. However, that is simply not the case and all of these suggestions ignore pertinent medical information. I regret to conclude that my original opinions remain the same, and are further supported by the opinions of Dr. Waid and Dr. McCaffrey, that Mr. Baker did in fact sustain a permanent physical brain injury as a result of his on-the-job injuries. Mr. Baker is unable to sustain gainful employment for an 8-hour day, 5-days per week.

In the event that Mr. Baker might yet, apparently against all odds, achieve further medical improvement which would permit him to engage in full-time employment, the jobs described earlier by Mr. Myers would remain in appropriate and unfeasible. However, at best, Mr. Baker could expect to earn no more than about \$7.00 per hour - \$8.00 per hour in jobs for which a high school dropout without further skills, training, or certifications and credentials could possibly earn. Using the mid-point of those figures, at \$7.50 per hour, Mr. Baker will thus be experiencing a significant loss of weekly income. At the time of his injuries he was reportedly earning \$833 per week, working two full-time jobs simultaneously.

PSYCHOLOGICAL AND TRAINING SERVICES, P.A.

920 St. Andrews Rd., Columbia, SC 29210

PH: 803-731-0588 FAX: 803-731-0589

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MASTER'S IN REHABILITATION COUNSELING
CERTIFIED BRAIN INJURY SPECIALIST-INSTRUCTOR
CERTIFIED LIFE CARE PLANNER

BETH BURNETT, BA, ED.
MAYA LENYOUN, MS, CLCP

PSYCHOLOGICAL and VOCATIONAL EVALUATION

Name: Bobby Baker

ID Number:

Date of Birth:

Age at Evaluation: 52

Date of Evaluation: 07-20-2010

Date of Report: 07-21-2010

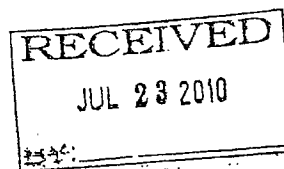
Referral and Background Information: Mr. Baker is a 52-year-old former full-time Resort (Hotel) Maintenance Worker for The Hilton. He also simultaneously worked a second full-time job as an Auto Mechanic. He was referred for an independent psychological and vocational evaluation to determine vocational implications, and earnings issues, if any, related to limitations resulting from on-the-job injuries he sustained on 05-05-2008.

Mr. Baker sustained on-the-job injuries while inspecting fireproof ceiling tiles with his supervisor. One of the tiles, which weighed approximately 30-pounds, fell about 10-12 feet and struck him in the head. He indicated that his supervisor noted that he had experienced a brief loss of consciousness after being "knocked to the ground". He suffered a scalp laceration which required 12 staples. He subsequently developed neck and back pain.

He returned to work the following day, but was unable to perform his essential job duties and was sent home by his supervisor. He was later diagnosed with a low back strain and restricted to "no lifting more than 5 pounds", but was again told to go back to work. (As will be noted, however, his supervisors concluded he was not able to perform his duties and they were not able to provide restricted permanent assignments.) He also developed a respiratory infection which further eliminated his ability to continue work as a Maintenance Worker. He also began to develop bilateral leg pain due to degenerative disc disease at L4-L5. He has not been cleared to return to work without restrictions and, thus, has been unable to return to any gainful employment as a result of his medical condition related to his on-the-job injuries.

With the passage of time, now more than 2 years after his injuries, behavioral and cognitive changes have persisted, as will be noted, sufficient to conclude that he obviously sustained post-concussion injuries, i.e. a physical traumatic brain injury, clearly the result of his on-the-job injuries.

He and his wife have been married for 26 years. They have 2 adult children. Ms. Baker has never worked outside of the home, but handled the "books and paperwork" in Mr. Baker's auto mechanic business.



Mr. Baker arrived promptly for this evaluation and drove himself. He still drives 1-2 times per week, but locally only to appointments and stores. However, he indicates he continues to experience considerable low back pain when seated in a relatively fixed position, as driving requires.

His general appearance, hygiene and personal grooming were good. He is 5' 8" in height, and weighs about 187 pounds, his usual weight. He wears glasses for reading and indicated that his eyesight has worsened following his on-the-job injuries. It is noted that changes in visual acuity are often noted following brain injuries. He does not require the use of a hearing aid, but began experiencing ringing in the ears following his on-the-job injuries. Again, this is a symptom often noted following brain injuries. He requires the use of a cane for mobility and stability and noted even with the use of a cane, he has fallen on two occasions since his on-the-job injuries. Balance difficulties not completely accounted for by orthopedic issues are also frequently seen following brain injuries. He wriggled and changed positions throughout the evaluation, citing low back pain.

At the time of this evaluation he was receiving \$623 per week in Worker's Compensation benefits, his only income. He noted having a "very bad problem" with the timely arrival of his weekly worker's compensation checks. He and his family continue to experience significant financial hardship as a result of his loss of income related to his medical conditions and ongoing symptoms. He indicated that "...I am on the verge of losing my home/land...I'm two years behind..."

Sources of Information:

Medical Records from:

Coastal Orthopaedic Associates, P.A.	Jeffrey Wilkins, M.D.
Pain, Spine & Sports Medicine	C. Gregory Kang, M.D.
	Constance Alger, FNP
Community Rehab Physical Therapy	Louise Pearce, RPT
Work Strategies/Select Physical Therapy	Kevin Bullard, P.T.
Lowe's Therapy	Phillip Lowe, P.T.
Waccamaw Community Hospital Pain Ctr.	Jason Rosenberg, M.D.
Strand Regional Specialty Associates	Michael McCaffrey, M.D.
Doctor's Care	
Grand Strand Regional Medical Center	Matthew Desalvo, M.D.

Psychological Testing and Evaluation Results:

- Wechsler Adult Intelligence Scale - Fourth Edition
- Wide Range Achievement Test - Revision 4
- Beck Depression Inventory - II
- Clinical Interview and Behavioral Observations
- Mental Status Examination
- Brain Injury Screening

Activities of Daily Living: He lives with his wife in a mobile home. He has difficulty navigating the 4 steps leading into the home and experienced one fall about 8-months ago which required EMS be called to the scene.

On most days, he gets up at about 9 AM and is able to handle his basic personal grooming and toilet needs without assistance. He occasionally requires assistance getting dressed due to his inability to bend without experiencing significant pain. He takes showers only due to his fear of falling getting in and out of the bath tub due to his balance difficulties. He avoids shoes with laces. He performs light chores around the home, but requires frequent breaks when doing so. He is unable to perform any strenuous chores/activity.

He seldom shops alone, and holds onto the grocery cart for stability. However, he cannot shop for any significant length of time due to pain. His "primary exercise" is simply to walk out to the horse barn, only about 400 feet, for daily exercise, but then requires a break to recover before returning to the house. In generally he is not able to sustain much activity, despite efforts to initiate activity due to pain.

In a typical 8-hour day he indicates he must spend about "50%" of the day reclining/resting on the sofa with pillows as a result of his physical limitations and pain. He watches television to pass the time. He noted, "...I'm bored to death..."

In a 5-day work week he indicated that he would have to miss about 2-3 days per week at any potential job due to pain problems associated with medical conditions that resulted from his on-the-job injuries. This would of course greatly exceed the number of days available for personal/sick leave in an average job in South Carolina, about 2-weeks per year. He noted, "...even with prescription medication...I can't get across town..."

He returns to bed at about 10 PM but gets only about 3-4 hours of non-restorative sleep, often interrupted by pain. He noted no prior history of sleep problems, but now requires prescription Ambien to "get off to sleep".

As a direct result of his on-the-job injuries he now participates in far fewer social or leisure activities than was the case prior to his injuries. He indicated that his relationships with friends, family and others have also changed as a result of his medical conditions. He noted he could no longer garden, hunt, fish, ride a four-wheeler, travel, water ski, ride horses, or volunteer with Cowboys for Christ, all activities he enjoyed prior to his on-the-job injuries.

He also admits that he has inadequate patience and is easily irritated. He noted he has difficulty concentrating and sustaining attention to complete any task. He noted, "...especially with prescription medication...it makes me stupid..." He pointed out his dilemma as to whether to avoid medications and then be subjected to severe pain, or take the medications and then be subjected to severe side-effects. His sexual activity has also changed as a result of his medical conditions as evidenced in multiple medical records, which adds to the depression he is experiencing. The overall quality of his life has clearly been greatly diminished by his injuries.

Educational Background: He has a limited educational background, having completed high school through the 9th grade. He quit school during the 10th grade and went to work. Thus, at the age of 52, he remains a high school dropout.

He noted a history of academic difficulties, failing the 1st grade and "barely passing all others". He acknowledged that he was "good with my hands" but described himself as having been "retarded in the books". He has received no further formal training and has no military experience. He also noted that he had been unable to handle the paperwork or financial aspects of his auto mechanics business in the past.

Work History: Mr. Baker has a stable work history. At the time of his on-the-job injuries, he was working full-time as a Resort (Hotel) Maintenance Worker for The Hilton for whom he had worked for the past 4 years. He earned \$11.45 per hour, working 40 hours per week. He also simultaneously worked a second full-time job as an Auto Mechanic.

Work as a Resort (Hotel) Maintenance Worker is defined by The Dictionary of Occupational Titles as semi-skilled and medium in physical demands. Such work is actually heavy as performed, at times, requiring that he lift in excess of 50 pounds, bend and stoop on a regular basis as part of his essential job duties. The heaviest items he was required to handle would have been air conditioning units or replacement furniture for the hotel or condo units.

As noted previously, he simultaneously worked a second full-time job as an Auto Mechanic for Hardwick Lube-It, earning \$10.00 per hour, clearing \$375.00 weekly. All of his prior work experience was as an Auto Mechanic (self-employment), earning about \$30,000.00 annually.

He insisted that in his employment he had no personnel or performance problems. He enjoyed his co-workers, his colleagues and got along well with his supervisors. He has never held an office/sedentary position and has no office/computer skills. He noted, "...I can't type a lick..." He has not been medically cleared to return to work and his employer is not able to provide permanent restricted duty work.

When asked about any prior injuries or pre-existing conditions, Mr. Baker noted a prior hand injury. However, he indicated that this injury did not prevent him from working. This prior injury is noted for historical purposes only, as Mr. Baker was working two full-time jobs simultaneously without difficulty at the time of his 2008 on-the-job injuries. Clearly it is the on-the-job injury in 2008, which began his medical problems.

Medical Problems: The medical aspects of his injury are documented in other reports, and will not be addressed in great detail herein. However, several more recent medical references have vocational significance and are noted accordingly.

On 05-06-08, Dr. Matthew Desalvo, an Emergency Room physician, noted, "...installing ceiling tiles...one of them fell down and hit him on the top of the head...he suffered a scalp laceration...neck pain...he did lose consciousness...knocked him down to the ground...cleared from C-collar...head contusion..."

On 06-16-08, records by Doctor's Care indicated, "...lower back and neck pain...tenderness...muscular spasm to low back...low back strain...ortho referral...no lifting more than 5 pounds...ground level work only, no ladder or heights...no repeated

bending, stooping, squatting, pushing, jerking, twisting or bouncing...no continuous standing and/or sitting...minimum walking, climbing (includes stairs)..."

On 06-26-08, Dr. Michael McCaffrey noted, "...low back pain...MRI of the lumbosacral spine showed degenerative disc disease at the L4-L5 level... weakness, fatigue, and difficulty sleeping since the accident...he wears glasses and has intermittent ringing in his ears...leg pain with exertion...low back pain with bilateral leg radiation and cold dysesthesia in his left leg...recent closed-head injury...frequent urination with micturition at night...intermittent muscle cramping in his lower extremities...difficulty climbing stairs and arising from the chair secondary to low back pain...check a nerve conduction study EMG of the right lower extremity to evaluation for any evidence of active lumbar radiculopathy...start on Tramadol...closed-head injury with a left occipital laceration...no work until further notice..."

On 07-07-08, Dr. McCaffrey indicated, "...nerve conduction study and EMG of the right lower extremity demonstrated a mild sensory neuropathy versus tarsal tunnel syndrome...refer for lumbar epidural steroid injections..." On 07-11-08, Dr. McCaffrey noted, "...he is having severe low back pain radiating into his right leg, which does not improve with Ultram...start on Dilaudid..."

On 07-17-08, Dr. Barbara Sarb performed an L4-5 lumbar epidural steroid injection. A second injection was performed on 07-31-08. (Mr. Baker indicated that these injections provided only relatively brief improvement in his pain symptoms.)

On 08-11-08, Dr. McCaffrey noted, "...he only received 10% improvement with his injections on 07/17/08 and 07/31/08...taking Ultram for low back pain...occasionally takes Dilaudid for severe pain of his low back...walking with a cane secondary to recurrent falls from severe right lower extremity pain with subsequent onset of right leg weakness...increasing problems with left occipital headaches...refer to chronic pain specialist for further evaluation and treatment of low back pain with right leg radiation ...remain out of work until 10/14/08...continue on Ultram and Dilaudid...left occipital headaches have been worsening over time...he may need to be put on a prophylactic medication for atypical migraine/cluster headaches in the very near future..."

On 09-21-08, Dr. Jason Rosenberg indicated, "...low back and right lower extremity pain...back pain is greater than leg pain...stiffness in the morning...increased pain associated with change in weather...cramping component which comes and goes...pain in his neck secondary to back and leg pain...job related injury...facet arthropathy...annular tear...neck pain...I suspect the pain in his back can be coming from his facet joints on his right side...it is common in acceleration/deceleration type injuries such as falling and can lead to inflammation and trauma to the facet joints...this manifests itself as low back pain radiating down the legs stopping at the knee, with stiffness in the morning...I recommend performing right-sided L3-S1 diagnostic medial branch blocks at the next available time...I would expect a 50% or greater reduction in his symptoms lasting four or longer hours...if we achieve this milestone, he would indeed suffer from facet arthropathy and would then be scheduled for radiofrequency ablation of the same nerves...once his low back pain is abated, I would consider further treatment for his neck..."

On 10-02-08, Dr. McCaffrey indicated, "...he has had intermittent sharp headaches with upper extremity tremor...continued low back pain with right leg radiation...increasing problems with impotence since his second lumbar epidural steroid injection...no response to Cialis or Levitra to help improve erectile dysfunction...he is developing worsening problems with impotence and we will start him on Viagra... he had a very mild 6 to 8 Hz tremor in the upper extremity which worsened on finger-nose-finger testing...no work until further notice..."

On 10-08-08, Dr. Rosenberg performed right L3 through S1 diagnostic medial branch block. On 10-15-08, he performed radiofrequency ablation right L3-S1 medial branch nerves.

On 11-02-08, Dr. Rosenberg noted, "...he is markedly reduced in his pain...the remainder of his pain is coming from his left-sided back...he has noticed a rash over the area that was treated which has been present since the procedure...job-related injury May 5, 2008 with resultant facet arthropathy...I am delighted he had excellent result from his right-sided radiofrequency procedure...I will see him back pending worker's compensation approval for left-sided diagnostic medial branch blocks leading to radiofrequency ablation..." On 11-17-08, Dr. Rosenberg performed left L3 through S1 diagnostic medial branch blocks. On 11-18-08, he performed radiofrequency ablation left L3-S1 medial branch nerves.

On 11-24-08, Dr. McCaffrey noted, "...he underwent radiofrequency ablation of the lumbar spine...developed reaction to the local anesthetic that was used at that time...he continues to have pain in the left occipital scar on the scalp...continue on Dilaudid...no work until further notice..."

On 12-01-08, Dr. Rosenberg noted, "...overall he is markedly improved...he has no pain when he is inactive...once he starts moving, he will have pain, which is as high as seven out of ten...facet arthropathy...skin rash with injections...he is now hurting in the area higher than previously treated...I would like to see if the pain is coming from his T12-L3 medial branch nerves by performing diagnostic medial branch blocks bilaterally at T12-L3..."

On 01-15-09, Dr. McCaffrey indicated, "...he had radiofrequency ablation done in the right lumbar region with improvement of his symptoms...he underwent a block in the left side of his lumbar spine which worsened the symptoms...he continues to have left occipital headaches which radiate into the left shoulder...these do start in a scar where he suffered a laceration in his left high parietal/occipital region of the scalp...chronic impotence secondary to Dilaudid which improves with Viagra...continue Dilaudid, Viagra...start on Gabapentin for left occipital headaches/neck pain..."no work until further notice..."

On 03-11-09, Dr. McCaffrey noted, "...he continues to have left occipital headaches which have not improved with Gabapentin...Viagra works for his impotence...continues to have macular rash in the left posterior flank after previous treatment with radiofrequency ablation...no work until further notice...patient at MMI... total/permanent disability due to workmen's compensation injury..."

On 04-09-09, Dr. Rosenberg indicated, "...his low back has greatly improved...he continues to have pain in the middle of his back and upper back...to determine the cause of the rash, I would continue by performing bilateral T12-L3 diagnostic medial branch blocks leading to radiofrequency ablation if positive..."

On 05-18-09, Phillip Lowe, P.T. performed a Functional Capacity Evaluation with Impairment Rating and concluded, "...the optimal work capacity at present was demonstrated to be at a light physical demand level...*examinee did not demonstrate the necessary physical demands to perform usual and customary job duties as a maintenance man*...the specific previous job tasks cannot be safely performed...performance of the previous job would require modification of technique or equipment...activities of daily living are significantly affected...potential for improvement of physical condition is unexpected...he may benefit from work condition...Guides to the Evaluation of Permanent Impairment, 5th Edition...his diagnosis is a lumbar facet arthropathy and an annular tear of the lumbar disc...7% whole person impairment due to the lumbar spine with the annular tear of his lumbar disc...for loss of flexion he receives a 4% whole person impairment...for loss of extension he receives a 2% impairment, for a total of a 6% whole person impairment...combining 6% whole person for loss of motion and 7% whole person for his diagnosis, produces a total of 13% whole person impairment...when converted to a regional spine impairment using the range of motion method, it equals a 14% impairment of the lumbosacral spine..."

On 07-22-09, Dr. Rosenberg performed right T12, right L1, right L2, and right L3 diagnostic medial branch blocks. On 07-30-09, he performed a repeat right T12 through L3 diagnostic medial branch blocks.

On 08-05-09, Dr. Rosenberg noted, "...no relief from the diagnostic medial branch blocks...several hours later...choking-type sensation...felt his throat was closing over...he continues to have pain in his low back on his right side, greater than left side...burning and stabbing...tingling sensation in his buttocks...relieved when he is lying down and better with activity...he will not be a candidate for the radiofrequency procedure on the right side from T12 through L3...we discussed spinal cord stimulation in great detail...I can create paresthesia encompassing the painful areas...the paresthesia is reportedly more pleasant than the sensation of pain...if he wishes to proceed with further workup for a spinal cord stimulation implant, he will need to undergo a psychological evaluation...once cleared, we would make arrangements to bring the patient back for a 1 or 2 lead trial...I think it is reasonable to see if he might improve from his chronic pain of his trunk and right lower extremity..." (Mr. Baker pointed out that he was anxious to cooperate and to receive the spinal cord stimulator, but it was never provided by the worker's compensation insurance carrier.)

On 08-06-09, Dr. Rosenberg noted, "...he underwent diagnostic medial branch blocks on the right side at T12-L3 at last visit...he was unable to determine the efficacy of the procedures...continues to have pain in his low back, worse on the right side...at the thoracolumbar junction...six out of ten...some relief with Dilaudid...pain is intensifying with walking and sitting...I would like to repeat his right T12-L3 diagnostic medial branch blocks..."

On 09-08-09, Dr. Jeffrey Wilkins indicated, "...chronic back pain...being evaluated for a stimulator...he has not had any physical therapy...current medications include Nucynta, which does help...he has worked in maintenance for approximately 4 years...he has prominent low back pain...his right leg occasionally gives way and he has some left calf cramping...we think a formal course of physical therapy would be more likely to benefit...prior to any stimulator, we think a Functional Capacity Evaluation would also be reasonable to get a determination of the patient's vocational abilities..."

On 09-29-09, Louise Pearce, RPT performed a Physical Therapy Evaluation and indicated, "...this patient presents to the department with signs and symptoms consistent with a diagnosis of acute low back pain...painful and limited ROM...deconditioned...muscle guarding...poor tolerance for weight bearing on right hip...poor tolerance for walking...rehab potential to reach goals is fair...to be seen 2-3 times a week...treatments to include IHEP, ongoing education, manual therapy, E-stim, STM, MFR, possible US, gentle stretching exercises..." Mr. Baker attended physical therapy on 09-30-09 and 10-02-09 and notes by Ms. Pearce on those dates noted, "...patient arrived utilizing a cane held in left hand and walking with difficulties... difficulties coming to stand and ambulate...less difficulties with positional changes... walking with better control with cane held in left hand...still exhibiting muscle guarding..."

On 10-05-09, Dr. Wilkins indicated, "...he returns today with terrible incapacitating pain for two days after 10 pounds of traction...he ambulates with a single point cane...we have no neuromusculoskeletal pathology to explain how one can walk with a cane whose purpose would be to unload your spine would be fine, but 10 pounds of traction which would basically cause no demonstrable affect on the lumbar spine be so painful... he is doing well on the Xodol...I cannot recommend any further physical therapy or other interventional techniques for such a non-physiologic response...recommend a Functional Capacity Evaluation...two days of incapacitation from 10 pounds of traction does not strike me as the profile of someone likely to have dramatic improvements in their quality of life, and more importantly ability to function with a spinal cord stimulator..."

On 11-04-09, Dr. C. Gregory Kang noted, "...lower back...pain radiates into the right leg and sometimes into the calf...occasional numbness in the right calf...occasionally his legs will turn cool...back pain far more than leg pain...he uses a cane because at times the right leg will give out due to back pain...he recently had a fall about two weeks ago when his right leg gave out...lumbar degenerative disc disease with lumbar facet syndrome...treatment modalities that seemed to have had the most success for the patient in the past were the radio frequency ablation as well as medical management...I think he is deserving of repeat radio frequency ablation in the lumbar spine through Dr. Rosenberg...he will also need continued medical management with his pain medications including Xodol...I do think that if he does get a radio frequency ablation procedure in the future and he does get pain reduction...this should be followed up by a physical rehabilitation program to increase his lower back flexibility and strength..."

On 11-18-09, Dr. Kang performed a diagnostic right L3, L4, L5 medical branch block. On 12-01-09, Dr. Kang performed radio frequency neurotomy of the right L3, L4 medical branch nerve and radio frequency neurotomy of the right L5 dorsal ramus.

On 12-31-09, Constance Alger, FNP-BC, assistant to Dr. Kang, noted, "...returns for evaluation of chronic low back pain...he reports that the last radiofrequency rhizotomy has not helped, but he realizes he is only 4 weeks into a 6-8 week healing process...he also reports that the Percocet is not working very well...he continues to have pain radiating down his right leg which significantly interferes with his sleep...lumbar degenerative disc disease with radicular pain...started Gabapentin for neuropathic pain...started Atarax for itching..."

On 01-28-10, Ms. Alger indicated, "...he reports that the last radiofrequency rhizotomy has continues to be ineffective and he has significant back and leg pain...still interferes with sleep...Gabapentin is not very effective, but it remains at a very low dose...he is having erectile dysfunction and is wondering if it could be related to his back or medications...lumbar degenerative disc disease with radicular pain...probable opiate induced hypogonadism and erectile dysfunction...refilled Percocet...increased Gabapentin ...started Klonopin for sleep and leg movement at night...significantly positive for low testosterone levels...Cialis... completed a Handicapped placard application..."

On 02-25-10, Dr. Kang noted, "...lower back pain is worse...pain is worse in the right leg and is also starting to develop in the left leg...radiofrequency ablation did not help at all...he is taking Percocet which is not relieving his pain to a significant degree...he is not sleeping at nighttime...he has not been able to return to work...lumbar degenerative disc disease with chronic lower back and leg pain...he pretty much has failed radiofrequency ablation, as well as physical therapy...I think it would be reasonable for him to have a spinal cord stimulation trial and if successful, permanent implantation...he is not at maximal medical improvement at this time...*I have asked him not to return to work...*"

On 03-22-10, Dr. McCaffrey completed a questionnaire wherein he concluded, "...I concur with the restrictions and impairment ratings of May 18, 2009 by Phillip Lowe... 14% impairment to the lumbar spine...5% impairment...dysfunction...18% whole person impairment..."

On 03-25-10, Dr. Kang indicated, "...he still has chronic back pain radiating down both lower extremities...he has failed radiofrequency denervation...his spinal cord stimulator was just denied...he is getting some relief with Oxycodone, Ambien, and Neurontin... multiple level lumbar degenerative disc disease with chronic back and leg pain...I don't have much more to offer Mr. Baker other than palliative care...refilled his medications..."

On 04-22-10, Ms. Alger noted, "...he reports that his medications are adequate most of the time...he has not heard anything about the FCE nor the neurostimulator...he continues to rate his pain as 7/10...he continues to ambulate with the aid of a cane...he continues to have lumbar paraspinal tenderness with limited range of motion to include flexion and extension...lumbar degenerative disc disease with radicular pain...opiate induced hypogonadism and erectile dysfunction...Oxycodone, Gabapentin and Ambien..."

On 05-10-10, Kevin Bullard, P.T. performed a Functional Capacity Evaluation and concluded, "...results of this evaluation indicated that Bobby Baker is functionally capable of work within the Light classification for an 8 hour work day...special considerations must be given in reaching/lifting to the floor level, carrying, crouching,

and climbing ladders due to exacerbation of low back pain..." He indicated that he could not drive or even sit up in a car for two weeks following the recent FCE. (With only a 9th grade education and markedly limited academic skills, as will be noted, the inability to do more than light work results in significant vocational barriers.)

On 05-20-10, Ms. Alger indicated, "...medications are not working properly and he has constant significant lower back pain...he continues to have significant leg pain at night interfering with his sleep...he continues to use the Testim as ordered...continues to ambulate with the aid of a cane...continues to have lumbar paraspinal tenderness with limited range of motion to include flexion and extension... lumbar degenerative disc disease with radicular pain...increased Oxycodone...refilled Gabapentin and Ambien..."

On 06-08-10, Dr. Kang noted, "...he continues to have lower back pain radiating into the leg...rates his pain to be consistent 7-8 out of 10...functional capacity evaluation showed consistent effort...he was occasionally able to lift about 15 pounds...therapist basically rated him at the light duty level...he has CNS side effects and light-headedness on occasion when he takes Oxycodone...it is giving him some pain relief where he can at least function on a day-to-day basis...limited lumbar flexion and extension...he walks with a straight cane...he does have some give-away weakness due to pain...multiple level lumbar degenerative disc disease with probable discogenic pain...he is at maximal medical improvement...*I don't think he is capable of working at the light duty level...I do think he is capable of sedentary type activity...AMA Guides, 5th Edition...18% lumbar spine impairment...he will continue to require palliative care including testosterone gel, Gabapentin, Oxycodone, and Ambien...I would also suggest that he at least get a spinal cord stimulator trial to see if this would be an acceptable alternative for pain control in the lower back and legs...*"

At the time of this evaluation, Mr. Baker is still prescribed Neurontin, Tramadol, Ambien, and Oxycodone. He noted that he experiences the typical side-effects associated with pain medications, however.

Numerous references to pain in records exist over an extended period of time. He indicated treatment has included prescription medications, epidural steroid injections, and a formal pain management program. When asked to describe his pain, he indicated that since his on-the-job injuries he experiences pain at a level 8 on a 10-point scale, 7-days per week. He noted movement, bending, and daily activities exacerbate the pain. His pain is best relieved by prescription medication and rest. His pain would result in unexpected absences and an inability to work, at least 2-3 days per week. His pain would prevent his ability to sit/stand for an 8-hour day. His medications would limit his effectiveness of work or performance of daily activities.

Mental Status Evaluation: He was well oriented to all spheres, and neither demonstrated nor reported any hallucinations or delusional thought processes. He noted no prior mental health history.

He described clinical significant symptoms as required to establish the continued presence of a level of depression. His depressive symptoms include a considerable loss of interest or pleasure which is nearly always present.

This includes social withdrawal even from family activities; significant reduction in previous levels of sexual interest or desire; decreased energy, tiredness and fatigue out of proportion to actual activity; impaired ability to concentrate, or make decisions; and is easily distracted with memory difficulties. These symptoms have clearly resulted in significant distress/impairment in social, occupational, and other important areas of functioning. These symptoms are not better described by any other general medical condition and there is no evidence of any substance abuse which would cause these same symptoms.

In spite of his depression, he denies any suicidal attempts or plans at this time. His anxiety is increased by the fact that he realizes he cannot do what he has done in the past, an anxiety provoking thought.

He does not use illegal drugs and does not consume alcohol. He continues to smoke about a half a pack of cigarettes each day, but realizes that it might be helpful to again quit smoking.

Psychological Test Results: He appeared to cooperate and to give optimal effort during this evaluation. Thus these results are believed to be valid indicators of his current levels of functioning.

On the Wechsler Adult Intelligence Test – Fourth Edition, he obtained a Full Scale IQ score of 76. Relative to examinees of comparable age, this individual is currently functioning within the "Borderline" range of intelligence on a standardized measure of intellectual ability. It should be noted that this score is consistent with his reported history of difficulty in school, i.e. failing a grade and having academic difficulties throughout his limited educational tenure.

On the Wide Range Achievement Test – Revision 4, his Reading Standard Score of 43 is only a 4.6 grade level score, his Arithmetic Standard Score of 25 is only a 2.9 grade level score, and his Spelling Standard Score of 30 is only a 5.5 grade level score. Mr. Baker predicted that his Math score would be very low and noted, "...my wife handles our money..."

On the Beck Depression Inventory-II, he obtained a Raw Score of 29, defined as a "Severe" level of depression. He should be considered for treatment for his severe level of depression related to his on-the-job injuries. (It should be noted that the Beck Depression Inventory-II was verbally administered to Mr. Baker due to his difficulty reading.)

His academic skills are not sufficient for use in work settings in which such skills would be essential.

Evidence and Symptoms Associated With An Acquired Physical Brain Injury:

It appears that the orthopedic injuries and resulting pain symptoms were more immediately obvious and thus received more timely medical attention. However, there are also multiple medical references over an extended period of time confirming that Mr. Baker sustained a (physical) traumatic brain injury.

He continues to present classic evidence as to the continuing presence of cognitive deficits that resulted from his brain injury. A variety of behavioral symptoms are evident and have been noted, including attentional problems, irritability, anxiety, depression, apathy, and other similar changes in personality.

He has also developed multiple cognitive deficits of such severity as to have caused impairment in occupational and social functioning which clearly represents a marked decline from his previously higher level of functioning. Memory impairment is required to confirm the diagnosis of his cognitive deficits. He noted considerable changes in his ability to "multi-task" as was required on his job. He described, for example, his ability to remember several assignments and specific repairs that needed to be made in various rooms at the hotel/resort, but indicated he was completely unable to do that at this time. Mr. Baker also described, with some embarrassment, that he is unable to recall the names of individuals he has known for years. He has also misplaced and lost objects, and has made driving errors, such as missing exits, being in the wrong lane, etc.

In summary, he has developed a decline in his executive functioning, a common manifestation of brain injuries. He is unable to sufficiently plan, initiate, sequence, or monitor complex behaviors.

Cognitive deficits are also often accompanied by multiple disturbances of gait leading to falls as has been noted in this report. There are also other physical manifestations including ringing of the ears, changes in visual acuity, and significantly his reports of frequent headaches, perhaps one of the most significant symptoms following brain injuries. The multiple cognitive impairments that he has experienced are also associated with anxiety, mood and sleep disturbances. Individuals with brain injuries/cognitive deficits are often especially vulnerable to physical stressors, as well as other psychosocial stressors which tend to exacerbate their deficits and associated problems.

In a publication by the Brain Injury Association of America, some of the common symptoms include, but were not limited to: short term memory loss; trouble concentrating; slowed ability to process information; organizational problems; headaches; major balance problems; depression or mood swings; increased anxiety; easily agitated; changes in vision, appetite, hearing, in balance or muscle coordination; sensitivity to sound and temperature. Mr. Baker exhibits literally each and every one of these clinically significant indicators.

Utilizing the AMA Guides to the Evaluation of Permanent Impairment-5th Edition, specifically Chapter 13 (The Central and Peripheral Nervous System), Mr. Baker is assessed as having impairments based on the Clinical Dementia Rating Scale (CDR). This reflects his apparent lack of awareness of some residual cognitive deficits that continue to be present. He is quite compromised in his attention/concentration, speed of mental processing and multitasking. He avoids most social and recreational activities that previously afforded him pleasure. He still has marked physical limitations and restrictions that clearly prevent him from performing the full range of job duties that his past employment setting required.

Based on the CDR ratings, Mr. Baker is assessed as having a "Class 2 Impairment", a level of impairment which requires "direction of some activities", resulting in a 15%-29% impairment of the whole person. Using the midpoint in this range, this equates to about a 22% impairment rating. Specifically, this is based on his memory loss; moderate difficulty in handling some activities; as to community affairs he "appears normal to casual inspection", but has limited his activities; as to home and hobbies, he has abandoned most of his leisure and hobby activities he enjoyed prior to his injuries.

Diagnosis: After observing him during this evaluation, and from careful review of records of past behavior and levels of functioning, he is clearly manifesting signs and symptoms consistent with the requirements to establish and/or maintain several diagnoses. He is continuing to experience major pain episodes and references to pain exist in several medical records over an extended period of time. He is also anxious about his future, especially since he realizes that his past work is no longer an option for him, an anxiety-provoking thought for someone at the age of 52. Finally, his multiple losses, personal, financial, social and leisure, all have led to a level of depression.

Therefore the following diagnoses apply, in keeping with all diagnostic requirements for each:

307.89 Pain Disorder

311 Depressive Disorder NOS

300.02 Generalized Anxiety Disorder

294.1 Cognitive Disorder, Secondary to Traumatic Brain Injury

These medical/mental conditions are in addition to his other physical medical problems that are well documented in his files.

Social Security Considerations: Mr. Baker indicated that at age 52 he fully expects it will be necessary for him to apply for Social Security Disability Benefits. As a courtesy to Mr. Baker, in the event that this report might be used for those purposes as well, this additional paragraph is being included in this report. Based on the evidence in his files, and following the guidelines as noted in the Psychiatric Review Technique, SSA Form 2506-BK, he clearly meets the requirements of a 12.04 Affective Disorder.

As to the Affective Disorder, his depressive syndrome is characterized by (1) loss of interest in almost all activities, as noted by his withdrawal from social and recreational activities; (2) sleep disturbance, as evidenced by prescription medications for sleep; (3) decreased energy, as evidenced by the need to "rest" for hours of typical days; (4) and difficulty concentrating, as evidenced by his inability to remember even simple bills and financial obligations.

He also clearly meets the "B" Criteria of the Listings as evidenced by his current "Marked" inability to function independently outside the area of one's home; his "Marked" difficulties in maintaining social functioning as evidenced by his withdrawal from nearly all such activities; and his "Marked" difficulties in maintaining concentration and persistence to even simple chores.

P12

The combination of his advanced age, his high school dropout educational background, his Borderline intellect, and his multiple physical and psychiatric conditions clearly results in an inability to sustain gainful employment.

Vocational Opinion and Rationale: Several factors must be considered in reaching a vocational opinion. They include his age of 52, defined as "approaching advanced age", a negative factor; his high school dropout educational background is negative; his profound cognitive impairments have significant vocational implications, a negative factor; his stable work history would be positive, but is offset by his inability to perform any work on a sustained basis and thus becoming a negative factor; due consideration must also be afforded to the pain that he experiences on a daily basis, which requires that he spend 50% of the day "resting or reclining". His depression and anxiety also interfere with his ability to maintain sufficient attention and concentration, which becomes a negative factor.

Taking all of these factors into consideration, it is my opinion, to a high degree of professional certainty, based on nearly fifty years of vocational rehabilitation and psychology experience, and nearly a decade of experience as the Executive Director of the Brain Injury Alliance of SC, that he has experienced a (Physical) Traumatic Brain Injury and must be expected to permanently remain, unable to engage in full-time gainful, competitive employment as a result of his medical conditions resulting from his on-the-job injuries in May 2008.

Earnings Consequences of Injuries: At the time of Mr. Baker's on-the-job injuries, he was working two full-time jobs simultaneously. He worked as a Resort (Hotel) Maintenance Worker for The Hilton, earning 11.45 per month, and was simultaneously working also on a full-time basis for Hardwick Lube-It as an Auto Mechanic, earning \$10.00 per hour. Thus, he was earning a total of approximately \$833 per week even though only a portion of that income was through his employment at The Hilton.

As a result, he is now experiencing a loss of earned income of about \$833 per week. A weekly loss of $\$833 \times 52 = \$43,316.00$ annual loss of earning. In summary, he has experienced a severe loss of weekly earnings.

The rationale for my opinion is essentially based on the following observations:

Credibility: He appeared credible in his description of his limitations and remaining functional capacities. As a result of the limitations on his back area, he cannot complete significant tasks or activities on a regular, sustained basis.

It is noted that the information provided during this interview was highly consistent with information reported in other reports. This provided additional confirmation that the responses and description of events and circumstances was candid, was not feigned or exaggerated, and does not appear to represent any symptom magnification.

Medications: He is prescribed numerous medications, and is carefully compliant with dosages and times as prescribed, and has been so since his injuries. However, he experiences the usual and predicted side-effects of anti-depressant medication, including

feelings of fatigue and an inability to function at optimal levels while taking his medications. It is also clear that his medications are directly related to his on-the-job injuries, and therefore should be provided by Workers' Compensation.

Pain Factors and Attendance Implications: Even with pain medication he continues to experience significant pain at such levels as to interfere with his ability to sustain physical activity. His cognitive deficits would also cause difficulty in his ability to pay attention to job tasks and job duties for hours each week, on average. The inability to maintain concentration and persistence interferes with the ability to meet production expectation for even unskilled jobs.

Limitations on Sitting and Standing: His limitations on sitting and standing are such that vocationally any sedentary work, which might otherwise have been suggested, is precluded. Vocationally, any work requires some combination of sitting, standing and/or walking for a full 8-hour workday, without the need to rest for prolonged periods of time, something he is unable to do in his present condition.

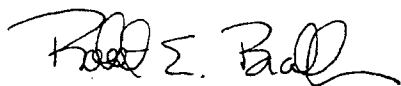
Furthermore, any such jobs would require that he be able to use his back repetitively and continuously while meeting minimal production standards. As evidenced during this evaluation, he would not be able to sustain any repetitive activity for an eight-hour basis, day after day, in his present condition.

Summary and Conclusions: Based on all the evidence as described above, consistent with observations during this evaluation and various reports in his file, he would be unable to effectively perform the essential duties in any gainful work activity. It is also clear that the unfortunate combination of factors and characteristics he now faces are directly related to the injuries he sustained while working.

He is unable to perform any substantial gainful work activity, which exists in the SC or the national economy. Directly as a result of his on-the-job injuries the only services he could perform are so limited in quality, dependability, or quantity that no reasonably stable market for them exists.

The opinions noted in this report are offered within a reasonable degree of professional certainty, based on nearly 50 years of vocational rehabilitation and psychology experience. Thank you for the opportunity to work with you in this matter.

If you have any questions, or if I could address additional issues, please do not hesitate to contact me.



Robert E. Brabham, Ph.D.
 Licensed Psychologist
 Master's in Rehabilitation Counseling
 Brain Injury Specialist, Former Director of the Brain Injury Alliance of South Carolina

L. Randolph Waid, Ph.D.

Licensed Clinical Psychologist

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The Oaks Business Center
1459 Stuart Engals Blvd.
Suite 204-A
Mt. Pleasant, S.C. 29464

Telephone
(843) 881-2778
Fax
(843) 881-6878

REPORT OF NEUROPSYCHOLOGICAL EVALUATION Confidential-For Professional Use Only

Name: Bobby Baker

Age:

Sex: Male

Handedness: Right

Date of Consultation/Evaluation: September 29th, 2010

Identifying Information: Mr. Bobby Baker is a 52-year-old, married Caucasian male who was seen for purpose of neuropsychological consultation/evaluation per the referral of Luke Rankin, Esquire. Mr. Baker is status post sustinment of a closed head injury as the result of a ceiling tile falling and hitting him on the top of the head. He was emergently evaluated at Grand Strand Regional Medical Center and underwent suture repair for a scalp laceration/contusion. Subsequently, Mr. Baker has been involved in neurological care with Michael McCaffrey, M.D. and pain management intervention with a variety of physicians. Mr. Baker has been assessed as permanently and totally disabled as the result of the injuries sustained in the work related accident. Recently, Mr. Baker underwent psychological and vocational evaluation by Robert E. Brabham, Ph.D. (7/20/10). Dr. Brabham extensively reviewed the records regarding Mr. Baker's acute injury and subsequent involvement in medical care with multiple physicians including Michael McCaffrey, M.D., Barbara Sarb, D.O., Jason Rosenberg, M.D., Jeffrey Wilkins, M.D., and C. Gregory Kang, M.D. Dr. Brabham noted that Mr. Baker continues to experience behavioral and cognitive difficulties consistent with the sequelae of physical injury to the brain associated with a mild traumatic brain injury as well as the interfering effects associated with his orthopedic injuries and chronic pain. The current neuropsychological evaluation was conducted to assess Mr. Baker's brain behavior and emotional functioning.

History of Presenting Difficulties: Review of Dr. Brabham's report (07/21/10) provided a summary of Mr. Baker's acute injuries and subsequent difficulties necessitating provision of intervention by numerous physicians in multiple specialties. My understanding of Mr. Baker's case was assisted by review of the following records:

1. Medical records from the emergency room of Grand Strand Medical Center.
2. Treatment records from Doctor's Care of North Myrtle Beach.
3. Treatment records from Dr. Michael McCaffrey.
4. Medical records from Jason Rosenberg, M.D.
5. Treatment records from Lowe's Physical Therapy.
6. Report of functional capacity examination conducted at Select Physical Therapy.
7. Treatment records from Community Rehab and PT.
8. Medical records from Gregory Kang, M.D.
9. Medical records from Coastal Orthopedic Associates.
10. Report of psychological and vocational evaluation by Robert. E. Brabham, Ph.D.

Germane to the current evaluation, Mr. Baker sustained injury when he was serving in employment capacities on May 6th, 2008. Mr. Baker was employed as a maintenance worker for the

Hilton Resort, also maintaining a second job as an auto mechanic. He was installing ceiling tiles when one of the tiles, which weighed approximately 30 lbs, fell about 10 to 12 feet, striking him in the occipital region of the head. Mr. Baker was dazed and knocked to the floor, suffering a scalp laceration, but it does not appear that he experienced an extended period of loss of consciousness. He described a brief period of patchy recall, but was alert and oriented upon being evaluated at Grand Strand Regional Medical Center. The focus of emergent treatment was on conduction of cervical spine x-rays which failed to reveal an acute fracture. The head laceration underwent repair using wood clips with good reapproximation of the skin edges. He was cleared from the C-collar.

Acutely following the accident, Mr. Baker was seen at a Doctor's Care Clinic as well as his primary care physician. Reportedly, he developed an upper respiratory infection following the accident. There was also development of low back pain with bilateral leg radiation, right greater than left. A subsequent MRI study of the lumbosacral spine showed degenerative disc disease at the L4-5 level. He was reported to have cold dysesthesias affecting the left leg upon ambulation. Mr. Baker was referred to Michael McCaffrey, M.D. Dr. McCaffrey's initial evaluation focused primarily on low back pain with right leg radiation. There was plan to conduct nerve conduction study/EMG of the right lower extremity. Dr. McCaffrey stated that Mr. Baker did sustain a closed head injury with left occipital laceration. He was not viewed as being highly-disrupted by that injury.

Mr. Baker remained in treatment with Dr. McCaffrey. Nerve conduction study and EMG demonstrated mild sensory neuropathy versus bilateral tarsal tunnel syndrome. There was provision of lumbar epidural steroid injections. Injections proved not to be highly efficacious for relief of pain. There was continuing use of pain medications. Mr. Baker experienced increasing problems with left occipital headaches. There was referral to a pain management specialist. In September, 2008, Mr. Baker commenced in treatment with Dr. Jason Rosenberg. A variety of intervention strategies were pursued including diagnostic medial branch blocks and radial frequency ablation on the left L3-S1 medial branch nerve. Mr. Baker continued to complain of pain including pain at the left occipital scar on the scalp. There was continuing use of pain medications.

Mr. Baker continued in intervention with Drs. Rosenberg and McCaffrey. As of March, 2009, Dr. McCaffrey stated that Mr. Baker continued to experience left occipital headaches which did not improve with prophylactic treatment (gabapentin). As of March, 2009, Dr. McCaffrey viewed Mr. Baker to be at maximum medical improvement with total and permanent disability due to Workers' Compensation injuries.

Following March, 2008, Mr. Baker continued in intervention with Dr. Rosenberg. There was discussion regarding Mr. Baker being a candidate for spinal cord stimulation implant. There was involvement in physical therapy as well as undergoing a functional capacity examination with provision of impairment ratings by Phillip Lowe, PT. There were additional consultations with Jeffrey Wilkins, M.D. and involvement with Louise Pearce, RPT with regard to physical therapy.

Mr. Baker also came under the care of C. Gregory Kang, M.D. This included Dr. Kang performing a radio frequency neurotomy of the right L3-L4 medial branch nerve and radio frequency neurotomy of the right L5-S1 dorsal ramus. The radio frequency rhizotomy was not assessed as being helpful. There was continuing use of gabapentin for neuropathic pain and Atarax for itching. Mr. Baker continued in care with Dr. Kang. There was also continuing discussion regarding Mr. Baker being an appropriate candidate for undergoing a clinical trial of a neurostimulator. There was a subsequent functional capacity examination conducted in May, 2010. In June, 2010, Dr. Kang provided impairment ratings stating that Mr. Baker was not capable of working at the light duty level. Dr. Kang also made recommendations regarding Mr. Baker's future treatment needs. Dr. Kang remained supportive of Mr. Baker undergoing a spinal cord stimulator trial.

As mentioned, Mr. Baker has recently undergone psychological and vocational evaluation by Robert E. Brabham, Ph.D. This included administration of the Wechsler Adult Intelligence Scale-4th

Edition, Wide Range Achievement Test-Revision 4, and Beck Depression Inventory-II. Dr. Brabham made that data available for the current evaluation. Dr. Brabham stated that Mr. Baker continues to experience neurocognitive impairments with a decline in attention and memory functioning as well as executive functioning. He also stated that Mr. Baker experiences a multitude of symptoms generally associated with the sequelae/residuals of a traumatic brain injury. Dr. Brabham opined that Mr. Baker experiences disruptive sequelae/symptoms from a postconcussive/mild traumatic brain injury, though views the orthopaedic injuries and chronic pain to be the primary obstacle to Mr. Baker's successful return to pursuits and role functions.

Current Clinical Presentation: In interview, Mr. Baker reported that he continues to experience chronic low back pain that radiates down both extremities. There is continuing head pain particularly emanating from the occipital region where the laceration occurred, consistent with a neuralgia. Mr. Baker complained of decreased attention as well as being "very good about forgetting things." He described how he used to be able to take motors apart and put them back together and do other mechanical duties which are now difficult for him. Mr. Baker reported experiencing continuing difficulties with imbalance and ambulation, offering that on one occasion, he fell off a porch, suffering a hematoma to the "butt." There was also complaint of tinnitus particularly affecting the left ear.

Mr. Baker remains on a medication regimen consisting of oxycodone 30 mg q.i.d., Neurontin 300 mg b.i.d., testosterone cream, as well as use of Ambien to assist with sleep. He has been provided Cialis.

A structured symptom evaluation failed to reveal any complaints by Mr. Baker with regard to olfactory or gustatory senses. There was expressed concern regarding decreased visual accommodation and episodes of blurring. There was no report of diplopia. Mr. Baker did not view himself as having any auditory acuity difficulties other than tinnitus particularly affecting the left eye.

With regard to motor functioning, there is weakness affecting the lower extremities as well as cramping. Mr. Baker utilizes a cane to assist with ambulation. He was observed to have a fine tremor affecting the hands. There is lingering numbness and paresthesias in the lower back and buttocks area.

Mr. Baker continues to experience low back pain that radiates down both extremities. There is also episodic pain that he experiences in between his shoulder blades. There is continuing head pain generally located in the left upper parietal occipital region where the laceration occurred. Mr. Baker was not highly complaining of dizziness. There was no report of vertigo. He is without history of seizures.

With regard to cognitive functioning, Mr. Baker complained of a decreased capacity for attention/concentration including an easy distractibility. Thinking was described as slower than he appreciated before the accident. There was also complaint of memory problems/forgetfulness.

With regard to psychological functioning, Mr. Baker acknowledged being depressed and Dr. Brabham's evaluation assessed Mr. Baker as having affective difficulties. He noted that use of Ambien helps him with sleep, though he offered, "I fall asleep more sitting around than going to bed." Mr. Baker was without complaint of nightmares. He remains anxious and nervous about his future. Mr. Baker was described by his wife as "having no patience anymore." He denied episodes of anger dyscontrol. Energy level was characterized as low with an easy fatigability. Clinical evaluation failed to reveal paranoid ideation or delusional thinking. There was no report of phobic symptomatology. Mr. Baker denied hallucinatory activity and there was no evidence of psychotic symptomatology. He denied appetite disturbance. He has been experiencing problems with libido.

Medical History: Mr. Baker reported that he has been a healthy individual. He denied previous head or neck injury. He has undergone previous hernia repair as well as repair of a broken right hand.

Mr. Baker denied any history of serious infections, diabetes, or hypertension. There was no report of previous stroke or heart problems. He denied history for migraine or tension headaches.

Mr. Baker denied any history of psychiatric illness or formal treatment. He reported that his religion is one of being a free will baptist and thus he has never consumed alcohol or illicit drugs. There has been no involvement in formal substance abuse treatment.

Family History: Noncontributory for psychiatric illness or substance abuse problems.

Psychosocial History: Mr. Baker has been married to his wife for 26 years. Ms. Baker accompanied him to the appointment and participated in the interview. There are two adult children with four grandchildren.

Mr. Baker has limited formal education, completing the 9th grade and quitting school during the 10th grade. He commenced employment at that time. He reported that he failed the first grade and had difficulties passing all of his other grades. Mr. Baker reported that he has always been mechanical and good with his hands but not a "good book learner."

Mr. Baker did not serve in the military. He has limited educational skills and this was confirmed via evaluation by Dr. Robert Brabham who administered the Wide Range Achievement Test-Revision 4 revealing Mr. Baker's reading/word recognition abilities to be at the 4.6 grade level with arithmetic at the 2.9 grade level and spelling at the 5.5 grade level. He has been assisted throughout his life with regard to financial billing aspects by his wife.

Mr. Baker was employed as a maintenance worker for the Hilton at the time of the accident. He was also active in other employment capacities including being an auto mechanic.

Procedures: I had available the data from Dr. Robert Brabham's evaluation including the Wechsler Adult Intelligence Scale-IV. In this office, Mr. Baker was administered the Wechsler Memory Scale-III, California Verbal Learning Test-II, Stroop Test, Conners' Continuous Performance Test-II, Judgment of Line Orientation Test, Wisconsin Card Sorting Test, Trail Making Test, Controlled Oral Word Association Test, Scashore Rhythm Test, Speech Sounds Perception Test, Tactual Performance Test, Sensory Perceptual Examination, Behavioral Dyscontrol Scale, Test of Memory-Malingering, and Personality Assessment Inventory. Ms. Baker completed the family form of the Frontal System Behavior Scale regarding her husband.

Examination Results: Most test scores in this report are expressed in statistical terms including *Standard Scores (SS)*, *T-Scores*, *Scaled Scores*, *Percentile Rankings (%ile)*, and *Composite/Index Scores*. The following is a general guide to assist in interpretation:

<u>Standard Score</u>	<u>T-Scores</u>	<u>Composite/Index Score</u>	<u>Scaled Score</u>	<u>%ile</u>	<u>Descriptor</u>
130+	70+	130+	18+	98+	Very Superior
120-129	63-69	120-129	16-17	90-97	Superior
110-119	57-62	110-119	13-15	75-89	High Average
90-109	44-56	90-109	8-12	25-74	Average
80-89	37-43	80-89	7	10-24	Low Average
70-79	31-36	70-79	3-6	3-9	Borderline
<70	<31	<70	<3	<3	Deficient

Neurobehavioral Observations: Mr. Baker presented appropriately attired with good personal hygiene. There was maintenance of appropriate eye contact and social reciprocity. He ambulated in a slow manner utilizing the assistance of a cane. Mr. Baker did not demonstrate disruptive psychomotor retardation or excitement. Mr. Baker was friendly and cooperative in his interactions with the examiner.

He did experience episodic difficulties understanding instructional sets necessitating repetition. He was also noted to have some difficulties with auditory acuity more affecting the left side. It did not appear that functional factors including depression, anxiety, or pain behaviors significantly interfered with Mr. Baker's ability to meet the demands of neurocognitive testing.

Specific assessment of Mr. Baker's testing effort was undertaken via administration of a symptom validity test as well as review of validity indices embedded within the battery of the neuropsychological tests. Mr. Baker's performance on the Test of Memory Malingering (TOMM), including an errorless performance on criterion trial 2, was consistent with provision of good effort. Mr. Baker's performance on the long delay, forced choice recognition test of the CVLT-II was consistent with provision of good effort. Similarly, his performance on the Digit Span Test (reliable digit span) was consistent with provision of good effort. The obtained test results appear to be a fair and valid assessment of Mr. Baker's current functioning.

Language Functions: Mr. Baker demonstrated some spelling and reading difficulties that appear to be longstanding and related to educational deficiency. There was no other evidence of aphasic or agnostic symptoms. Mr. Baker's conversational speech was prosodic, of mildly slow rate but normal tone, without dysarthria or paraphasic errors. Mr. Baker was generally responsive to the examiner's inquiries without tangentiality, derailment, or disruptive word finding difficulties.

Sensory Perceptual/Motor Functioning: Evaluation failed to reveal any imperceptions or suppressions affecting tactile or visual modalities during unilateral and bilateral stimulation paradigms. Mr. Baker demonstrated a few suppression errors to the left side during bilateral stimulation of the auditory modality. This appeared to be secondary to the interfering effects of tinnitus affecting the left side. He performed errorlessly on a tactile finger recognition test. Mr. Baker was slow but able to correctly identify gross tactile forms in each of his extremities.

Mr. Baker reports being right hand dominant. He continues to ambulate with the assistance of a cane. He continues with low back pain that radiates down the lower extremities. There was complaint of weakness affecting the lower extremities. Formal motor testing was not conducted in the current evaluation.

Attention/Memory Functioning: Mr. Baker's performance on an extended test of information and orientation revealed him to make a lone error with regard to the day of the month. Mr. Baker had no difficulty correctly estimating the time of day without observing a clock.

Mr. Baker's performance on the Stroop Test revealed below average processing speed for word (T=35) and color (T=33) stimuli. Mr. Baker performed in the average range, without added decrement, on the Stroop Divided Attention Test. Mr. Baker's performance on attentional tests demanding discrimination of rhythmic sounds (T=35) and discrimination of speech sounds and matching them to their phonemes (T=31) was in the mild to moderately impaired range. Mr. Baker performed in the low to below average range on working memory tests including the spatial span test (25th percentile), digit span test (16th percentile), and letter/number sequencing test (16th percentile).

Mr. Baker was administered the Conners' Continuous Performance Test-II to further assess his attentional capacities. Observation of Mr. Baker's performance revealed him to be generally erratic in his responding, indicative of poor attention capacities. Mr. Baker appeared to have limitations in quickly and effectively processing stimuli. His overall performance on the CPT was classified as poor and consistent with attention problems. The CPT discriminant function indicated that his results better matched a clinical versus nonclinical profile at a confidence index of 75.72%.

Mr. Baker was administered the Wechsler Memory Scale-III (WMS-III) to assess different components of anterograde memory. Mr. Baker's performance on WMS-III tests assessing immediate auditory memory was in the impaired range (9th percentile) with greater impairment in his performance

on tests assessing immediate visual memory (0.5 percentile). Mr. Baker demonstrated an adequate ability to retain and recall previously learned auditory (23rd percentile) and visual (7th percentile) information after a period of delay.

Analysis of separate WMS-III scale performance revealed Mr. Baker to have a low average ability to immediately learn and recall orally presented narrative passages (25th percentile). Mr. Baker was deficient in his performance on a verbal paired associate test (5th percentile). He was significantly impaired in his performance on visual memory tests involving facial recognition skills (1st percentile) and free recall of family pictorial stimuli (5th percentile). Mr. Baker demonstrated an above average ability to retain and recall previously learned narrative passages after a period of delay (percent retention = 91/92nd percentile). He demonstrated an intact ability to retain and recall previously learned verbal paired associates (percent retention = 100). Mr. Baker's performance on a visual memory test involving the immediate learning and reproduction of visual designs placed him at the 9th percentile. He demonstrated a good ability to retain and reconstruct previously learned visual designs after a period of delay (percent retention = 87/84th percentile). Mr. Baker demonstrated an intact ability to retain and recall previously learned facial stimuli (percent retention = 100) after a period of delay. Yet, he was less efficient in his ability to retain and recall previously learned family pictorial stimuli (percent retention = 70/1st percentile).

Mr. Baker's anterograde memory functioning was further assessed via administration of the California Verbal Learning Test-II (CVLT-II), a repetitive word list learning test. Mr. Baker's total recall score after five administrations of the word list placed him at the 13th percentile compared to age related peers. Observation of test performance revealed a below average initial trial consistent with compromise in the attentional aspects of memory. Mr. Baker had difficulties effectively profiting from repetitive administrations of the word list as he did not demonstrate the expected learning curve. Mr. Baker had considerable difficulties learning a new word list after repetitive administrations of a previous word list. He demonstrated an average ability to retain and recall previously learned words in a short delay, free and cued recall process. He was below average in his ability to retain and recall previously learned words in a long delay, free and cued recall process. Assessment of learning characteristics revealed below average recall of words from the middle region of the word list. There was a mildly elevated rate of intrusive errors. He was mildly below average in his performance on a recognition test demanding that he discriminate target from nontarget words, but without excessive false positive errors.

Visual Spatial/Visual Constructional Functions: There was no evidence of visual inattention or neglect processes. Nor was there evidence of constructional dyspraxia. In previous evaluation conducted by Dr. Brabham, Mr. Baker performed deficiently on WAIS-IV visual spatial tests including the Block Design Test (9th percentile), Matrix Reasoning Test (16th percentile), and visual puzzles (9th percentile). Mr. Baker's performance on a test demanding fine discriminations of lines in space was in the low average range (22nd percentile). The pattern of his errors suggested that concentration difficulties contributed significantly to his impaired performance. On a visuographic sequencing test involving the serial processing of numbers, Mr. Baker's performance was slow and in the mild to moderately impaired range (T=33). When the task became more demanding, involving alternations between numbers and letters in sequential fashion, Mr. Baker's performance was slow and in the mild impairment range (T=37) with one set shifting error.

In previous evaluation conducted by Dr. Brabham, Mr. Baker was administered the Wechsler Adult Intelligence Scale-4th Edition (WAIS-IV). Mr. Baker's overall performance resulted in a Full Scale I.Q. of 76 placing him at the 5th percentile compared to age related peers. Yet, it was noted that Mr. Baker performed in the average range on the Vocabulary Test (37th percentile) which is generally a good predictor of an individual's premorbid intellectual abilities. Mr. Baker had considerable difficulties on a WAIS-IV test demanding the finding of a common construct between disparate items (5th percentile). Yet, he performed in the low average range on the Information Test (25th percentile), another good predictor of premorbid intellectual abilities.

In the current evaluation, Mr. Baker's reasoning and problem solving abilities were further assessed via administration of the Wisconsin Card Sorting Test and Tactual Performance Test.

On the Wisconsin Card Sorting Test, Mr. Baker was observed to experience difficulties effectively generating and discovering the correct solution sets as well as sustaining the correct solution set across changing visual arrays. He was able to attain four out of the expected six categories with a relatively significant rate of perseverative errors (19%) and one failure to maintain set.

Mr. Baker was administered the Tactual Performance Test (TPT) which demands keen kinesthetic/proprioceptive abilities as well as organizational/planning skills. Mr. Baker's initial dominant hand performance was in the low average range (T=42) for an individual of his age and educational level. He showed an ability to profit from this initial learning trial during his second trial, nondominant hand performance (T=44). Mr. Baker's third trial, both hands performance was slow and in the mild impairment range (T=38). Mr. Baker's total time performance on the TPT was in the low average/mild impairment range (T=40) for an individual of his age and educational level. His incidental memory score was in the mild impairment range (T=36) while his location score was within average limits (T=46).

Mr. Baker completed the Personality Assessment Inventory (PAI). Mr. Baker was informed that if he had any difficulties with the reading of items, that we would be available to assist him. He appeared able to effectively read the PAI test items, though in a slow manner. Mr. Baker's response set (validity scales) to the PAI indicated that he had a markedly negative view of himself and his current life. Elevations in this range are often indicative of a "cry for help."

The PAI clinical profile revealed a significant elevation on the SOM scale. The finding is consistent with clinical interview in revealing Mr. Baker to be compromised by residual pain and somatic symptoms. These symptoms appear to be chronic and accompanied by fatigue and weakness that renders Mr. Baker compromised with regard to meeting role expectations.

Mr. Baker also reported some difficulties consistent with relatively mild and transient depressive symptomatology. He described his thought process as being marked by confusion, distractibility, and difficulty concentrating. He also reported experiencing, to a mild degree, maladaptive behavior patterns aimed at controlling anxiety. There was description of being rather moody and others may view him as overly sensitive.

Mr. Baker's self concept appears to vacillate between periods of pessimism and self doubt to periods of relative self confidence and self satisfaction. He denied having difficulties in the management of his anger. He denied being distressed from thoughts of self harm.

Ms. Peggy Baker (wife) completed the Frontal System Behavior Scale regarding her husband. The Frontal System Behavior Scale assesses for behavior changes commonly associated with injury to the frontal lobes of the brain. The Frontal System Behavior Scale assesses individuals pre and post injury with regard to apathy, disinhibition, and executive dysfunction.

Ms. Peggy Baker's responses indicated that her husband experienced some mild difficulties with disinhibition prior to the sustainment of injury. Yet, there was no complaint of apathy or executive dysfunction.

With regard to postinjury functioning, Ms. Peggy Baker assessed her husband as being significantly more compromised with regard to disinhibition (T=86) as well as compromise with regard to apathetic changes to his personality (T=81) and executive dysfunction (T=87).

Elevated scores on the apathy subscale reflect problems with lack of initiation, drive, lack of spontaneity, reduced pursuit of interest, and fatigue/lethargy.

Elevated scores on the executive dysfunction subscale reflect problems with the sustainment of attention/concentration, working memory, planning, sequencing, and mental flexibility.

Elevated scores on the disinhibition subscale reflect problems with irritability, impatience, low frustration tolerance, and emotional lability.

Summary/Case Discussion: Mr. Bobby Baker is a 52-year-old, married Caucasian male who is status post a head injury sustained in work related capacities on May 5th, 2008. Mr. Baker has had an extended course of difficulties necessitating evaluations and interventions by multiple physicians in a variety of specialties. Due to the persistence of Mr. Baker's chronic pain and physical limitations, he has been assessed as being totally and permanently disabled. In addition to chronic pain and physical limitations secondary to his orthopedic injuries, there has been concern that Mr. Baker experiences residual impairments associated with a mild traumatic brain injury.

The current neuropsychological evaluation was revealing of an individual who has a history of educational deficiencies. Intellectual functioning was assessed as in the borderline range. Yet, intellectual testing conducted in Dr. Brabham's office revealed Mr. Baker to have average vocabulary skills as well as performing in the average range on a test assessing his general fund of information. In contrast, he demonstrated significant weakness on working memory tests as well as tests assessing perceptual organizational abilities. These weaknesses are likely associated with the residual impairments that Mr. Baker is experiencing.

Neuropsychological evaluation revealed Mr. Baker to have compromise in his capacity to sustain attention/concentration with slow mentation and significant compromise in anterograde memory. Evaluation of anterograde memory revealed Mr. Baker to be most significantly compromised with regard to immediate learning/memory capacities consistent with impairment in the attentional/executive aspects of memory. Mr. Baker did demonstrate variability in his capacities to retain and recall information once it was effectively learned. Receptive and expressive language functioning appear to be intact. Evaluation of sensory perceptual functioning revealed tinnitus affecting the left ear. Mr. Baker continues to be compromised in his motor functioning, particularly with regard to weakness and spasms affecting the lower extremities. Due to concerns regarding poor balance, there is use of a cane to assist with ambulation.

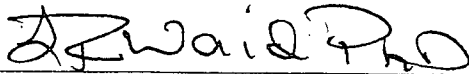
Assessment of emotional functioning revealed an individual who is most encumbered by pain, somatic symptoms, and physical limitations. Evaluation also revealed comorbid depression, sleep disturbance that is assisted by the use of a medication, as well as increased irritability/impatience. Energy level was characterized as low with an easy fatigability.

I am in agreement with previous opinions that Mr. Baker is not capable of returning to employment capacities. It is also evident that Mr. Baker is experiencing neurocognitive impairments affecting his capacity for attention, concentration, memory and other brain behavior functions. The causal factors for Mr. Baker's neurocognitive impairments appear to involve multiple etiologies including the interfering effects of chronic pain/somatic symptoms; psychological disruption; fatigue; use of a regimen of medications; and residuals of a mild traumatic brain injury. I believe it evident that the primary obstacle to Mr. Baker's ability to return successfully to role functioning are the residuals from the orthopedic injury with resultant chronic pain, somatic symptoms, and balance/dyscoordination difficulties. Utilizing the DSM-IV-TR, the following multiaxial assessment is provided:

Axis I	Cognitive Disorder, NOS (294.9) secondary to the interfering effects of chronic pain/somatic symptoms; psychological disruption; fatigue; use of medications; and residuals of a mild head injury.
Axis II	Mood Disorder with depressive features (293.83) secondary to chronic pain syndrome. No diagnosis V71.09.

Axis III Status post mild traumatic brain injury; chronic low back pain with radiation down the legs; dysequilibrium/poor balance; head pain/neuralgia; tinnitus affecting the left ear.
Axis IV Need for continuing pain management intervention; disability/unemployment; Workers' Compensation.
Axis V GAF=50 (Current).

In closing, it is evident that Mr. Baker is experiencing compromises in his physical, emotional, and neurocognitive functioning. It is evident that Mr. Baker's chronic pain and somatic symptoms are residuals from his orthopedic and head injury and serve as the greatest obstacle to his ability to return successfully to role functions. I am in agreement with Dr. Brabham that Mr. Baker is experiencing neurocognitive impairments due to a head injury (physical brain injury) that are contributing to his overall compromise in functioning. I remain available to respond to further inquiries as it relates to the evaluation conducted on Mr. Bobby Baker.



L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist
Clinical Associate Professor in Psychiatry/Neurology, MUSC

LRW/emf

ROBERT E. DEYSACH, Ph.D.

*Licensed Clinical Psychologist
Diplomate, Forensic Psychology
1723 Glenwood Road Columbia South Carolina 29204 782-9807*

NEUROPSYCHOLOGICAL EVALUATION

Patient: Bobby Baker

Date Seen: 12/04/10

Birthdate:

Date of Accident: 05/05/08

Social Security #:

Examiner:

Robert E. Deysach
Robert E. Deysach, Ph.D.
Clinical/Neuropsychology
Licensed Clinical Psychologist (S.C. #81)

Mr. Bobby Baker is a 52 year old right handed white male who was referred for a neuropsychological examination by Ms. Aisha G. Taylor, attorney. The present examination was conducted as an Independent Neuropsychological Examination as part of a comprehensive Workers' Compensation evaluation.

Background Information: Case records were provided by Ms. Taylor and included initial emergency room records and follow-up diagnostic work-up from the Grand Strand Regional Medical Center; results of an MRI on 06/23/08 at Long Bay Diagnostic Imaging; a Vocational Evaluation on 10/02/08 by James Meyers, Rehabilitation Counselor through the CorVel Corporation; a Psychological and Vocational Evaluation on 07/20/10 by Robert Brabham, Ph.D.; and the report of a neuropsychological examination by L. Randolph Waid, Ph.D. on 09/29/10. Each of the latter reports provided a case history summary which was relied upon as a continuous record of medical complaints, diagnostic work-ups and treatment.

Emergency room records indicated that the patient was injured on the evening of 05-05-08 while at work for the Hilton Company as a maintenance worker. He received a "laceration to (the) scalp and neck pain when part of (a) ceiling fell on him." At that time, he denied "numbness, tingling of (his) arms or legs" but experienced a "cramping sensation in (his) neck." He suffered a "scalp laceration." He reportedly "did lose consciousness" and was knocked "to the ground" when struck by a ceiling tile. A spine series at the time of initial medical contact revealed "spondylosis without acute fracture." There was also disc narrowing at C5-7. In June, 2008, he continued to complain of "lower back pain" and "neck burning" and underwent

an MRI of the lumbar spine that revealed an abnormality at the L4-5 level and degenerative disc and facet joint disease along with an annular tear at T11-12.

Medical care summaries provided in previous examinations indicated that subsequent treatment centered on lower back pain and radiation bilaterally into the lower extremities. Lumbar epidural steroid injections were of time-limited value. The patient was managed pharmacologically for relief of back, neck and head pain. Dr. Waid reported that Mr. Baker was rated to be at maximum medical improvement (MMI) with total and permanent disability by Michael McCaffrey, M.D. in March, 2009. Subsequently, Mr. Baker participated in a course of physical therapy and a radio frequency neurotomy without evidence of marked symptomatic improvement. In June, 2010, according to Dr. Waid, Mr. Baker was estimated to be incapable of light duty by Gregory Kang, M.D., who also supported the use of a spinal cord stimulator trial. Jeffery Wilkens, M.D. did not believe the spinal cord stimulator would be effective and apparently this has not been approved by Workers' Compensation. It has apparently continued to be recommended by Dr. Kang.

Dr. Brabham summarized a treatment note one month following the accident in which Dr. McCaffrey indicates that Mr. Baker was reporting an "intermittent ringing in his ears" and the following month stated the patient was experiencing "increasing problems with left occipital headaches." No other post-concussive symptoms were noted in the medical record summarized by Dr. Brabham. Dr. Brabham himself however, interviewed Mr. Baker on 07/20/10. Dr. Brabham highlighted symptoms of depression as reported by the patient on the Beck Depression Inventory-II (BDI-II). His complaints on this measure also included fatigue, reduced ability to concentrate, indecisiveness, distractibility and memory difficulties.

Dr. Brabham noted that, by history, the patient had limited academic progress, completing nine (9) grades of education and, by examination, was found at time of examination to have a Wide Range Achievement Test (WRAT-IV) score falling at the elementary grade level. His general cognitive ability, as measured on the Wechsler Adult Intelligence Scale, was 76, falling in the Borderline range and surpassing only five (5) percent of age mates. According to Dr. Brabham, the patient's reports of a reduced ability to multi-task, failure to recall people's names, misplacing objects and making driving errors were all consistent with a post-concussive syndrome and physical brain damage.

Previous Neuropsychological Evaluation: On 09/29/10, Mr. Baker was examined neuropsychologically by Randolph Waid, Ph.D. Dr. Waid cited Dr. Brabham's observation that the patient "continues to experience neurocognitive impairments with a decline in attention and memory functioning as well as executive functioning" and that Dr. Brabham had suggested that these symptoms were "generally associated with the sequelae/residuals of a traumatic brain injury." Dr. Waid, however, opined that, in spite of this, it was "orthopedic injuries and chronic pain" that were the "primary obstacle to Mr. Baker's successful return to pursuits and role

functions." In a clinical interview with Dr. Waid, Mr. Baker indicated problems in "attention/concentration including an easy distractibility," "slower" thinking and "memory problems/forgetfulness."

Dr. Waid felt that the patient's performance was indicative of "good effort." He found Mr. Baker to be variable in his success across tasks. Although deficits in attention/concentration, new learning, memory and executive skills are not inconsistent with developmental cognitive abilities (e.g., as indicated by his school performance), distractions from chronic pain and depression, Dr. Waid felt that the patient's relative success on Dr. Brabham's tests of word knowledge and general information (i.e., from the WAIS-IV Vocabulary and Information subtests) served as a measure of his premorbid cognitive abilities. He contrasted this success (i.e., approximately the 30th percentile compared to age mates) with Mr. Baker's compromised attention/concentration and anterograde memory as evidence of some cognitive deficits as "residuals of a mild traumatic brain injury."

Present Patient Interview: Mr. Baker is a solidly-built individual who was casually but appropriately dressed from the examination. He was accompanied by his wife and brother-in-law on the 2 ¼ hour drive from his home. He indicated that drives of this distance were difficult for him, and that he had tried various positions to the car to keep from becoming too sore. He did walk stiffly with the use of a cane to provide additional stability. He indicated that he attempted to "go without it around the house." He reported lower back and leg discomfort with his "right leg worse" than the left. He was physically uncomfortable throughout examination and shifted position frequently. At times, he would stand and lean against the wall. However, he did cooperate with all requests and appeared to be diligent in his approach to tasks. He reported that he takes oxycodone but did not take any before his trip because of its impact on his cognitive functioning (i.e., affects his alertness). The reports of cognitive changes by his wife to Dr. Waid did not indicate whether these symptoms were associated with his medication use.

Mr. Baker adopted a rather shy and reserved personal style throughout the examination. He acknowledged that he had history of not being particularly socially outgoing. His delivery was quiet and at times he was asked to repeat a comment or a response to a test item. [He reported that he had inherited the manner of speaking from his father.] He appeared to have insight into his prevailing personality style as well as his cognitive strengths and weaknesses. He denied dizziness but indicated that he was concerned about balance relative to lower extremity weakness and had a handrail and seat in his shower.

Mr. Baker was open in discussing his difficulties in school. He apparently was kept back in first grade and had difficulty academically from that point forward. At one point, he was asked by the examiner to recite the alphabet and claimed to get "mixed up" after the letter "L".

The patient has been married approximately over 25 years and has a daughter from his present marriage living locally but with whom he has little contact. He does have contact with a son from his first marriage. The patient stated that he completed nine (9) grades but quit at the start of the 10th grade because he "wanted a car." He presently smokes less than a pack per day and has not drunk alcohol for over ten (10) years (i.e., "since I got saved").

At the time of his work accident, he recalled "looking at the wall" that needed work. The next recollection was his co-worker saying "don't move" and that he was bleeding. He indicated that he does not recall hearing the tiles fall. He reported that the tile was likely to have weighted 30 lbs. and fell from a distance of 12 feet. He assumed he had a brief loss of consciousness.

Prior to the accident, Mr. Baker owned his own shop as a mechanic but leased the business before date of his accident. He went to work for the Hilton Corporation in maintenance and had worked for them for four (4) years at the time of his injury. At the time, he was also working a second job as an auto mechanic for Hardwick Lube-It.

Neuropsychological Examination: On the present examination, Mr. Baker completed some tasks which were previously administered by Dr. Waid and some that were not. The purpose of the specific set of tasks was to compare the consistency of previous results and to extend them in various areas of cognitive functioning.

Effort Testing: Mr. Baker was administered the WMT, a memory test designed to measure effort and response bias. His failures on the battery are usually a sign of poor effort. However, caution should be exercised in situations in which testing is performed on an individual who is severely limited cognitively.

General Ability: On the Wechsler Abbreviated Scale of Intelligence (WASI), Jeffrey obtained an estimated Full-2 estimated IQ of 62. This places him in the Mildly Handicapped range, surpassing approximately 1% of those his age. His performance on the Vocabulary subtest also fell at the 1st percentile compared to age mates. This performance is considerably less adequate than that obtained by Dr. Brabham and reported by Dr. Waid. This level of performance does not, in this instance, serve to indicate a level of premorbid verbal ability that fell in the average range. It is instead more consistent with his Reading grade equivalent of 4th grade and his stated premorbid language deficits (i.e., "not a good book learner"). As such, these results tend to negate the assumption of higher premorbid functioning suggested by Dr. Waid.

Mr. Baker also completed the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), a battery that is comprised of tasks measuring basic neuropsychologically-relevant abilities. On this battery, Jeffrey obtained a Combined Index of 76, placing him at approximately the 5th percentile compared to age mates. His performance was quite consistent across subtests with his greatest success on a scale designed to measure Attention/Concentration. His weakest area of functioning was in the area of verbal learning/immediate memory and

delayed verbal and non-verbal recall. In general, his performance on this battery is quite consistent with expectations based on his premorbid level of functioning. Individual subtest scores are listed below:

Immediate Memory	78 (7 th percentile)
Visuospatial/Constructional	84 (14 th percentile)
Language	82 (12 th percentile)
Attention	88 (21 st percentile)
Delayed Memory	71 (3 rd percentile)
Combine Indices	76 (5 th percentile)

Attention/Concentration: On the Seashore Rhythm Test, he was required to match pairs of rhythmic patterns. [This task was previously administered by Dr. Waid.] The task requires sustained attention and the ability to complete one item and "reset" to attend to a new pair of non-verbal stimuli. On this task, Mr. Baker obtained a score of 15/30, placing him at the 2nd percentile (i.e., Mildly Impaired) compared to those of his age and level of education. It should be noted however that this performance is less adequate than was obtained by Dr. Waid and approximately no better than random performance (i.e., getting 15 items correct within a 30 item two-choice format). It should be noted that the test is timed and the pressure of having to respond fairly rapidly did appear to serve as a distracter for Mr. Baker.

Language: On the MAE Token Test, Mr. Baker was required to perform a series of single and multiple step operations, processing object color, shape and size. The task requires attention to aural instructions, and Mr. Baker obtained a score of 43/44, which places him solidly in the Average range and surpassing at least 50% of non-clinical adults. His error appeared to reflect more a brief lapse in attention than difficulties in aural comprehension. In general, it can be anticipated that Mr. Baker has the ability to understand multiple-step instructions requiring knowledge of syntax.

Memory: On the Wechsler Memory Scale - III (WMS-III), he obtained a Working Memory index score of 85, which places him in the Low Average range, surpassing slightly more than 15 percent of adults of his age in the general population. His level of success was slightly more adequate than on the RBANS test of immediate memory. He had previously completed this Scale. If there were practice effects, they were not likely in recall of the correct responses but rather in the increased familiarity with the format.

Cognitive Flexibility/Executive Skill: On the Trail Making Test, the patient was required to perform two search tasks of varying degrees of difficulty. On the more rote Part A, he completed the task in 52 secs., a performance falling in the Low Average range and surpassing

10% of those his age and level of education. On the more complicated task (i.e., Part B), he required 133 secs., placing him also in the Low Average range and falling at the 10th percentile. In other words, the component demanding cognitive flexibility did not cause him greater difficulty compared to the more rote visual search task in spite of his difficulty with serial alphabet recitation. In general, the pattern and level of his performance matches that obtained by Dr. Waid.

On the Wisconsin Card Sorting Test (WCST), Mr. Baker was required to solve a series of sorting problems, using success-failure feedback. On the task, he completed six of six categories (i.e., falling within normal limits), committing 33 errors (i.e., Average range, 37th percentile), only 11 of which were perseverative (i.e., Above Average range, 66th percentile). Mr. Baker did complete this test for Dr. Waid. His performance under present testing conditions represents an improvement that is likely due in part to practice effects. In other words, he likely demonstrated procedural learning as a result of his exposure to the task 2 ½ months ago.

Psychological Assessment: Mr. Baker also completed the Millon Clinical Multiaxial Inventory (MCMI). The measure assesses personality factors in a manner paralleling the testing performed by Dr. Waid. Similar to the findings of Dr. Waid, the patient did exhibit a lowered threshold for reporting psychological problems. Dr. Waid described this as a "cry for help." Another way of describing this response bias is to focus on a tendency to be especially sensitive to personal difficulties and environmental stressors than on the sources of strength or support present in his daily life. This is likely to include heightened sensitivity to both emotional and cognitive difficulties.

The patient had an elevation of a scale consistent with marked intense erratic moods and distressing thoughts. No psychotic thought process or content was evident in the present examination. He very strongly endorsed symptoms of clinical anxiety and depression as well as preoccupation with physical symptoms. His responses suggested that the risk of alcohol and substance abuse was not high.

Mr. Baker obtained a Basic Personality profile of 83* 2* 1* - 7/. Such a profile highlights a number of personality traits that could be inferred from his clinical case record as well as the interview conducted in the present session. He clearly expressed his discontentment with his current circumstances and pessimism regarding a change in his situation without intervention. His preoccupation with his physical dysfunction is understandable in light of the implications for a man whose strengths have also been in the less sedentary and academic sorts of pursuits.

On the other hand, individuals with such a profile have a hard time settling on a direction for change, feeling instead helpless to proceed on their own. Lacking a solution, negative emotions are often displaced onto others and in situations in a manner out of proportion to the

inconvenience they impose. Finally, this profile also reflects the social withdrawal that is apparent from his reports of a growing tendency toward social withdrawal.

Summary and Recommendations: Mr. Bobby Baker is a 52 year old male who was injured on the job when he was struck by a 30 lb. tile falling from a distance of approximately 12 ft. He sustained a putative neck and back injury and has not experienced a great deal of symptomatic relief from treatments prescribed to date. A review of the medical record does not suggest a clear course of treatment for his complaints. It does appear, in fact, that the specific discomforts have over time generalized to problems in the area of mood management and cognitive efficiency.

Previous evaluations have accentuated the role that chronic pain has played in both his productivity and adjustment. He has been accorded a disability rating that highlights the physical barriers preventing his return to his former occupation. This has not only reduced the family's income but has also limited his sense of accomplishment. For example, he indicated on personality testing that he has come to "feeling like a failure" recently. He reported both to Dr. Waid and this examiner (RED) that his adjustment has also suffered in his reduced ability to contribute at home and his inability to participate in valued avocational activities. He indicated to Dr. Waid that feelings of sexual intimacy with his spouse have also decreased.

Dr. Waid concluded that Mr. Baker "is not capable" of returning to a competitive job market. I also agree with Dr. Waid that the "primary obstacles" are the "residuals from the orthopedic injury." These problems are compounded by the cognitive limits which are in large part developmental (i.e., premorbid) in nature. In other words, up to the present, the patient has been able to compensate for his intellectual shortcomings by his physical competencies and a strong work ethic (e.g., working two full time jobs before his accident). The accident and his failure to return to productivity has made more salient to him and the family that he has significant deficits in the area of language and math (i.e., skills critical for activities of daily living). [His wife appears to manage most interactions with the community requiring these skills.]

Dr. Waid has highlighted some of these deficits. Although the present examination has also documented cognitive deficits for Mr. Baker, the data indicate that these deficits are basically developmental (i.e., existing before the accident) rather than the result of physical brain damage from the accident. Dr. Waid pointed to his success on tasks likely to be robust in the face of a brain injury (e.g., the Vocabulary score obtained by Dr. Brabham) as a measure of his premorbid verbal competency (i.e., a score falling in the Average range). His performance on the present examination (i.e., WASI Vocabulary test) was quite poor, calling into question the reliability of the previous findings. For example, he acknowledged on the present testing that he was unfamiliar with words such as "reveal," "enthusiastic," "trend" and "devout" (i.e., appearing to reflect deficits in word knowledge).

Although the findings of Dr. Waid and this examiner are sensitive to the cognitive deficits the patient is exhibiting, they do not specifically point to physical brain damage as a critical cause. Rather his difficulties, as mentioned above, appear linked to developmental (i.e., chronic) difficulties in learning combined with an increase in distraction (i.e., from chronic pain), some cognitive difficulties as a side effect of pain medication, and increased sensitization to his own areas of learning difficulties (i.e., to which he is sensitized because he is unable to engage in his compensatory strengths). As he indicated in the record, he has always been "good mechanically" but understands he is no longer able to do such work.

Based on a review of the medical record and interview with the patient, it is reasonable to conclude that Mr. Baker did suffer an injury to the head with brief and mild post-concussive symptoms. However, the data do not appear to support the presence of an acquired brain injury nor restrictions in productivity or quality of life as a result of the physical brain damage. To his detriment, a conclusion of this sort is likely to suggest to him that he is "damaged" beyond the orthopedic injuries and chronic pain he reports from those injuries. In addition such a conclusion, it is likely to direct attention and treatment away from factors that are most critical for recovering — i.e., his exploring avenues of productivity and learning to adapt to his present medical condition.

In general, Mr. Baker appears to be a sincere individual whose life has been altered by his accident in May of 2008. It is clear that both productivity and adjustment have suffered. Mr. Myers suggested several alternative employment opportunities for which Mr. Baker appeared to possess "transferable skills." Although beyond the scope of the present evaluation, the discomfort he exhibited during the present half day examination would seem to preclude his capacity to manage any of the proposed "sedentary" occupations. As a consequence, it is not clear that he is a reasonable candidate for involvement with the Department of Vocational Rehabilitation at this time. In addition, while multiple treatment strategies have been employed to deal with his complaints of chronic pain, these have not brought effective relief. It is possible that he may benefit from a time-limited program of pain management designed to assist him to live with his pain.

Thank you for allowing me to consult with you regarding this patient. If I can be of further assistance, please let me know.

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Fee Dee
Orthopaedic
Associates, PA

W.S. (Bill) Edwards, Jr., M.D. * Rakesh P. Chokshi, M.D.
Patrick K. Denton, M.D. * Anthony W. Alexander, M.D. * Barry L. Clark, D.O.
Nigel A.R. Watt, M.D. * Robert E. Elvington, Jr. M.D. *
Matthew D. Welsch, M.D. * Jason B. O'Dell, M.D. * Dewey N. Ervin, M.D. *

901 E. CHEVES ST., SUITE 100 - FLORENCE, SC 29506-2769
1580 FREEDOM BLVD., SUITE 100 - FLORENCE, SC 29505
(843) 662-5233 - FAX (843) 678-9003 - WWW.PDOA.COM

Lumbar IME Examination

PATIENT ID: 320260

Patient: Bobby Baker
Address:

Date of Service: 10/21/10
Gender: male

DOB:
Employer: Hilton Hotel Corp

Age: 52 years old
Occupation: Disabled

Referring Physician: .IME, , ; Hutson, Jody, ;
Other Physicians:

Date of injury/onset:

Date: 05/05/2008
Type: injury

Chief Complaint: Low back pain and bilateral leg pain for Independent Medical Evaluation.

(X) Low back pain (X) Leg pain (X) L (X) R () Thoracic back pain
() Neck pain () Arm pain () L () R

History of Present Illness: This very pleasant 52 year old white male has been sent for evaluation of the above symptoms emanating from a work related injury that occurred in May of 2008 when a ceiling tile fell on the top of his head. He sustained a significant laceration that was repaired and some mechanical neck symptoms and several days later severe back pain. These latter symptoms have continued despite extensive conservative efforts and he describes an aching discomfort that is occasionally sharp in the lumbosacral region radiating into the posterior buttocks and thighs down to the lower calf regions bilaterally. Symptoms do not fall in any dermatomal pattern. His pain is rated at a level 8 on a scale from 0 to 10. Extensive work up and conservative efforts have been carried out down to the Myrtle Beach area including various therapeutic injections such as epidural steroid injection and facet blocks. Dr. Kang has most recently cared for him and released him on June 8th of this year having reached maximum medical improvement with an 18% lumbar spine impairment. He is on chronic Neurontin, Oxycodone and Ambien and also uses Cialis and Testosterone gel for sexual impairment felt to be brought on by the chronic opoid usage. His activity level is severely limited by his symptoms and uses a cane on the right side for support. He denies any neurogenic sounding bowel or bladder dysfunction. Previously worked in maintenance at a hotel and has not worked since his injury. Three to four Oxycodone tablets are utilized throughout the day even with his low activity level. A functional capacity evaluation was performed May 10th, 2010 which has been reviewed and demonstrates capability of working in a white physical demand level. Appears to be reliable without evidence of non-organic physical signs. At the time of discharge from Dr. Kang's treatment a spinal cord stimulator trial was offered. The patient declines to consider this since it would not return him to his routine work activities and normal physical capabilities.

Medications: Ambien, Cialis, Neurontin, Oxycodone Hydrochloride (Dosage: 30mg)

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Report Date: November 09, 2010 Patient: Baker, Bobby DOS: 10/21/10

Allergies: .No Known Drug Allergies
Surgical History: .None reported
Medical History: .None
Family History: Heart Disease; Parents: Father-Living; Parents: Mother-Living
Social History: Alcohol use: None; Drug Use: Never; Employment: Disabled; Marital Status: Married

REVIEW OF SYSTEMS:

Review of Systems: General, neuro, psychiatric, respiratory, cardiovascular, GI, GU, blood and lymph, EENT, musculoskeletal, skin and endocrine systems are normal except what is noted below:
.No abnormal findings known

PHYSICAL EXAM:

Vitals: HEIGHT: 5'8" WEIGHT: 170 lbs 0 oz BMI: 25.8
Appearance: No acute distress
Psychiatric: Mood and affect were appropriate.
Head: Normocephalic, atraumatic.
Skin: Clean, dry, no lesions, no rashes.
Neuro: Alert and oriented x 3.

LUMBAR FOCUSED EXAM: Healthy appearing white male, very pleasant and conversant and in no acute distress. He gave an appropriate effort on examination and exhibited no non-organic physical signs. He rose slowly from sitting to standing. He stands erect leaning slightly forward and to the right side on the cane. Decreased lordosis is noted. Tenderness is present throughout the lumbosacral region not well localized in any anatomic site. There is no spasm or trigger points. No sciatic notch tenderness is noted. Forward flexion is limited to 30 degrees and he returns to the erect posture with an extensor lag. Lateral bending 20 degrees each way and extension 10 degrees beyond neutral. He described discomfort at each of these movements. Straight leg raising produced back pain bilaterally but no distal radicular symptoms. Motor strength is 5/5 in the lower extremities. Reflexes are 2+ symmetric. No dermatomal paresthesias are noted. No long tract findings are evident. Hip and knee motion is full. Pulses are full.

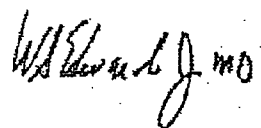
Xrays: Plain films of the lumbar spine are normal with good preservation of disc space height. No traumatic or degenerative changes are present. Hips and sacroiliac joints appear normal.
MRI: MRI scan apparently has been performed but did not accompany the patient today.

ASSESSMENT:

Diagnosis: -Lumbar strain/sprain.

PLAN:

This gentleman appears to have mechanical low back pain not associated with any neurologic deficit or radicular symptoms. He has had extensive conservative efforts and it is very unlikely that any further intervention would be of assistance to him. Specifically I would recommend against any further invasive treatment including spinal cord stimulator trial. It would be appropriate to personally review the MRI scan that has been performed before making final statements but this gentleman does appear to be at maximum medical improvement and assuming the scan does not show any significant pathology it would be reasonable for him to be as active as his symptoms allow. Since the FCE was apparently a reliable and valid examination, the findings of this study can be used to outline work ability.


W. S. Edwards, M.D.
Spine Surgeon
Pee Dee Spine Center

This document was electronically signed on 10/21/10

To: RelayFax via port COM1

From: Fax

11/9/2010 10:50:58 AM (Page 4 of 4)

11/9/2010 10:48 AM FROM: Fax TO: 18037714484,,, PAGE: 004 OF 004

Report Date: November 09, 2010 Patient: Baker, Bobby DOS: 10/21/10

Referral Reply Letter(s) - Dated 11/02/10

Hutson, Jody - SPECIALTY: Family Practice

CORVEL

200 Center Point Circle
Suite 290
Columbia, SC 29210
Telephone: 843-650-0653
Facsimile: 843-650-4941

Initial Vocational Evaluation

Date of Report: 10/02/10

Date of Referral: 09/25/10

Claimant Name: Bobby E. Baker
Claimant Address:
City, State, Zip:

DOI:

Employer: Kingston Plantation
Employer Address: 9770 Kings Road
Employer City, State, Zip: Myrtle Beach, SC 29577

Plaintiff Attorney: Luke Rankin, Esq.
Plaintiff Address: 201 Beatty St. Ste 1
Plaintiff City, State, Zip: Conway, SC 29526

Defense Attorney: Collins and Lacy Law Firm
Defense Address: P. O. Box 12487
Defense City, State, Zip: Columbia, SC 29201

Treating Physician: Dr. Gregory Kang	Claimant Phone #: 843-365-2722
Physician Address: 3029 New Castle Loop	Employer Phone #: 843-449-0006
Physician City, State, Zip: Myrtle Beach, SC 29588	Physician Phone #: 843-215-8868

SUMMARY AND RECOMMENDATIONS:

Overview/Summary of Case:

Mr. Baker reported work related injury occurred on 05-05-08 and was employed as a Maintenance Engineer with Kingston Plantation in Myrtle Beach, SC. Mr. Baker reported while attempting to repair a wall a fireproof ceiling tile fell out of the ceiling and struck him in the head. The supervisor who was present at the time of the injury transported Mr. Baker to the emergency room at Grand Strand Hospital. Mr. Baker had a laceration to the scalp and also injured his lower back. X-rays were taken of the neck, and staples were used to close the wound. Mr. Baker tried to return to work but due to feeling ill he was advised by his employer to seek treatment at Doctors Care. Mr. Baker was then sent for an MRI at Long Bay Diagnostics. After the MRI was reviewed, Mr. Baker was

C O R V E L

referred to Dr. McAffrey who requested an EMG. According to Mr. Baker, Dr. McAffrey recommended a series of Epidural Steroid Injections. The injections did not help and actually made the condition worse according to Mr. Baker. Dr. McAffrey recommended conservative treatment and the claimant was referred to Dr. Rosenberg for pain management. Dr. Rosenberg recommended a Radio Frequency Ablation procedure. Mr. Baker reported the first one provided significant relief but reported it caused severe itching in the lower back. The claimant was then sent to an allergist who could not determine causation. Dr. Rosenberg then recommended a spinal cord stimulator, which was denied and Mr. Baker was referred to Dr. Wilkins who recommended physical therapy for a couple of sessions. The claimant discontinued therapy due to pain while in traction.

Mr. Baker later reported falling at home and he went to the emergency room, received several pain shots, x-rays were taken, the doctor on staff reported that Mr. Baker had a hematoma and would also need an MRI. Mr. Baker was referred to a surgeon, whom after review of the MRI the surgeon reported the claimant was not a surgical candidate and was referred to pain management with Dr. Kang. Mr. Baker reported Dr. Kang recommended a nerve block which caused a reaction. Due to the hematoma, Dr. Kang tried to drain the wound and performed an injection which did not help. Medication was changed and Mr. Baker is currently being treated by Dr. Kang conservatively.

Identify Potential Barriers:

Mr. Baker is performing at a sedentary physical demand, per the recommendations of Dr. Kang.

MEDICAL ASSESSMENT:

Date of Diagnosis and symptoms started:

05-05-08 - Reported work related injury while working for the employer.

Treatment history to include hospitalizations and diagnostic testing:

Mr. Baker's treatment to date has consisted of: Physical Therapy, MRI, X-rays, ESI, Radio Frequency Ablation, EMG, Medications, Allergist and conservative treatment.

Current symptoms:

Mr. Baker reported having pain in lower back and radiates down both legs.

Current treatment:

Conservative, medications prescribed by Dr. Kang.

Claimant's perception of limitations for work and activities of daily living:

Would like to re-enter the work force, Mr. Baker reported limited mobility would hinder his ability to sustain any type of work for an eight hour day. Mr. Baker also reported he used to enjoy riding horses, fishing, water ski, cutting his own grass, mechanic work but is unable due to his reported work related injury.

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Personal and family medical history:

Mr. Baker reported no other medical problems were noted which would hinder rehabilitation development. Claimant reported family history of heart disease.

Medications:

Medication	Dose/Frequency	Purpose
Oxycodone	3 mg x 4	Pain
Neurontin	300 mg x 2	Neuropathy
Ambien	1 x daily, ? mg	Sleep
Testosterone Cream	1.5 Tubes daily	Impotence
Cialis	1x daily	Impotence

VOCATIONAL ASSESSMENT:

Physical/Mental demands of job at the time of employment:

Repairs and maintains physical structures of commercial and industrial establishments, such as factories, office buildings, apartment houses, and logging and mining constructions, using handtools and power tools: Replaces defective electrical switches and other fixtures. Paints structures, and repairs woodwork with carpenter's tools, repairs plumbing fixtures, repairs plaster and lays brick. Builds sheds and other outbuildings.

DOT: 899.381-010 STRENGTH: M GED: R4 M3 L3 SVP: 7 DLU: 81

Potential return to work with employer?

Claimant reported still being employed.

Availability of light duty, transitional program, gradual return to work per employer?

Mr. Baker reported no light duty was available with the employer.

Previous Employment History:

Employer	Dates of Employment	Position	Wages	Reason for Leaving
Kingston Plantation	2005-2009	Maintenance Engineer	11.00 per hour	injured
Hardwick's	2008-2008	Mechanic	380.00 per week	Working dual jobs
Self employed	1994-2008	Mechanic/and Mobile	1,200 per week	Lease expired
Ford	1984-1994	Mechanic	Unknown	Better Opportunity
Horry Ice	1983-1984	Bagged Ice	Unknown	Better Opportunity

CORVEL

Miscellaneous Comments regarding employment history:

Mr. Baker has been employed in a variety of occupations. Mr. Baker has experience as a Mechanic, Self-employed, Bagged Ice, Mobile Mechanic and Maintenance Engineer. Mr. Baker reported no other transferable skills, which would enhance a successful return to work.

EDUCATIONAL ASSESSMENT

Education and Training:

Mr. Baker reported going to the tenth grade at Conway High School.

Military:

N/A

CLAIMANT ASSESSMENT:

Appearance and Behavior Observations:

Mr. Baker is 5'8 and weighs approximately 180 lbs. Mr. Baker is a well nourished Caucasian male and appeared to take care of himself in a hygienic manner. The claimant reported being a smoker and does not consume alcoholic beverages. Mr. Baker appeared calm during the interview, answered questions appropriately and made appropriate eye contact. Affect was appropriate. Mr. Baker reported being married for 26 years and currently owns his own home in Conway. Mr. Baker reported having two adult children.

Description of a typical day:

Mr. Baker reported getting up in the morning; gets dressed, lays on the couch watching TV, walks to the barn to help with the horses, goes to grocery store, and does light housekeeping, uses a computer while working at Hilton for security as a description of a typical day. Mr. Baker reported he also enjoys going to church.

Pain Levels (location and intensity)

Mr. Baker reported on a scale of 1-10 his average pain level was a 7 and located in the pain mainly in the lower back and legs.

Transportation:

Mr. Baker possesses a valid Driver's license and drives a Ford explorer.

Legal History/Convictions:

N/A.

CORVEL

PSYCHOSOCIAL ASSESSMENT

Adaptation to diagnosis and coping strategies:

Mr. Baker reported he is having difficulty dealing with his current situation and continues to have pain in his lower back. Mr. Baker reported he tries to perform exercises, walks and takes pain medication.

Family environment and support systems:

Mr. Baker identified his spouse and pastor as supportive of his current condition.

Motivation:

Mr. Baker indicated on several occasions his desire to re-enter the work force, if he were physically able to do so. He is unsure of what type of positions he could pursue based on his restrictions.

Vocational interests/Goals:

Mr. Baker reported he would like to return back to work being a Maintenance Engineer or Mechanic. Mr. Baker reported he was not aware of the SC Department of Vocational Rehabilitation Services.

FINANCIAL ASSESSMENT

Compensation type and amount:

Mr. Baker reported receiving \$623.00 per week from Workers Compensation.

Other sources of income:

Mr. Baker reported no other income.

Financial difficulties:

Mr. Baker reported his disability has caused severe financial difficulties, due to the length of the disability and inability to earn an income. He also reported he lost his health insurance due to costs.

Characteristics of Prior jobs held and analysis of skills:

On 10/10/10, a Vocational Diagnosis of Residual Employability (VDARE) was completed on Mr. Baker within his geographic labor market to determine his transferable skills. Mr. Baker has a variety of transferable skills. Therefore, the following General Educational Development Skills were identified (1=low, 6=high)

Reasoning: 4

Math: 4

CORVEL

Language: 3

Throughout Mr. Baker's previous work history and experience, the following General Development Skills were identified (1=high, 5=low).

APTITUDES	Score
G - Intelligence	4
V - Verbal	3
N - Numerical	4
S - Spatial perception	3
P - Form perception	3
Q - Clerical perception	3
K - Motor coordination	4
F - Finger dexterity	3
M - Manual dexterity	3
E - Eye/hand/foot coord	5
C - Color discrimination	4

The following Physical Demands were identified to be within Mr. Baker's previous work experience:

STRENGTH:

Heavy- Exert force over 100 lbs. occasionally, over 50lbs. frequently, or over 25 lbs. constantly.

PHYSICAL DEMANDS:

Occasional	CL - Climbing
Frequent	BA - Balancing
Occasional	ST - Stooping
Occasional	KN - Kneeling
Occasional	CR - Crouching
Not present	CW - Crawling
Occasional	RE - Reaching
Frequent	HA - Handling
Frequent	FI - Fingering
Occasional	FE - Feeling
Not present	TA - Talking
Occasional	HE - Hearing
Frequent	NE - Near Acuity (Under 20 inches)
Not present	FA - Far Acuity (Over 20 feet)
Frequent	DE - Depth Perception
Occasional	AC - Accommodation (Focal length change)
Occasional	CV - Color Vision
Not present	FV - Field of Vision (Peripheral vision)

C O R V E L

The VDARE identified the following environmental conditions within Mr. Baker's previous employment:

Loud NO - Noise Intensity Level
Occasional AT - Atmospheric Conditions
Occasional MP - Moving Parts

SPECIFIC VOCATIONAL PREPARATION: - Over two years up to and including four years (SVP=7).
This demonstrates a skilled worker.

Transferable Employment Occupations:

Based upon Mr. Baker's past work experience and transferable skills, the following positions have been identified as possible alternative employment opportunities.

	Occupation	DOT/SVP	Exertion Level
1.	Collection Clerk	241.357-010/5	Sedentary
2.	Industrial Order Clerk	249.362-026/4	Sedentary
3.	Sorter	734.687-082/3	Sedentary
4.	Assembler	734.687-018/4	Sedentary
5.	Escort Driver	919.663-032/4	Sedentary
6.	Greeter	241.367-014/2	Sedentary

Vocational Diagnosis and Assessment of residual Employability (VDARE), Dictionary of Occupational Titles (DOT), and the Classification of Jobs (COJ).

Comment Section:

Mr. Baker was cooperative throughout the Initial Vocational Evaluation and indicated on several occasions his desire to return to gainful employment if he was physically able to do so. Mr. Baker is considered a skilled worker.

It is this CRC's opinion that Mr. Baker is a viable candidate for Vocational Rehabilitation Services and will benefit from his continued participation with those services. Based upon the recommendations of the Dr. Kang, Mr. Baker is functioning at a sedentary physical demand level and should be able to return to work as a clerk or one of the other identified sedentary positions. For the purposes of the evaluation sedentary positions were utilized to determine actual positions. Mr. Baker could choose to search for employment and Mr. Baker was encouraged to consult with his attorney for available resources through Vocational Rehabilitation Services and the Employment Security Commission, if he desires to return to gainful employment.

Submitted by: James R Myers MA, QRP, CCM, CRC
Certified Rehabilitation Counselor

CorVel Corporation
www.corvel.com

200 Center Point Circle
Suite 290
Columbia SC 29210

843/650-0653 Phone
843/650-4941 Fax

CORVEL

cc:

Privileged and Confidential:

All information on this report hereby is intended only for the use of the addressee(s) named above. If the reader of this report is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient(s), please note that any distribution or copying of this communication is strictly prohibited. Anyone who receives this report in error should notify us immediately by telephone and return the original message to us via the U.S. Mail.

CorVel Corporation
www.corvel.com

200 Center Point Circle
Suite 290
Columbia SC 29210

843/650-0653 Phone
843/650-4941 Fax

Baker, B

CORVEL

200 Center Point Circle
Suite 290
Columbia, SC 29210
Telephone: 843-650-0653
Facsimile: 843-650-4941

Date: 10/07/10

Claimant Name: Bobby E. Baker
Claimant Address:
City, State, Zip: C

DOI:

Employer: Kingston Plantation
Employer Address: 9770 Kings Rd.
Employer City, State, Zip: Myrtle Beach, SC 29577

Plaintiff Attorney: Luke Rankin, Esq.
Plaintiff Address: 201 Beatty St Ste 1
Plaintiff City, State, Zip: Conway, SC 29526

Defense Attorney: Collins and Lacy Law Firm
Defense Address: P. O. Box 12487
Defense City, State, Zip: Columbia, SC 29201

Treating Physician: Dr. Gregory Kang	Claimant Phone #: 843-365-2722
Physician Address: 3029 New Castle Loop	Employer Phone #: 843-449-0006
Physician City, State, Zip: Myrtle Beach, SC 29588	Physician Phone #: 843-215-8868

LABOR MARKET SURVEY

This referral for a Labor Market Survey for Mr. Baker was received from Ms. Taylor with Collins and Lacy Law Firm. An Initial Vocational Evaluation (IVE) was completed on 10-02-10 that included Mr. Baker's vocational background, transferable skills analysis, and list of jobs he could perform based on his transferable skills and physical restrictions. The jobs identified were: Assembler, Greeter, Order Clerk, Collection Clerk, Escort Driver and Sorter.

Work History

Job Title: Maintenance Engineer

Company: Kingston Plantation

Dates: 2005-2009

20

Baker, B

DOT: 899.381-010

Salary: 11.00 per hour

Duties: Mr. Baker's responsibilities included: Repairs and maintains physical structures of commercial and industrial establishments, such as factories, office buildings, and apartment houses using handtools and power tools: Replaces defective electrical switches and other fixtures. Paints structures, and repairs woodwork with carpenter's tools, repairs plumbing fixtures, repairs plaster and lays brick and builds sheds and other outbuildings.

A Labor Market Survey was conducted within a 50 mile radius of Conway, SC. Employers were located via the Internet, Newspapers and Skill Tran services.

The Bureau of Labor Statistics (BLS) reports the national annual median values of the weekly wage information collected by the Bureau of the Census during its monthly Current Population Survey (CPS). Monthly results of the CPS are collapsed into an annual pool of data, from which the median value is calculated for each CENSUS occupational group. The median value represents all full-time employed workers. The median wage for the position of Maintenance Engineer was 9.10 per hour.

Of the twelve employers located during the Labor Market Survey, twelve (100%) indicated they were hiring or would be hiring in the near future. Wages ranged from 8.00 per hour to 15.29 per hour. The average wage was 10.49 per hour.

Details of the twelve employers located:

1. Wal-Mart

2999 Outlet Blvd.

Myrtle Beach, SC 29579

Position: Greeter

DOT: 241.367-014

Salary: 8.00 per hour

Minimum Qualifications for hire: Meet and greet customers coming into the store. As an Associate with Wal-Mart, you will receive competitive wages and may be eligible for a variety of traditional and non-traditional benefits that enhance your career, compensation, home and life
Physical requirements: Sedentary

2. Coastal Workforce Center

200 A Victory Lane

Conway, SC 29570

Fax: 843-871-1446

Position: Assembler

DOT: 734.687-018

Minimum Qualifications for hire: High School or GED, One Year as an assembler with mechanic and electric experience, disassemble, assemble x-ray tubes. Replace worn out parts, bench test components: 9:00AM-5:00PM

Current starting Salary: 10.00 per hour

Physical requirements: Sedentary PDL

Baker, B

3. Toys R'Us

1100 Seaboard Street
Myrtle Beach, SC 29577
Phone: (843) 576-6006

Position: Assembler
DOT: 706.684-022

Salary: 9.00 per hour

Minimum Qualifications for hire: If you are hard working and a committed "kid-at-heart" who enjoys working in the retail industry, then a position at Toys "R" Us may be the ideal career opportunity for you. Toys "R" Us, we call our employees "associates" because we consider everyone a part of the team dedicated to success. We are looking for associates who will continue our legacy as the authentic and ultimate toy destination.

Physical requirements: Sedentary to Light

4. Target

1150 Seaboard St.
Myrtle Beach, SC 29577
Fax: 843-946-6968

Position: Greeter
DOT: 241.367-014

Salary: 8.00 per hour

Minimum Qualifications for hire: Excellent customer service, greet customers entering store.

Current starting Salary: 8.00 per hour

Physical requirements: Sedentary

5. Coastal Workforce Center

200 A Victory Lane
Conway, SC 29570
Fax: 843-871-1446

Position: Industrial Order Clerk
DOT: 249.362-026

Minimum Qualifications for hire: previous experience in warehouse setting, placing orders etc. General office environment, No special physical demands required. Some lifting and/or moving up to 10 pounds required.

Current starting Salary: 15.29 per hour

Physical requirements: Sedentary

6. Department of Veterans affairs

109 Bee St.
Charleston, SC 29401
Phone: 843-577-5011

Current Starting salary: 15.12 per hour

Position: Collection Clerk
DOT: 241.357-010

Minimum Qualifications for hire: The Ralph H. Johnson VA Medical Center is recruiting for a Program Support Clerk for our newly expanded Homebound Primary Care (HBPC) in Conway, SC. The area had a 26,000+ total Veteran population in 2009 that is only expected to grow in the coming years. Conway's downtown has been revitalized with shops and bistros. Highlighting the renovation of the downtown area is the Riverwalk, an area of fine dining which follows a stretch of the Waccamaw River that winds through Conway.

Physical requirements: Sedentary

Baker, B

7. Alpine Access University
1120 Lincoln Street, Suite 1400,
Denver, CO 80203
Phone: 303-279-0585
Position: Collection
DOT: 241.357-010
Salary: 9.00 per hour

Minimum Qualifications for hire: Customer Care Professionals (CCP,s) working this program will be responsible for delivering superior customer service in all customer interactions, which include the handling of inbound and outbound customer service calls for wireless phone customers. The ideal candidate has the ability to build a professional and friendly rapport with callers and be comfortable asking for payment and negotiating payment solutions. Work from Home.

Physical Requirements: Sedentary

8. Career Step Up
2425 SW Winterbond Ct.
Lees Summit, MO 64081
Phone: (913) 599-8221
Position: Sorter
DOT: 612.462-010
Salary: 14.00 per hour

Minimum Qualifications for hire: Sorting mail, US Government Jobs Myrtle Beach Sc

Physical Requirements: Sedentary

9. Hertz
1100 Jet Port Lane
Myrtle Beach, SC 29577
Fax: 843-448-3191
Position: Escort Driver
DOT: 919.663-032
Salary: 8.50 per hour

Minimum Qualifications for hire: In this position, you will drive only late-model rental cars with automatic steering and power brakes in and around our service facility and customer area. You will assist the location with on-lot moves to ensure adequate spacing for the vehicles.

Physical requirements: Sedentary

10. Advance to Payday
1420 Mill Pond Road
Conway, SC 29306
Position: Collection Clerk
Phone: (843) 248- 5313
DOT: 241.357-010

Minimum Qualifications for hire: Experience in Collections - Hospitality or Customer Service is a plus, experience handling cash is highly desired.

Current starting Salary: 10.00 per hour

Physical requirements: Sedentary

Baker, B

11. Title Max

1627 Highway 501

Myrtle Beach, SC 29579

Position: Collection Clerk

DOT: 241.357-010

Minimum Qualifications for hire: Excellent customer service, excellent written and verbal communication skills, High School Graduate, Management skills.

Current starting Salary: 10.00 per hour

Physical requirements: Sedentary

12. Olsten Staffing

1361 21st Ave.

North Myrtle Beach, SC

Phone: 843-626-8202-5460

Position: Assembler

DOT: 734.687-018

Minimum Qualifications for hire: assembling stereo parts, lighting and equipment.

Current Starting salary: 9.00 per hour

Physical requirements: Sedentary

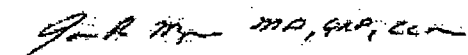
Summary:

Based on the results of the Labor Market Survey for Assembler, Greeter, Order Clerk, Collection Clerk, Escort Driver and Sorter, these jobs exist in a variety of counties within the 50 mile radius of the claimant's home. The majority of positions located were in and around the city of Myrtle Beach, SC. Based upon Mr. Baker's previous vocational experiences and transferrable skills; it appears that he would qualify for all of the positions that were surveyed. Some of the positions identified through the Labor Market Survey preferred a High School Diploma or GED but were suitable for the claimant to pursue based upon the Dictionary of Occupational titles (DOT) and O'NET (Occupational Information Network) that reports related work experience and on-the-job training should be taken into account with initial Job Zone assignments. For instance, if the data suggest that a long duration of related work experience and/or training is associated with an occupation, the analyst may raise its Job Zone. A high level of related work experience is more likely to influence Job Zone assignments of occupations associated with lower education levels."

As previously noted, 100% of the employers located during the Labor Market Survey were hiring. The average wage of these employers were based upon the light physical demand level as provided by the Department of Labor, which reflects wages both below and above Mr. Bakers reported pre-injury wage of 11.00 per hour. The average wage was 10.49 per hour.

Mr. Baker lives in a urban area of Eastern SC, lives within a 50 mile radius of the City Of Myrtle Beach, SC, current unemployment is 9.1% compared to a state average of 12.2 %. This information was obtained from the South Carolina Statistical abstract and US Department of Labor and is based on 2009 data.

Sincerely,



James R Myers MA, QRP, CCM, CRC
Certified Rehabilitation Counselor

CHARLESTON NEUROSURGICAL ASSOCIATES, L.L.C.

STEPHEN E. RAWE, M.D., PH.D.
GEORGE H. KHOURY, M.D.
BRIAN G. CUDDY, M.D.
JOHN D. STEICHEN, M.D.
CYNTHIA W. ANDERSON, R.N., A.N.P.
LARRY G. HARRIS, P.A.-C., M.P.A.S.

10/30/2009

PATIENT NAME: Bobby Baker
DOB:
SS#
PHYSICIAN REQUESTING CONSULT: Dr.

NEUROSURGICAL CONSULTATION

CHIEF COMPLAINT: Low back pain and right greater than left lower extremity discomfort.

HISTORY: The patient is a 51-year-old male who is complaining of low back and right greater than left lower extremity discomfort since May of 2008. The patient had a work-related injury with a large fire-proof ceiling tile falling onto his back. He has had low back and lower extremity discomfort ever since. The patient also notably had a fall off of his porch approximately 10 days ago and has had re-aggravation of his low back pain primarily.

Duration of Symptoms: Since May of 2008.

Location: Low back with right greater than left lower extremity discomfort.

Frequency: Constant.

Severity: At its worst is 9/10.

Quality: Aching.

Improves the pain/symptoms: Oxycodone.

Worsens the pain/symptoms: Prolonged standing, and now he has discomfort with sitting.

The symptoms are associated with paresthesias in the left lower extremity. He also feels he has marked weakness in the right greater than left lower extremity. He has difficulty sleeping. He denies any bowel or bladder symptoms.

Treatment to date includes two epidural steroid injections with moderate improvement. The patient has also undergone traction.

PAST MEDICAL HISTORY:

Current Medications: Zodol, Phentermine, and Oxycodone.

Medical: Noncontributory.

Surgical: Right hand surgery and hernia repair.

Social: He smokes half a pack per day. He does not drink.

REVIEW OF SYSTEMS: A complete multisystem review is attached to the medical record.

PHYSICAL EXAMINATION:

General Findings: Well appearing individual in no acute distress.

HEENT: AT/NC, sclera clear, conjunctiva pink, throat benign.

NECK: Supple, full ROM, nontender to palpation.

DORSAL/LUMBAR SPINE: The patient has marked tenderness in his lumbar spine. He has marked ecchymosis with a small lumbar hematoma.

EXTREMITIES: Benign.

NEUROLOGIC:

Mental Status: Alert, oriented x 3, speech fluent, appropriate affect.

Motor: He is extremely guarded when checking his right and left lower extremity strength.

Sensory: Grossly intact to pinprick and light touch.

DTR (L/R):

Triceps (2/2)

Biceps (2/2)

Brachioradialis (2/2)

Patellar (2/2)

Achilles (2/2)

SUMMARY OF RADIOGRAPHIC FINDINGS: MRI scan of his lumbar spine is reviewed with Dr. Steichen. This is from June of 2008. It shows primarily degenerative disk disease at L4-L5. This is moderate in nature. There is no significant neural compression or evidence of disk herniation.

IMPRESSION/PLAN: This is a 51-year-old male status post work-related injury who has low back and radicular type symptoms with an MRI scan that primarily shows L4-L5 degenerative disk disease. The plan at this time is for the patient to continue conservative course with pain management. He will follow up with us on a p.r.n. basis.

John D. Steichen, M.D.

ADDENDUM: The question as to whether or not a spinal cord stimulator would benefit this patient has been raised. A stimulator would be more likely to benefit the radiating leg pain and less likely to relieve the low back pain. The only way to determine whether or not he would benefit would be to proceed with a stimulator trial. In that the preponderance of his pain is isolated to the low back, I think it less likely that he will benefit from further surgery.

John D. Steichen, M.D.

C: Dr.

BOBBY BAKER

Date: 09/08/2009
Case No. 10016
AGE/SEX:

Referred By:

CHIEF COMPLAINT: Evaluation for further treatment related to his chronic back pain.

PRESENT ILLNESS: Worker's comp. The patient had a work related injury 05/05/2008. He said a ceiling fell and hit him in the neck, head, and back and knocked him to the floor. He has had epidurals by Dr. Sarb, RF by Dr. Rosenberg. He is now being evaluated for a stimulator. He has had an MRI which is unavailable today. He has not had any physical therapy. Current medications include Nucynta which does help. Please see gray sheet for past family, social history, medications, medical problems, and review of systems. He has worked in maintenance at Kingston Plantation for approximately 4 years. He has prominent low back pain. He says his right leg occasionally gives way and he has some left calf cramping.

PHYSICAL EXAMINATION:

VITAL SIGNS: HT 5 feet 8 inches, WT 196 pound male, Respirations 18.
NEUROLOGIC/LOWER: Strength, sensory, reflex exam of lower extremity including patellar, Achilles, medial hamstring reflexes within normal limits. Plantar responses downgoing. No ankle clonus or increased tone/cogwheeling noted.
VASCULAR: Distal pulses intact. No skin changes consistent with vascular insufficiency.
HIP: Patrick's sign negative. Passive range of motion with internal/external rotation without pain. Log rolling negative. No significant trochanteric tenderness.
KNEE: No effusion, erythema or increased warmth noted. Lachman's normal. Varus/valgus stress at 0 and 30 degrees without abnormal laxity/instability. Joint line without tenderness. Patellar movement symmetric without tenderness of patellar facets. Apprehension sign

Initial Visit Report for BAKER, BOBBY

Case No. 10016

09/08/2009

Page 2

SHOULDER:

negative. Anterior/posterior drawer within normal limits.

Active/passive range of motion within normal limits without pain. No tenderness to palpation of AC joint, subdeltoid bursa or biceps tendon. Negative impingement or apprehension sign. No instability noted.

LUMBAR SPINE:

No SI or facet dysfunction. Negative straight leg raise in seated and supine position. He has moderate restriction of extension greater than flexion.

IMPRESSION:

Chronic back pain.

PLAN:

We have gone over the various options today. One, we think prior to stimulator, which we think _____ low yield subjective only treatment in this milieu. We think a formal course of physical therapy would be more likely to benefit. We will defer this, however, until we are able to see either or both the report and the actual films, to get an evaluation for true extent of underlying pathology, which is likely degenerative disk disease based on the patient's complaints and findings. In addition, prior to any stimulator, we think a Functional Capacity Evaluation would also be reasonable to get a determination of the patient's vocational abilities.

Jeffrey C. Wilkins, M.D.
6598

/5154

BOBBY BAKER REF:

10016

10/05/2009

He returns today with terrible incapacitating pain for two days after 10 pounds of traction. He notes _____ single point cane. We discussed with the patient's wife and his rehab nurse, we have no neuromusculoskeletal pathology to explain how one can walk with a cane, whose purpose would be to unload your spine would be fine but 10 pounds of traction which would basically cause no demonstrable affect on the lumbar spine be so painful. He says he is doing well on the Xodol, although it causes sedation. I cannot recommend any further physical therapy or other interventional techniques for such a non-physiologic response and we recommend a Functional Capacity Evaluation. Apparently Luke Rankin, the patient's attorney, wants to continue to push the spinal cord stimulator. He has asked for an additional opinion. We have recommended Dr. John _____. Dr. _____ is the physician that I think has the longest period of expertise in our area. He would be a different speciality than that obtained before and I think he would give a cogent treatment as he _____ performs these procedures. I cannot strongly enough recommend against the stimulator. I think that, again, two days of incapacitation from 10 pounds of traction does not strike me as the profile of someone likely to have dramatic improvements in their quality of life, and more importantly ability to function with a spinal cord stimulator.

Jeffrey C. Wilkins, M.D. /5154
6811

Chart Copy



Aisha Grant Taylor | Direct Dial: 803.255.0480 | E-Mail: ataylor@collinsandlacy.com

September 21, 2010

VIA FACSIMILE (843) 347-6337

Jeffrey Wilkins, M.D.
2376 Cypress Circle
Suite 300
Conway, South Carolina 29526-8920

Re: **Bobby Baker v. Hilton Hotels Corporation & ACE American Insurance**
WCC File No.: 0819190
Claim No.: Y7E01Z12C
Date of Accident: 05/05/2008
C&L File No.: 444-803

Dear Dr. Wilkins:

Please be advised that Collins & Lacy represents Hilton Hotels Corporation and ACE American Insurance in this workers' compensation claim. I enclose herewith a Subpoena which requires your office to provide me with a copy of Bobby Baker's medical records as listed on the Subpoena.

Please note the worker's compensation exception to the newly implemented HIPAA Law, 45 CFR Part 164.512 (l) and S.C. Code Ann. §42-15-95 and §42-15-80. The requested medical records will be used exclusively for purposes of a workers' compensation claim, initiated by the patient. By copy of this letter to Mr. Baker's attorney, I hereby notify him that these records are to be released to my attention.

If you have any questions on this matter please contact my paralegal, Jane Koon, at (803) 255-0483. We would appreciate your forwarding these records to us today if at all possible. They may be faxed to (803) 771-4484.

Sincerely,

A handwritten signature in dark ink, appearing to read "Aisha".

Aisha G. Taylor

AGT/jlk

Enclosure

cc: Luke A. Rankin, Esquire (w/encl.)
Jane Landry (w/encl.)

To: RelayFax via port COM1

From: 18433472606

9/21/2010 1:34:28 PM (Page 3 of 6)

Sep. 28. 2010 1:29PM coa
South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675



No. 7951 P. 3--
WCC File # 0810190

Carrier File #: YTE01212C
Carrier Code #: 00461
Employer FEIN #: 38-2058176

Claimant's Name: Bobby Baker SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: () _____
Preparer's Name: Peter H. Dworjanyn, Esquire
Employer's Name: Hilton Hotels
Address: 9600 Queensway Blvd
City: Myrtle Beach State: SC Zip: 29572
Carrier: ACE American Insurance Company
Preparer's Phone #: (803) 256-2660

SUBPOENA

To: Jeffrey Wilkins, MD; 2376 Cypress Circle, #300, Conway, SC 29526-8920

- ☐ YOU ARE COMMANDED to appear before the above-named Commission at the place, date and time specified below to testify in the above case.

PLACE OF TESTIMONY: _____

ROOM: _____

DATE AND TIME: _____

- ☐ YOU ARE COMMANDED to appear at the place, date and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION: _____

DATE AND TIME: _____

- ☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below.

LIST OF DOCUMENTS: Any and all medical records, reports, documents, interdepartmental notes or records pertaining to the treatment of Bobby Baker (SSN: 248-17-4926, DOB: 3/6/1958), including but not limited to any and all medical records, test results, radiology reports, progress notes, consultation notes, office notes, nurse's notes, health care questionnaires, correspondence, bills for services rendered, evaluations, interviews, charts, diagrams, treatment plans, medical flow charts, telephone call reports, medical logs, disability determination information, and any other written or printed information in your medical file concerning treatment provided to claimant prior to and subsequent to May 5, 2008.

PLACE: Collins & Lacy, P.C.
Post Office Box 12487
Columbia, South Carolina 29211

DATE AND TIME: Within 10 days of receipt

- ☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES: _____

DATE AND TIME: _____

THIS SUBPOENA SHALL REMAIN IN EFFECT UNTIL YOU ARE GRANTED PERMISSION TO DEPART BY THE COMMISSIONER OR AN OFFICER ACTING ON BEHALF OF THE COMMISSIONER. QUESTIONS CONCERNING THIS SUBPOENA SHOULD BE ADDRESSED TO THE FOLLOWING ISSUING OFFICER.

ISSUING OFFICER'S SIGNATURE AND TITLE

(803) 256-2660
PHONE NUMBER

9/21/2010
DATE

Serve this form according to R.67-212B. Refer to R.67-212 and R.67-214 for additional information. Procedural questions may be addressed to the Judicial Department at 803-737-5765.

WCC Form # 27
Rev. 3/96

27

SUBPOENA

31

12/14/2010 TUE 16:14 FAX

002/003

DOCTORS CARE

4 2:10 PM

ACCOUNT NUMBER	DATE	TIME	CHECKOUT TIME	TICKET NO.
	05/06/08	01:31pm	DC NORTH MYRTLE BEACH,	344336

NAME & ADDRESS TUESDAY

BAKER, BOBBY

DOB: (50 years)

GENDER: M
FCL: 7

INSURANCE	\$0.00
BALANCE	
ACCOUNT	\$0.00
BALANCE	
CURRENT	
CHARGES	
AMOUNT	
PAID	
NEW	
BALANCE	
CASH	
CHECK	
M.O.	
C.C.	

INSURED: BAKER, BOBBY
 INS: KINGSTON/EMBASSY RESORT/HIL
 REASON: WKC AND POST ACC UDS
 NICKNAME:

RELATION: OTHER
GRP:

COPAY: WKC

STORY: (- or +, or details)			ROS (/ or O)		PREVENTIVE (year of last)		Allergies:	
Personal Hx	Family Hx	Social Hx			Circle recommendations			
DM	DM	Alcohol	Fever, Chills		Tetanus TD		Women	
HTN	HTN	Tobacco	N, V, D Constip.		Cholesterol		Men	
MI<50	MI<50	Drugs	SOB, CP		Colonoscopy		LMP	
CVA	CVA	Reg. Exor.	Headache, Fatigue		Flu Shot		PAP	
CA	CA	Occup.	UTI Sx. & Compl.		Pneumovax		Mamm	
					BMD DEXA		Rectal	

v. chart rev., no sig chg Above Hx reviewed

GT 186	BP 109/72	Pulse 76	Resp 18	Temp 97.2

PHYSICAL: (see reverse) Omit if N/A

If nmbl., O if abnml. & give details

General

HEENT

Neck

Nodes

Lungs

CV

Abd

Back

Ext

GU

Neuro

Skin/Breasts

Sts/Labs: (in-house)

CBC

Strep

Mono

U/A

Labs - sent out

H-Pylori

FBS

U Preg

Home

Microalbumin

HbA1c

KOHU IV

Wet Prep

EKG

X-Ray

Inject / Rx

ASSESSMENT / DIAGNOSIS/ES:

Day 1 of 5 calp location BT + WKC

Patient Care Instructions Discussed:

Lifestyle Modification

Return to:

If worse:

If not better:

For Follow-Up:

to ER if:

Work / School

Instructions:

to: If outside tests are ordered, we will call with results, positive or negative. If you haven't heard from us in 5-7 days after the test, please call us.

I, Bobby Baker

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Doctor's Care and its associated physicians, clinicians and other personnel. I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctor's Care. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Doctor's Care Notice of Privacy Practices.

I authorize payment of medical benefits to Doctor's Care physicians or their designees for services rendered.

Signature of Authorized Person's Signature:

Bobby Baker

Date: 5-06-08

Prescriptions / OTC Meds

CONTAINER SEAL

DTS - RTP

3000

0922543985

PSR Notes:

Patched Made
 RTW: given to employee
 and filed to Ray
 99273
 142.00

99000,5 -20.00

FAXED



RETURN TO WORK FORM

☐ SURFSIDE MEDICAL CENTER
1600 Hwy. 17 North
Surfside Beach, S.C. 29575
238-1481

☐ GEORGETOWN
1068 North Fraser St.
Georgetown, S.C. 29440
545-7200

GRAND STRAND AREA

☐ STRAND MEDICAL CENTER
1220 21st Ave., North
Myrtle Beach, S.C. 29577
626-8379

☐ CONWAY
1400 Main St.
Conway, S.C. 29526
248-6268

☐ NORTH MYRTLE BEACH
1714 Highway 17 South
North Myrtle Beach, S.C. 29582
361-0705

NAME: BOBBY BAKERDATE: 5-6-08ARRIVAL TIME: 1:06 PMDISCHARGE TIME: 2:10 PMCOMPANY NAME: Kingston Plantation

FAXED
5-6-08 2:39 PM

WORK STATUS: (Check appropriate boxes)

☒ 1. May perform Full Duty work as of 5/6/08 without accommodations.

☐ 2. Off Duty due to work-related condition.

Estimated return to work date modified duty: _____

Estimated return to work date full duty: _____

Return for re-evaluation at this office on _____ Time: _____

☐ 3. May work with the following accommodations as of: _____

☐ No lifting more than _____ lbs.

☐ No operation of hazardous or fast-moving machinery; no driving.

☐ Ground level work only, no ladder or heights.

☐ No repeated bending, stooping, squatting, pushing, jerking, twisting or bouncing.

☐ No continuous standing and/or sitting.

☐ Minimum walking, climbing (includes stairs).

☐ Limited use of _____

☐ No overhead lifting.

☐ No high repetitive hand activities for extended periods of time.

☐ No use of _____

☐ 4. Has reached Maximum Medical improvement (MMI).

☒ 5. Return for re-evaluation at this office on 5/18/08 Time: _____

COMMENTS: for 5th center

PATIENT DISCHARGE INSTRUCTIONS:

Medications: ☐ as directed ☐ as needed

Wound Care or Injury Care:

☐ keep dry & clean

☐ elevate extremity

☐ warm soaks

☐ wear elastic support/immobilizer/keep taped

☐ do not remove dressing

☐ apply ice every _____

☐ apply heat every _____

☐ Home exercise instructions given

☐ Follow instruction sheet given

☐ Bed rest for _____

REFERRAL: (If a referral is made to Therapy, or another Physician, please complete this section)

To: _____ Date: _____ Time: _____

For: _____

Address: _____

FAXED
5-6-08

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my Employer.

EMPLOYEE SIGNATURE: [Signature]

5-6-08 22

06/16/2008 MON 15:15 FAX

002/002

EXAM ROOM TIME

DOCTORS CARE

CHECKOUT TIME

N: 1:05

ACCOUNT NUMBER
115554DATE
06/16/08TIME
12:00pm

DC NORTH MYRTLE BEACH,

TICKET NO
366604

NAME & ADDRESS

MONDAY

BAKER, BOBBY

DOB:

(50 years)

GENDER: M
FCL: 6INSURANCE \$221.00
BALANCEACCOUNT \$221.00
BALANCECURRENT
CHARGESAMOUNT
PAIDNEW
BALANCE

CASH CHECK FID C.C.

INSURED: BAKER, BOBBY
INS: WC/INTRACORP/HILTON
REASON: WKC EVAL NECK / SHOULDER
NICKNAME: *OK Ray Davis*RELATION: OTHER
GRP:

COPAY: WKC

HISTORY: (- or +, or details)

Personal Hx

Family Hx

Social Hx

ROS (/ or 0)

PREVENTIVE (year of last)

Circle recommendations

Allergies:

Medications:

DM

DM

Alcohol

Fever, Chills

Totalus

Cholesterol

Wagon

Code

HTN

HTN

Tobacco

N, V, D Constip.

Colonoscopy

LMP

Men

PSA

CV

MK-50

Drugs

SOB, CP

Flu Shot

PAP

Rectal

Medications:

CA

CVA

Reg. Exor.

Headache, Fatigue

Pneumovax

Mamm

BMD DEXA

Medications:

Surg.

CA

Occup.

UTI Ex: 9 Compl.

Chief Complaint:

Chief Complaint:

Chief Complaint:

Chief Complaint:

Prev. chart rev., no sig chg

Above Hx reviewed

WGT

BP

Pulse

Resp

Temp

Chief Complaint:

Chief Complaint:

Chief Complaint:

PHYSICAL: (see reverse) Omit if N/A
(✓ if normal, 0 if abnormal, & give details)

General

HEENT

Neck

Nodes

Lungs

CV

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06/16/2008 MON 15:43 PA

002/002



RETURN TO WORK FORM

☐ SURFSIDE MEDICAL CENTER
1600 Hwy. 17 North
Eunice Beach, S.C. 29575
236-1461

☐ GEORGETOWN
1068 North Fraser St.
Georgetown, S.C. 29440
645-7200

GRAND STRAND AREA

☐ STRAND MEDICAL CENTER
1223 21st Ave., North
Myrtle Beach, S.C. 29577
636-9379

☐ CONWAY
1400 Main St.
Conway, S.C. 29526
248-6282

☒ NORTH MYRTLE BEACH
1714 Highway 17 South
North Myrtle Beach, S.C. 29582
861-0705

NAME: Bobby Decker

DATE: 6/16/08

ARRIVAL TIME: Noon

DISCHARGE TIME: 1:05 PM

COMPANY NAME: Hilton

WORK STATUS: (Check appropriate boxes)

- ☐ 1. May perform Full Duty work as of _____ without accommodations.
- ☐ 2. Off Duty due to work-related condition.
Estimated return to work date modified duty: _____
Estimated return to work date full duty: _____
Return for re-evaluation at this office on 6/16/08 Time: _____
- ☒ 3. May work with the following accommodations as of: _____ Time: _____
- ☒ No lifting more than 5 lbs.
 - ☐ No operation of hazardous or fast-moving machinery; no driving.
 - ☒ Ground level work only, no ladder or heights.
 - ☒ No repeated bending, stooping, squatting, pushing, jerking, twisting or bouncing.
 - ☒ No continuous standing and/or sitting.
 - ☒ Minimum walking, climbing (includes stairs).
 - ☐ Limited use of _____
 - ☐ No overhead lifting.
 - ☐ No high repetitive hand activities for extended periods of time.
 - ☐ No use of _____
- ☐ 4. Has reached Maximum Medical Improvement (MMI).
- ☐ 5. Return for re-evaluation at this office on _____ Time: _____
- COMMENTS: _____

PATIENT DISCHARGE INSTRUCTIONS:

Medications: ☐ as directed ☐ as needed

Wound Care or Injury Care:

☐ keep dry & clean

☐ elevate extremity

☐ warm soaks

☐ wear elastic support/immobilizer/keep taped

☐ do not remove dressing

☐ apply ice every _____

☐ apply heat every _____

☐ Home exercise instructions given

☐ Follow instruction sheet given

☐ Bed rest for _____

Diagnosis: Lumbar Radiculopathy

REFERRAL: (If a referral is made to Therapy, or another Physician, please complete this section)

To: _____

Date: _____

Time: _____

For: Orthopedic Referral

Address: _____

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my Employer.

EMPLOYEE SIGNATURE: Bobby Decker

PHYSICIAN SIGNATURE: [Signature]



FAXED

Date: 6/16/08

Date: 6/16/08

Patient

BAKER, BOBBY E

F000579818

Adm Date Service/Location

05/06/08 EMERGENCY DEPT

Status

REG ER

Account #

F01019559491

PATIENT

Soc Sec No DOB Age Sex MS Race Religion
M M W BAPTIST

Address:

Home Ph:

County: Horry

GUARANTOR

BAKER, BOBBY E

SS#:

Address:

Home Ph:

County: Horry

Relationship to Patient: SELF

OTHER GUARANTOR

BAKER, PEGGY

SS#:

Address:

Home Ph:

County: Horry

Relationship to Patient: SPOUSE

PERSON TO NOTIFY

BAKER, PEGGY

Home Phone:

Work Phone:

Relationship to Patient: SELF

PATIENT EMPLOYER

KINGSTON PLANTATION
9770 KINGS RD
MYRTLE BEACH, SC 29577
Work Phone: (843)449-0006
Occupation: ENGINEER

GUARANTOR EMPLOYER

KINGSTON PLANTATION
9770 KINGS RD
MYRTLE BEACH, SC 29577
Work Phone: (843)449-0006
Occupation: ENGINEER

OTHER GUARANTOR EMPLOYER

HOUSEWIFE
HOUSEWIFE
HOUSEWIFE, SC 29406
Work Phone: (999)999-9999
Occupation: HOUSEWIFE

TEMPORARY ADDRESS

INSURANCE #1

622 WORK COMP
9800 QUEENS WAY BLVD
MYRTLE BEACH, SC 29572
Phone (843)449-0006
PA CODE 99870

Policy # 248174926

Coverage #

Subscriber BAKER, BOBBY E

Rel to Pt SELF

Eff.

to

Rel Y Assign Y

Group

AUTHORIZATION

Treat/Precert

Ins Verif

Pro Review Not Required

INSURANCE #2

Phone
PA CODE

Policy #

Coverage #

Subscriber

Rel to Pt

Eff.

to

Rel Assign

Group

AUTHORIZATION

Treat/Precert

Ins Verif

Pro Review

INSURANCE #3

Phone
PA CODE

Policy #

Coverage #

Subscriber

Rel to Pt

Eff.

to

Rel Assign

Group

AUTHORIZATION

Treat/Precert

Ins Verif

Pro review

OCCURRENCES

Code Type Date Time
04 ACCIDENT - EMPLOYMENT RELATED 05/05/08 2200

CONDITIONS

Code Type
02 EMPLOYMENT RELATED

Special Program

Unit BarCode Number

Last Hospitalization

Admission Comment

SEE COLLECTION NOTES

Financial Class
04

Attending Physician

HCIS

Admitting Physician

HCIS

Emergency Room Physician

HCIS

Prim Care Physician

HCIS

Family Physician

HCIS

HEALTH, CAROLINA

89-1

Pt Did Not Know/Have PCP

Other Physician

ADMISSION/REGISTRATION

Date Time Source Rm/Bed Arrival Mode Chief Complaint/Reason for Visit
05/06/08 0054 PHYSICIAN/SELF REFER WI HEAD LAC

Admitted By
R.L. HES

REGISTRATION FORM

Grand Strand Regional Medical Center
809 82nd Parkway ** Myrtle Beach ** SC 29572
(843) 692-1000

Printed: 05/06/08 0056

Date: 5/15/08 Time of Arrival: 0313 Patient Name: BOBBY BAKER Index: 30151 To Room # 11

ID Band Yes ☐ No ☐ TB Screen ☐ POS ☐ Lateral Allergy ☐ Yes ☐ No ☐ Visual OS ☐ N/A ☐ Mode of Arrival ☐ EMS ☐ Walk-in ☐ W/C ☐ Carried

Triage Nurse: S. J. [Signature] LMP: N/A Imm: ☐ UTD ☐ Not UTD Tetanus: unknown

VIS 6/19/94 given: ☐ Yes ☐ No ☐ N/A

Info. Obtained From: patient Triage Time: 0031

CC - Onset: operation to scalp and neck pain when part of ceiling fell on him. Severe numbness/tingling of face and legs. No pain sensation in neck.

PCP: Hudson in A. [Signature] ☐ None ☐ DOT

Tx PTA: [Signature] [Signature] controlled

Treatment at Triage: ☐ Ice ☐ Splint ☒ Cervical-collar ☐ Elevation ☐ DSD ☐ Respiratory Isolation

Time	Temp.	BP	HR	RR	SpO2	Pain 0-10	G	C	S	R	T	S
97	164	103	64	116		7	4	5	6			

Time to Room: 0047 Comments:

☐ CBC with DIF ☐ CSF Panel ☐ BNP RN to insert times of applications

☐ PT/PTT ☐ Tube 1 - cell with diff count ☐ pCXR/CXR ☐ O2 Via ☐ applied @

☐ Hepatic Panel ☐ Tube 2 - protein + glucose ☐ pCS/TCSP ☐ Cardiac Monitor applied @

☐ BMP ☐ Tube 3 - gram stain + culture ☐ CT Head w/o ☐ EKG done @

☐ CMP ☐ Tube 4 - ☐ CT Abd/pel w/o

☐ D-Dimer ☐ BHCG ☐ CT Abd/pel with ☐ Type/Screen

☐ Cardiac Panel ☐ UHCG ☐ KUB / Abd X-ray ☐ Type/Cross for ☐ units as follows

☐ Trauma Panel ☐ UA ☐ X-ray of ☐ PRBC

☐ CK/ISO/TROP ☐ UDS ☐ Other: ☐ FFP

☐ Amy / Lipase ☐ ABG ☐ Platelets

☐ ETOH ☐ Pulse Ox

* Atix Allergy Band ☐ Yes ☐ No ☐ NKA ☐

ALLERGIES: Codeine Type of Reaction

PHYSICIAN ORDERS: 1% Lidocaine 2 epi Small Stapler.

INITIAL EXAM: Time of Initial Exam: 0045 Consult Called @ By: WC / RN

☐ No risk for PE / TAD / AAA / CAD (CIRCLE if applicable)

Dictated By: ☐ EMP ☐ Consultant ☐ PCP Physician(s) Signature: M. Doe

Provisional Dx: Scalp lacer 6cm Head contusion

Condition on Disposition: ☐ Improved ☐ Stable ☐ Unstable ☐ Deceased

Return to emergency room if symptoms worsen

Discharge Instructions:

Rx:

Disposition: Consult ☐ Discharge ☒ 0202 Time:

EPIC INSTRUCTIONS: Work/School note _____ days.

Dx: STA

Rx:

FAU With: out 10-12 in Days

ExitCare® Patient Information - BOBBY BAKER

Grand Strand Regional Medical Center
809 82nd Parkway
Myrtle Beach, SC 29572
Main (843) 692-1000

EXITCARE® PATIENT INFORMATION

Patient Information:

Patient Name: BOBBY BAKER	Patient Address:
Patient ID:	Patient Email:
Patient Medical Record Number:	Patient Gender:
Patient DOB:	Responsible Adult:
Patient Phone Number: () -	Diag:

Primary Caregiver Information:

Attending Caregiver: BORIS SHKLYAR, MD

Primary Follow-up Info: () -

User Information:

Login ID:	User Name:	Dept: ED

>>>> Staple Wound Closure-El - English - {705836B6-E304-49D6-A8E1-05C1BAAB91B3}

Additional Notes:

HAVE STAPLES REMOVED IN 10-12 DAYS.

>>>> ZZ Discharge Statement - English - {EA6B5205-77B3-4E4A-A559-244F3EF8EFE7}

This Document has either been modified or created by the Issuing facility or caregiver.

Signature acknowledges that Patient and/or Guardian has received these instructions and understands them.

Bobby Baker

Patient or Guardian Signature

Time /Date

Ha 3300 LP 5-6-08

Witnessed & Instructed by

Time/Date

0220

GRAND STRAND REGIONAL MEDICAL CENTER

ER REPORT

NAME: BAKER, BOBBY E
MED REC #: F000579818

PHYSICIAN: DESALVO, MATTHEW J
ACCOUNT #: F01019559491

PT: BAKER, BOBBY E
DOS: 05/06/2008
DICT PHY: MATHEW J DESALVO, MD

CC: "I got hit in the head with a ceiling tile."

HX: A 50-year-old male was installing ceiling tiles, one of them fell down and hit him on the top of the head, and he suffered a scalp laceration. He is complaining of neck pain. He has not injured anywhere else. He did lose consciousness. He stated it did knock him down to the ground, but he has not injured anywhere else.

ALLERGIES: Codeine.

MEDICAL HISTORY: Hypercholesterolemia.

CURRENT MEDS: Noted.

SH: Noted.

PE: VITAL SIGNS: Temperature is 97.4, blood pressure 164/103, heart rate 64, and respiratory rate 16. GENERAL: He is awake, alert, and in no acute distress, sitting comfortably at the side of the bed. He was placed in a C-collar in triage. HEENT: His head normocephalic. He has a 6-cm laceration on the scalp. NECK: Supple. There is really no localizable tenderness to the spinous processes of the C-spine or T-spine. He is left in a C-collar. C-spine x-rays are obtained.

EMERGENCY DEPARTMENT COURSE: C-spine x-ray was read as no acute fracture by the radiologist. His scalp wound was cleansed and prepped and draped in usual sterile fashion, skin anesthetized with 1% lidocaine with epinephrine and cleaned. The partial thickness of the scalp was closed using wound clips with good reapproximation of the skin edges.

TREATMENT PLAN: I clinically cleared from the C-collar. He is discharged home with instructions to follow up with his primary care physician for recheck within the next week. Have the staples removed in 10 to 12 days.

CLINICAL IMP: Scalp laceration, 6 cm and head contusion.

DISPOSITION: Home.

IN: ED/F.HIM/DESM/31ANO S: 05/06/2008
D: 05/06/2008 02:02
T: 05/06/2008 05:39 CONF#: 964171 / JOB#: 27343867

DESALVO, MATTHEW J

Electronically Signed by MATTHEW J DESALVO on 05/16/08 at 0153

Diagnostic Imaging Report
GRAND STRAND REGIONAL - 809 82ND PARKWAY - MYRTLE BEACH, SC 2957
Phone #: 8436921560 Fax #: 8436921555

Name: BAKER, BOBBY E Loc: F.ED Radiology No:
DOB: Age: 50 Sex: M Status: DEP ER Unit No: F000579818
Phys: DESMA - DESALVO, MATTHEW J Acct: F01019559491
Reason For Exam: Exam Date: 05/06/2008

Exams: 001214490 SPINE CERVICAL COMP REASON FOR EXAM:
INJURED/ER 11

Cervical spine series with obliques 5/6/08.

Indication: Trauma. Ceiling tile fell on patient's head.

Comparison: None.

Findings: Crosstable lateral, swimmer's lateral, repeat lateral, frontal, both oblique views and open-mouth view of the cervical spine shows limited evaluation of the dens due to overlying teeth artifact. There is spondylosis without acute fracture seen. Disc space narrowing is most pronounced at C5-6 and C6-7. Prevertebral soft tissues not widened.

Impression:

Spondylosis without acute fracture seen.

Limited evaluation of the dens.

PLEASE NOTE: If the patient has persistent pain, or if there is still high clinical suspicion of fracture, a CT of the cervical spine might be considered.

Diagnostic Imaging Report

GRAND STRAND REGIONAL - 809 82ND PARKWAY - MYRTLE BEACH, SC 2957
Phone #: 8436921560 Fax #: 8436921555

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Reason For Exam: Exam Date: 05/06/2008

Exams:
001214490 SPINE CERVICAL COMP
<Continued>

REASON FOR EXAM:
INJURED/ER 11

P

** Electronically Signed by YOUNG S SONG MD on 05/06/2008 at 0732 **
Reported and Signed by: YOUNG S SONG MD

CC: MATTHEW J DESALVO

Dictated Date/Time: 05/06/2008 (0157)
Technologist: JODY M. SMITH RT
Transcribed Date/Time: 05/06/2008 (0732)
Transcriptionist: FRAD.SMJ
Electronic Signature Date/Time: 05/06/2008 (0732)
Printed Date/Time: 05/06/2008 (0731)

PAGE 2

MEDICAL RECORDS COPY

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REGISTRATION FORM

Grand Strand Regional Medical Center
809 B2nd Parkway ** Myrtle Beach ** SC 29572
(843) 692-1000

Printed: 06/14/08 2011



UR

21

Date: 6-14-08 Time of Arrival: 11:05 Patient Name: Baker, Bobby DOB: 50 HL/WL: 170/70 Room #: 103

AD Band: ☒ Yes ☐ No TB Screen: ☐ Yes ☒ No Latex Allergy: ☐ Yes ☒ No Visual OS: ☐ Yes ☒ No Acuity OD: ☐ Yes ☒ No

Mode of Arrival: ☐ EMS ☒ Walk-In ☐ W/C ☐ Carried

Triage Nurse: [Signature] LMP: 10/20/07 Imm: ☐ UTD ☐ Not UTD Tetanus: 10/20/07

Info. Obtained From: 7:00

CC - Onset: lower back pain
neck burning

PCP: None ☐ None ☐ OOT

Tx PTA: None

Treatment at Triage: ☐ Ice ☐ Splint ☐ Cervical-collar ☐ Elevation ☐ DSD ☐ Respiratory Isolation

Time	Temp.	BP	HR	RR	SpO2	Pain 0-10	G	C	S	R	T	S
9:00	98.7											
11:03	108					16						

GCS: 5 with no response to stimuli: call LifePoint!

Time to Room: 4:00 Comments: None

Triage Level: ☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5

PMH: ☐ None ☐ Diabetes ☐ COPD/Asthma ☐ HTN

☐ Heart Disease

☐ Current Smoker (smoked within last 12 months) ☐ ETOH ☐ Illicit Drugs

Meds: ☐ None ☐ See attached Med Reconciliation List

Functional Screen: ☐ None ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Prosthesis

Nutritional Screen: Unintentional Weight Loss? ☐ Yes ☒ No On enteral / parenteral nutrition? ☐ Yes ☒ No Skin ulcer / Decubitus present? ☐ Yes ☒ No

ADL: ☐ Independent ☐ Dependent

Abuse Screen: Suspect Abuse / Neglect ☐ Yes ☒ No Do you feel safe at home? ☐ Yes ☒ No Positive screens? Refer to Abuse Policy/Procedure

Substance Risk Screen: ☐ See attached ☐ Deferred ☐ N/A ☐ Other: None

Orders

☐ CBC with DIF ☐ CSF Panel ☐ BNP RN to insert times of applications

☐ PT / PTT ☐ Tube 1 - cell with diff count ☐ pCXR / CXR ☐ O2 Via nasal applied @ 103

☐ Hepatic Panel ☐ Tube 2 - protein + glucose ☐ pCSP / CSP ☐ Cardiac Monitor applied @ 103

☐ BMP ☐ Tube 3 - gram stain + culture ☐ CT Head w/o ☐ EKG done @ 103

☐ CMP ☐ Tube 4 - ☐ CT Abd/pel w/o ☐ CT Abd/pel w/o stone protocol

☐ D-Dimer ☐ BHCG ☐ CT Abd/pel with ☐ Type/Screen

☐ Cardiac Panel ☐ UA ☐ KUB / Abd X-ray ☐ Type/Cross for units as follows

☐ Trauma Panel ☐ UDS ☐ X-ray of LB spine ☐ PRBC

☐ CK/ISO/TROP ☐ ABG ☐ Other: None ☐ FFP

☐ Amy / Lipase ☐ Pulse Ox ☐ Platelets

* Affix Allergy Band ☐ Yes ☐ No NKA ☐

ALLERGIES: Codeine

Type of Reaction: None

Physician

Time of Initial Exam: 11:05 Consult Called @ 11:05 By: WC / RN

☐ No risk for PE / TAD / AAA / CAD (CIRCLE if applicable)

Cooling felt on 6/14/08
which had no response

PHYSICIAN ORDERS

TORADOL 60mg PO BID

Dictated By: ☐ EMP ☐ Consultant ☐ PCP Physician(s) Signature: [Signature] 103/1156

Provisional Doc: BK Pain

Discharge

Condition on Disposition: ☐ Improved ☐ Stable ☐ Unstable ☐ Deteriorated

Return to emergency room if symptoms worsen

Discharge Instructions: None

Rx: None

Disposition: ☐ Consult ☐ Discharge ☐ Admit

EPIC INSTRUCTIONS: Work/School note 3 days.

Dr: None

Rx: None

FAU With: None in None Days

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ED Nursing Assessment / Disposition

Date: _____		Time of Assessment: _____		Initials: _____		Bed: _____		Page _____ of _____			
Psychosocial Behavioral Age/Devel. Approp. ☒ Yes ☐ No Eye Contact ☒ Yes ☐ No Affect ☒ Normal ☐ Abnormal Motor Behavior ☒ Cooperative ☐ Restless ☐ Agitated Speech ☒ Normal ☐ Abnormal Support System ☒ Lives Alone ☐ Family/Significant Other ☐ Other Language line offered? ☒ Yes ☐ No ☒ N/A Deal Talk offered? ☒ Yes ☐ No ☒ N/A		Skin ☒ Intact ☐ Lesions ☐ Dry ☐ Diaphoretic ☐ Warm ☐ Cool Turgor ☒ Normal ☐ Decreased Edema ☒ Absent ☐ Present ☐ Site/Degree: _____ Color ☒ Normal ☐ Pale ☐ Cyanotic ☐ Mottled ☐ Jaundice ☐ Flushed Mucous Membranes ☒ Moist ☐ Dry Ortho ☐ Pain ☐ Denies ☐ Swelling ☐ Deformity ☐ Limited Movement Site: _____ Color: _____ Sensation: _____ ROM: ☐ Limit ☐ Full		Respiratory ☒ Normal ☐ Denies ☐ Dyspnea ☐ Nasal Flaring ☐ Retractions ☐ Stridor ☐ Cough ☐ Non-Productive ☐ Productive ☐ Color: _____ ☐ Using Accessory Muscles ☐ Expiratory Grunt Breath Sounds R: ☐ Clear ☐ Crackles ☐ Wheezing ☐ Diminished ☐ Absent L: ☐ _____ ☐ _____ ☐ _____		Neurological ☒ Alert ☐ Oriented ☐ Disoriented ☐ Drowsy ☐ Confused ☐ Lethargic ☐ Unresponsive ☐ Combative ☐ Uncooperative ☐ Fontanelle ☐ Flat ☐ Depressed ☐ Bulging ☐ Crying ☐ Age Appropriate Responsive to Stimuli ☒ Verbal ☐ Painful Pupils ☐ Equal ☐ Unequal ☐ Reactive ☐ Non-Reactive		Cardiac ☐ CP ☒ Denies Onset ☐ Constant ☐ Intermittent ☐ Resolved ☐ Palpitations ☐ Non-Radiating ☐ Radiating Arm ☐ R ☐ L ☐ Back ☐ Neck / Jaw ☐ Pain Scale (0-10) _____ Heart Sounds ☐ Regular ☐ Irregular Pulses Radial ☐ R ☐ L ☐ Femoral ☐ R ☐ L ☐ Pedal ☐ R ☐ L Capillary Refill ☐ Normal ☐ Slow (2 secs) ☐ (> 2 secs)		G.I. ☒ Denies Abdomen ☐ Normal ☐ Distended ☐ Guarding ☐ Rigid Tenderness ☐ LUQ ☐ RLQ ☐ LLQ ☐ RLQ ☐ Epigastric Bowel Sounds ☐ Present ☐ Absent ☐ Hyper ☐ Hypo ☐ Last BM _____ ☐ Vomiting _____ ☐ Diarrhea _____ ☐ Blood in Stool _____ G.U. ☐ Flank Pain ☐ Denies ☐ Dysuria ☐ L ☐ R ☐ Hematuria ☐ Frequency ☐ Oliguria ☐ Retention ☐ Foley	

Clothing and Valuable Checklist

☐ Pants	☐ Jewelry	☐ Yellow Metal	☐ White Metal	☐ Clear Stones	☐ Colored Stones	☐ Other Items	☐ Glasses	☐ Pocketbook	☐ Denies
☐ Shirt	☐ Ring(s)					☐ Contacts	☐ Money	☐ Credit Cards	☐ Pregnancy Gestation: _____
☐ Dress	☐ Necklace(s)					☐ Dentures	☐ Partial Plate	☐ With Patient	☐ Cramping ☐ FHT: _____
☐ Coat	☐ Bracelet(s)					☐ Hearing Aid	☐ With Family	☐ Discharge ☐ LMP: _____	☐ Bleeding ☐ EDC: _____
☐ Shoes	☐ Watch					☐ Wallet	☐ Security	☐ # Pads Per Hour: _____	☐ Spotting: G: _____ P: _____ A: _____
Other: _____							☐ Clots: Small Medium Large		

Time	Temp	BP	HR	RR	SpO2	Pain 0-10	G	C	S	R	T	S	Eyes Open	Verbal	Motor
2150		153/90	65	16	97%	6							1. Never	1. None	1. None
2150		153/90	53	13									2. To Pain	2. Garbled	2. Extension
													3. To Speech	3. Inappropriate	3. Abn. Flexion
													4. Spontaneously	4. Confused	4. Withdraws
														5. Oriented	5. Localizes Pain
															6. Obeys Commands

IV Fluids/Medications	Site	Time	Initials	IV Fluids/Medications	Site	Time	Initials
Saline 100ml	2150	CP					

Lab drawn by ED or Lab @ _____

Intake: _____ Output: _____

Nurse Interventions / Evaluations

2015/05/07 2150 lower back pain & neck pain
 pulses all extremities - denies N/T. Disinfectant 2100 neck pain
 2150 H/OIC Thome - instructions given. Dr. Webster's instructions
 H/OIC Thome - instructions given. Dr. Webster's instructions
 H/OIC Thome - instructions given. Dr. Webster's instructions

Time orders written: _____ Delay code: _____
 Time patient physically left ED: 2150

Signature: _____ Signature: _____

Discharged by: _____

Report called: _____

BAKER, BOBBY E WFF000579818
 A#01019/R9171 REG ER ED
 DGS: 06/14/08 HEALTH, CAROLINA
 DCS 50/W

Grand & Regional Medical Center

Emergency Department

WORK/SCHOOL EXCUSE

(843) 692-1000

Date 6/14/08

Bobby Parker HAS BEEN SEEN IN THE EMERGENCY ROOM
ON 6/14/08

☒ EXCUSED FROM WORK/SCHOOL FOR 3 DAYS

☐ MAY RETURN TO WORK/SCHOOL IMMEDIATELY

RESTRICTIONS

☐ UNABLE TO BEAR WEIGHT FOR ____ DAYS

☐ UNABLE TO LIFT ____ LBS. FOR ____ DAYS

OTHER

DR. Meza / 24

REVIEWED BY:

3400301060 (08/20/07) FC 638162

ExitCare® Patient Information - BOBBY BAKER

Grand Strand Regional Medical Center
809 82nd Parkway
Myrtle Beach, SC 29572
Main (843) 692-1000

EXITCARE® PATIENT INFORMATION

Patient Information:

Patient Name: BOBBY BAKER	Patient Address:
Patient ID:	Patient Email:
Patient Medical Record Number:	Patient Gender:
Patient DOB:	Responsible Adult:
Patient Phone Number: () -	Diag:

Primary Caregiver Information:

Attending Caregiver: DR. SCOTT MAYHEW

Primary Follow-up Info: : - () -

User Information:

Login ID:	User Name:	Dept: ED

>>>> Back Pain & Injury-EI - English - {1375B1CE-4FC6-40CD-877C-779089C487BC}

Additional Follow-up caregivers:

: ROBERT LEAK, - 849 82ND PARKWAY MYRTLE BEACH SC 29572 (843)449-9457 - - ORTHOPEDICS

Additional Notes:

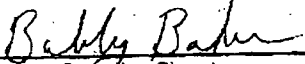
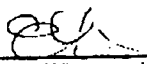
FOLLOW UP WITH AN ORTHOPEDIST
GET A MRI OF BACK

>>>> ZZ Discharge Statement - English - {EA6B5205-77B3-4E4A-A559-244F3EF8EFE7}

This Document has either been modified or created by the issuing facility or caregiver.

The Following Drug Information Sheets were given as part of this visit: FLEXERIL (CYCLOBENZAPRINE-ORAL), PERCOCET (OXYCODONE/ACETAMINOPHEN - ORAL)

Signature acknowledges that Patient and/or Guardian has received these instructions and understands them.

		6/14/08	2:55
Patient or Guardian Signature	Witnessed & Instructed by	Time /Date	Time/Date

Diagnostic Imaging Report

GRAND STRAND REGIONAL - 809 82ND PARKWAY - MYRTLE BEACH, SC 2957
Phone #: 8436921560 Fax #: 8436921555

Name: BAKER, BOBBY E Loc: F.ED Radiology No:
DOB: , Age: 50 Sex: M Status: DEP ER Unit No: F000579818
Phys: MEZYE - MEZA, YENNEY Acct: F01019789171
Reason For Exam: Exam Date: 06/14/2008

Exams: REASON FOR EXAM:
001230708 SPINE LUMBAR COMP W/OBLIQ BACK PAIN/ER 21

4 view lumbar spine 6/14/2008.

Indication: Back pain, history of prior injury.

Comparison: None.

Findings: Frontal, lateral and bilateral oblique radiographs of the lumbar spine were obtained on 5 images. Five lumbar type non rib bearing vertebral bodies are in grossly normal alignment. There is no evidence of acute fracture. I do not see any significant degenerative changes.

Impression:

Unremarkable lumbar spine.

P

** Electronically Signed by MICHAEL H BROWN MD **
** on 06/16/2008 at 0548 **
Reported and Signed by: MICHAEL H BROWN MD

CC: YENNEY MEZA

Dictated Date/Time: 06/14/2008 (2115)
Technologist: DIANN M. JONES
Transcribed Date/Time: 06/16/2008 (0548)
Transcriptionist: FRAD.BAA
Electronic Signature Date/Time: 06/16/2008 (0548)
Printed Date/Time: 06/16/2008 (0554)

PAGE 1 MEDICAL RECORDS COPY

GRAND STRAND REGIONAL MEDICAL CENTER

ER REPORT

NAME: BAKER, BOBBY E
MED REC #: F000579818

PHYSICIAN: MEZA, YENNEY
ACCOUNT #: F01019789171

PT: BAKER, BOBBY E
DOS: 06/14/2008
DICT PHY: YENNEY MEZA, MD

CC: Back pain.

HPI: A 50-year-old male with no past history, comes in today complaining of lower back discomfort which he has had after ceiling falling on his back on 06/06/2008, now having worsening pain to his lower back. Denies any urine or stool incontinence or urinary retention. No weakness to the lower extremities or in the proximal muscle groups. No fevers, chills, nausea, or vomiting. Just says basically it hurts when he twists or turns across, limiting his ability to ambulate. Aside from that has no other complaints.

ROS: Otherwise negative.

PMH: Noted.

MEDS: Noted.

ALLERGIES: Noted.

SH: Noted.

FH: Noncontributory.

PE: VITAL SIGNS: Blood pressure 163/108 most likely secondary to pain. See nursing note for repeat blood pressure. GENERAL: He is in no acute distress, nontoxic, and well appearing. HEENT: Normocephalic and atraumatic. Pupils are equal, round, and reactive to light. Mucous membranes are moist. LUNGS: Clear. HEART: Regular rate and rhythm. ABDOMEN: Soft and nondistended. No rebound or guarding. No pulsatile or palpable masses. BACK: No CVA tenderness. MUSCULOSKELETAL: No clubbing, cyanosis, or edema. He does have some tenderness in the LS spine region of the back. NEUROLOGIC: No gross motor or sensory deficits. Strength is 5 out of 5 in proximal and distal muscle groups.

ER COURSE: In light of the patient's symptoms, LS spines were done to rule out any back pathology. No acute findings were noted. The patient has no history or physical consistent with AAA, dissection, or cauda equina. The patient will be discharged home with Percocet and Flexeril. Told to follow up with orthopedics for MRI of the back to further delineate.

IMP: Back pain.

DISPOSITION: Discharged home.

PLAN: As per EPIC and previous dictation.

IN: ED/F.HIM/MEZYE/31ANO S: 06/14/2008

ED REPORT

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Page 1 of 2

GRAND STRAND REGIONAL MEDICAL CENTER

ATT. PHY MEZA, YENNEY

NAME: BAKER, BOBBY E
MED REC# F000579818
=====

D: 06/14/2008 21:30
T: 06/15/2008 04:19 CONF#: 1037156 / JOB#: 27893597

MEZA, YENNEY
Electronically Signed by YENNEY MEZA on 06/21/08 at 0011

ED REPORT

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Page 2 of 2

06/25/2008 WED 12:04 FAX

004/005

06/24/2008 TUE 15:04 FAX 843P20622 DOCTORS CARE SURFSIDE

001/002

Fax Server

6/24/2008 1:12:59 PM PAGE 2/003 Fax Server



AMB

PATIENT: Baker, Bobby
DOB:
MRN: 571102
PHYSICIAN: Ronald Reynolds, MD
DATE: 6/23/2008

EXAM: MRI LUMBAR SPINE WITHOUT CONTRAST

HISTORY: Low back injury, low back and left leg pain.

TECHNIQUE: Sagittal T1, sagittal T2, coronal T1, axial T2, and axial T1.

FINDINGS:

Overview: The renal contours, visualized paraspinal musculature and bone marrow signal within the pelvis and the hips all appear grossly unremarkable. No obvious organomegaly is evident.

Thoracic spine: There is loss of height and signal within the intervertebral disc at the T11-12 level. There is a tiny annular tear in the midline, perhaps slightly to the left. No compressive lesion is evident. Spinal cord terminates at the L1-2 level.

Lumbar spine: There is normal alignment of the lumbar vertebral bodies. There is a small hemangioma within the inferior endplate of L4. No other areas of signal abnormality within the osseous elements of the lumbar spine are evident.

Intervertebral discs:

L1-2, L2-3, L3-4: There is normal height and signal within the intervertebral discs. No compressive findings evident at this level. Facet joints and ligaments are normal in appearance.

L4-5: There is mild loss of signal within the intervertebral discs. There is a mild diffuse annular protrusion projecting into the neural foramina bilaterally and slightly into the right lateral recess. There are circumferential tears within the peripheral annular fibers within the neural foramina bilaterally, more so on the right than the left. There is mild facet hypertrophy.

L5-S1: There is normal height and signal within the intervertebral discs. No compressive changes are evident.

IMPRESSION:

1. The most significant abnormality is at the L4-5 level. There is degenerative disc and facet joint disease with bilateral annular tears within the peripheral annular fibers at this level.
2. There is degenerative disc disease with an annular tear noted at the T11-12 level as well. Please see above report for detailed description of findings.

David Goltra M.D.
DG/dg

DD: 6/24/2008
DT: 6/24/2008

FAX

Is pt referred to ortho?
6/24/08

06/25/2008 WED 12:04 FAX

005/005

06/24/2008 TUE 15:04 FAX 8438280622 DOCTORS CARE SURFSIDE

002/002

Fax Server

8/24/2008 1:12:59 PM PAGE 3/003 Fax Server

Patient: Baker, Bobby
MRN: 571102
Exam: MRILUMBAR SPINE WITHOUT CONTRAST

Job: 6399020

This document has been reviewed and signed electronically.

[Handwritten signature]

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Peter H. Dworjanyn | Direct Dial: 803.255.0404 | E-Mail: pdworjanyn@collinsandlacy.com

July 10, 2009

Medical Records Custodian
Grand Strand Regional Medical Center
809 82nd Parkway
Myrtle Beach, SC 29572

Bobby Baker v. Hilton Hotels Corporation & ACE American Insurance
WCC File No.: 0810190
Claim No.: YTE01212C
Date of Accident: 05/05/2008
C&L File No.: 444-803

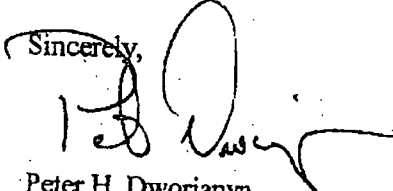
Dear Medical Records Custodian:

Please be advised that Collins & Lacy represents Hilton Hotels Corporation and ACE American Insurance in this workers' compensation claim. I enclose herewith a Subpoena which requires your office to provide me with a copy of Bobby Baker's medical records as listed on the Subpoena.

Please note the worker's compensation exception to the newly implemented HIPAA Law, 45 CFR Part 164.512 (1) and S.C. Code Ann. §42-15-95 and §42-15-80. The requested medical records will be used exclusively for purposes of a workers' compensation claim, initiated by the patient. By copy of this letter to Mr. Baker's attorney, I hereby notify him that these records are to be released to my attention.

If you have any questions on this matter please contact my paralegal, Catherine Ashbridge, at (803) 255-0452. Please forward the information to my office within ten (10) days of receipt.

Sincerely,


Peter H. Dworjanyn

PHD:caa

Enclosure

cc: Luke A. Rankin, Esquire
Kim Jordan

FILE NO. 444-803

JUL 20 2009

REC'D. PHD:caa
COLLINS & LACY

South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675



WCC File #: 0810190
Carrier File #: YTE01212C
Carrier Code #: 00461
Employer FEIN #: 36-2058176

Claimant's Name: Bobby Baker SSN: _____ Employer's Name: Hilton Hotels
Address: _____ Address: 9800 Queensway Blvd
City: _____ State: _____ Zip: _____ City: Myrtle Beach State: SC Zip: 29572
Home Phone: _____ Work Phone: () _____ Carrier: ACE American Insurance Company
Preparer's Name: Peter H. Dworjanyn, Esquire Preparer's Phone #: (803) 256-2660

SUBPOENA

To: Grand Strand Regional Medical Center
809 82nd Parkway
Myrtle Beach, SC 29572

- ☐ YOU ARE COMMANDED to appear before the above-named Commission at the place, date and time specified below to testify in the above case.

PLACE OF TESTIMONY: _____

ROOM: _____

DATE AND TIME: _____

- ☐ YOU ARE COMMANDED to appear at the place, date and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION: _____

DATE AND TIME: _____

- ☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below.

LIST OF DOCUMENTS: Any and all medical records, reports, documents, interdepartmental notes or records pertaining to the treatment of Bobby Baker (SSN: 248-17-4926, DOB: 3/6/1958), including but not limited to any and all medical records, test results, x-ray reports, progress notes, consultation notes, office notes, nurse's notes, health care questionnaires, correspondence, bills for services rendered, evaluations, interviews, charts, diagrams, treatment plans, medical flow charts, telephone call reports, medical logs, disability determination information, and any other written or printed information in your medical file concerning treatment of Bobby Baker.

PLACE: Collins & Lacy, P.C.
Post Office Box 12487
Columbia, South Carolina 29211

DATE AND TIME: July 20, 2009 at 5:00 pm

- ☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES: _____

DATE AND TIME: _____

THIS SUBPOENA SHALL REMAIN IN EFFECT UNTIL YOU ARE GRANTED PERMISSION TO DEPART BY THE COMMISSIONER OR AN OFFICER ACTING ON BEHALF OF THE COMMISSIONER. QUESTIONS CONCERNING THIS SUBPOENA SHOULD BE ADDRESSED TO THE FOLLOWING ISSUING OFFICER.

ISSUING OFFICER'S SIGNATURE AND TITLE

(803) 256-2660
PHONE NUMBER

7/10/2009
DATE

Serve this form according to R.67-212B. Refer to R.67-212 and R.67-214 for additional information. Procedural questions may be addressed to the Judicial Department at 803-737-5765.

CERTIFICATE OF SERVICE

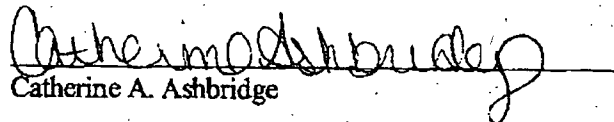
The undersigned employee of Collins & Lacy, P.C., Attorneys at Law, Post Office Box 12487, 1330 Lady Street, Columbia, South Carolina, 29211, does hereby certify that she has served the following named individual(s) with a copy of the pleading indicated below by mailing a copy of same to all counsel of record, in the United States mail, with sufficient postage affixed thereto and return address clearly marked on the date indicated below:

COUNSEL SERVED:

Medical Records Custodian
Grand Strand Regional Medical Center
809 82nd Parkway
Myrtle Beach, SC 29572

PLEADING(S):

FORM 27


Catherine A. Ashbridge

Columbia, South Carolina

July 10th, 2009.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO: 0810190

Bobby Baker,	)	
	)	
CLAIMANT/	)	
APPELLANT,	)	
	)	
VS.	)	
	)	
HILTON HOTELS	)	CLAIMANT'S APPELLATE BRIEF
CORPORATION,	)	
	)	
EMPLOYER,	)	
	)	
and	)	
	)	
ACE AMERICAN INSURANCE	)	
COMPANY,	)	
	)	
CARRIER,	)	
DEFENDANTS/	)	
RESPONDENTS.	)	
	)	

STATEMENT OF THE CASE

This case stems from an admitted injury to Claimant Bobby Baker's head, spine, and both left and right legs, which took place on May 6, 2008, in the performance of his duties as a maintenance worker for Hilton Hotels Corporation ("Employer"). The matter came before Single Commissioner G. Bryan Lyndon for hearing on January 4, 2011 as a result of the filing of the parties' Form 50 and Form 51 filings.

The parties stipulated before the hearing that:

- The accident causing Claimant's injuries, to the extent such were found by the Commissioner, occurred while Claimant was engaged in the scope of his employment and while performing his duties as a maintenance worker

for the Employer;

- Claimant's spine was injured; and
- Claimant's average weekly wage was \$964.84 and the applicable compensation rate was \$623.26.

Claimant worked for Employer as a maintenance worker for a Hilton property in the Myrtle Beach area. (Transcript of Hearing, p. 52.) His duties included, among other tasks, routinely lifting, stooping, and carrying heavy objects such as air conditioning units and furniture. (*Id.* at 53.)

Claimant was injured when a ceiling tile weighing approximately thirty pounds fell and struck him on the head, knocking him to the ground and causing a brief period of unconsciousness and confusion. (*Id.* at 57.) His supervisor, who witnessed the accident, drove Claimant to the Grand Strand Regional Medical Center's emergency room for treatment, where he received X-rays and 13 staples for a scalp laceration where the tile had struck his head. (*Id.*)

Treatment was also provided by Doctor's Care immediately following the injury. (Claimant's APA pp. 2-3.) Claimant was cleared to return to work, but was unable to return to work initially due to a severe respiratory infection. (*Id.*) Thereafter, Claimant was referred to Dr. McCaffrey for evaluation and treatment of severe back pain. (Claimant's APA p. 5.) Claimant also began experiencing ringing in the ears and severe headaches, both of which he reported to Dr. McCaffrey repeatedly during the course of his treatment with Dr. McCaffrey through March 11, 2009. (*Id.* at 14 and 28-29 *et seq.*)

Following a FCE by Lowe's Physical Therapy on May 18, 2009, he then began to see Dr. Kang for pain management in November 2009. Dr. Kang concluded Claimant

suffered from degenerative disk disease with lumbar facet syndrome. Dr. Kang prescribed a course of treatments for the back pain including repeated radio frequency ablations. (*Id.* at p. 133.) Claimant has been released at MMI by both Dr. Kang and Dr. McCaffrey, although both physicians note he continues to experience significant pain and limitations. (*Id.*)

Claimant's pain levels are significant. He testified at the hearing before Commissioner Lyndon that, without medication, he experiences severe pain, which he rates at an 8 or 9 on a scale from 1 to 10; with medication, the pain decreases to 5 or 6 (Transcript, p. 63.) He is unable to perform the functions of his former position with Hilton, and is limited in the physical capabilities required to perform his former job. (*Id.*; APA pp. 33 and 59.) His ability to perform tasks around the house and simple errands is quite limited, not only by his physical limitations but also because of the cognitive deficits that developed after the Claimant sustained the workplace injury. Those cognitive deficits include deficits in memory and retention, the ability to concentrate, and the ability to focus. (Transcript, pp. 29-31 and 60-61.)

Claimant has only a partial high school education having completed the ninth grade, and his entire work history consists of manual labor. (Transcript at 55-56.) He and his wife also ran their own automobile repair and mechanic business for several years. (*Id.* at 32.)

EVIDENCE OF THE CASE

At the hearing, Commissioner Lyndon received into evidence the following documents and exhibits as part of the Claimant's APA submissions:

- Grand Strand Medical Center (covering date of treatment 5/6/08) –

Claimant's APA p. 1

- Doctors Care of North Myrtle Beach (covering date of treatment 6/16/08)—APA pp. 2-3
- SRSA (Dr. Michael McCaffrey) (covering dates of treatment 6/26/08 - 10/12/10)—APA pp. 4-62
- Next Step Pain Management (Dr. Rosenberg) (covering dates of treatment 9/21/08 - 8/5/09) – APA pp. 63-106
- Lowe's Physical Therapy (covering date of treatment 5/18/09) – APA pp. 107-116
- Select Physical Therapy (FCE) (covering date of treatment 5/10/10) – APA pp. 117-128
- Community Rehab and PT (covering dates of treatment 9/29/09 - 10/2/09) – APA pp. 129-132
- Dr. Kang (covering dates of treatment 11/4/09 - 11/4/10) – APA pp. 133-160
- Coastal Orthopaedic Associates (covering dates of treatment 9/8/09 - 10/5/09) – APA pp. 161-169
- Robert E. Brabham, Ph.D. (covering dates of treatment 7/20/10 - 10/12/10) – APA pp. 170-188
- L. Randolph Waid, Ph.D (covering date of treatment 9/29/10) – APA pp. 189-197

Additionally, Claimant submitted two exhibits within his APA submissions:

- Claimant's medical bills (APA pp. 198-205); and
- Deposition of James Myers (APA pp. 206-271)

Defendants offered the following as APA submissions:

- Robert E. Deysach, Ph.D (covering date of treatment 12/4/10) –
Defendant's APA pp. 1-8
- W.E. Edwards, Jr., MD (covering date of treatment 10/21/10) – APA pp. 9-
11
- James R. Myers, MA, QRP, CCM, CRC (covering dates of treatment
10/2/10 & 10/7/10) – APA pp. 12-24
- John D. Steichen, MD (covering date of treatment 10/30/09) – APA pp. 25-
26
- Jeffrey C. Wilkins, MD (covering dates of treatment 9/8/09 - 10/5/09) –
APA pp. 27-31
- Doctor's Care (covering dates of treatment 5/6/08 & 6/18/08) – APA pp.
32-36
- Grand Strand Regional Medical Center (covering dates of treatment 5/6/08
& 6/14/08) – APA pp. 37-55

Claimant testified on his own behalf at the hearing. (Transcript, pp. 51 – 97.) He also offered the testimony of his wife, Peggy Ann Baker (*Id.* at 23 – 53.). The Defendants offered no witnesses at the hearing.

Commissioner Lyndon's Decision and Order was filed February 28, 2011. In that Decision and Order, Commissioner Lyndon made the following factual findings, among others:

I ... agree with Dr. Deysach's conclusion that although Claimant may have sustained an injury to the head with brief and mild post-concussive symptoms, the data does not support a finding of physical brain damage.

In addition to the results of the testing performed by Dr. Deysach, Defendants rely on the South Carolina Court of Appeals' decision in *Crisp v. SouthCo., Inc.*, 390 S.C. 340, 701 S.E.2d 762 (Ct. App. 2010) to support their position that there is not substantial evidence in the record to support a finding of a physical brain injury or physical brain damage. I agree that Crisp closely parallels this claim.

Based upon the greater weight of the evidence as a whole, including all of the medical evidence, I find that Claimant did not suffer a physical brain injury or any resulting physical brain damage.

(Decision & Order, p. 12, Findings of Fact #13 - 15.) He also found that Claimant was entitled to a finding of permanent and total disability due to the injury to his back, constituting a greater than 50% loss of use of the back under section 42-9-30(21). (*Id.*, Finding of Fact #16.) He ordered that the Claimant was to receive permanent and total disability benefits in the amount of \$623.26 per week from May 5, 2008, and continuing for 500 weeks. (*Id.* at p. 14.) Commissioner Lyndon also ordered future causally-related medical care. (*Id.*)

Following the filing of Commissioner Lyndon's Decision & Order on February 28, 2011, the Claimant filed a Form 30 Request for Review. This appeal ensues.

ARGUMENT

Standard of Review

In South Carolina Workers' Compensation Act cases, the standard of review for decisions of the Commission sitting in its capacity as an appellate body over orders of single commissioners is established by the Administrative Procedures Act. *Forrest v. A.S. Price Mech.*, 373 S.C. 303, 306, 644 S.E.2d 784, 785 (Ct. App. 2007) (citing *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 134-45, 276 S.E.2d 304, 306 (1981)). In workers' compensation cases, therefore, the Commission sitting in full acts as the ultimate fact finder. *Shealy v.*

Aiken County, 341 S.C. 448, 455, 535 S.E.2d 438, 442 (2000). "The final determination of witness credibility and the weight to be accorded evidence is reserved to the Full Commission." *Id.*, citing *Ford v. Allied Chem. Co.*, 252 S.C. 561, 167 S.E.2d 564 (1969)." The standard of review for this case is, therefore, *de novo*.

The appellate panel is the ultimate fact finder in Workers' Compensation cases and is not bound by the single commissioner's findings of fact. *Gadson v. Mikasa, Corp.*, 368 S.C. 214, 628 S.E.2d 262 (Ct. App. 2006) (citing *Bass v. Isochem*, 365 S.C. 454, 617 S.E.2d 369 (Ct.App. 2005); *Muir v. C.R. Bard, Inc.*, 336 S.C. 266, 519 S.E.2d 583 (Ct.App. 1999)). The final determination of witness credibility and the weight to be accorded evidence is reserved to the appellate panel. *Shealy v. Aiken County*, 341 S.C. 448, 535 S.E.2d 438 (2000).

Regulation 67-709(E) states in pertinent part:

E. A Hearing Commissioner's finding of fact or conclusion of law subject to review by the Commission may be modified by the entry of the review panel's order making a new finding of fact, conclusion of law, or modifying the Hearing Commissioner's finding of fact or conclusion of law.

S.C. Code of Regulations 67-709. Thus, the Commission, by a simple majority vote, may substitute its own judgment for that of the Commissioner who originally heard the case, regarding both findings of fact and conclusions of law reached by the original Commissioner. See S.C. Code Reg. 67-709(D) ("To reverse the Hearing Commissioner's decision requires a majority decision of the Commissioners reviewing the case.").

**I. THE COMMISSIONER BELOW ERRED IN HIS FAILURE TO
ISSUE A FACTUAL FINDING THAT CLAIMANT SUFFERED
A COMPENSABLE PERMANENT PHYSICAL BRAIN
INJURY AS A RESULT OF THE WORKPLACE ACCIDENT.**

- A. The Commissioner's failure to find that Claimant suffered a permanent physical brain injury was reversible error where the great weight and preponderance of reliable and substantial evidence contained in the record clearly established the existence of such a brain injury as a result of the admitted accident.**

It is axiomatic in Worker's Compensation cases in South Carolina that the Claimant bears the burden of proof to establish the existence of a compensable injury. *Herndon v. Morgan Mills*, 246 S.C. 201, 143 S.E.2d 376 (1965). In cases where, as here, the accident causing the claimed injuries is an admitted one, Claimant's burden is to produce credible evidence sufficient to establish the existence of an injury to his person consistent with statutory provisions regarding the same.

It is *not* the Claimant's responsibility to prove this beyond a reasonable doubt, or by clear and compelling evidence. The standard, as is true in most civil cases, is "a preponderance of the evidence." *Walsh v. U.S. Rubber Co.*, 238 S.C. 411, 120 S.E.2d 685 (1961). It appears that, in this case at least, the Commissioner below held Claimant to a much higher and improper standard, and that requirement, absent as it is from the provisions of the Worker's Compensation Act and all case law interpreting those provisions, is clear legal error.

Here, the Claimant produced competent medical evidence establishing he had suffered a brain injury. Claimant produced records from his treatment with Dr. McCaffrey, as well as primary opinions by both Dr. Brabham and Dr. Randall Waid, following psychological evaluations, that opined Claimant had suffered a brain injury.

Additionally, both of those doctors relied upon the evidence contained in other post-injury medical records, which contained references to symptoms associated with brain injuries.

Additionally, the Claimant and his wife both testified that, although they both attempted on numerous occasions to bring up Claimant's decline in cognitive function with treating physicians, they were repeatedly told by those physicians that they "couldn't talk about that" or "weren't authorized to discuss" brain injuries. Claimant and his wife are both "salt of the earth" type people, not highly educated, hard-working, and not terribly sophisticated in the finer points of law and procedure that govern Worker's Compensation cases. As such, they understandably trusted their physicians, and when those trusted doctors told Claimant and his wife that they *could not discuss brain injuries* with them, Claimant and his wife responded accordingly by turning their attention to the other significant physical injuries Claimant had suffered. Both Claimant and his wife were cross-examined at length on this point by Defendants' counsel, whose argument to the Hearing Commissioner appeared to boil down to "if it is not in the medical records, then it did not happen." Claimant was even questioned on this point by the Commissioner himself. Yet each time, the Claimant and his wife steadfastly repeated what they knew to be true: they had tried to bring up Claimant's decline in cognitive functioning, but had been rebuffed at each turn by the treating physicians.

In fact, the records *do* contain evidence of brain injury, as noted by Dr. Brabham in his report. (Claimant's APA pp. 177-178.) Time and again, Claimant informed his medical care providers that he had noticed a consistent ringing in his ear that only began after the accident. (*Id.* at pp. 5 - 64) He also informed his providers that his visual acuity

had diminished. (*Id.* at 64.) As Dr. Brabham points out, these facts are symptomatic of a brain injury. (*Id.* at 178.)

Further supporting Claimant's position – that he had attempted to bring up cognitive deficits but had been rebuffed – is the existence of a concurring opinion by one of his primary treating physicians, Dr. McCaffrey, who concurred with the opinions of other experts that Claimant had, in fact, suffered a brain injury. (Claimant's APA, p. 62.) Had Claimant and his wife *never* brought up symptoms or concerns relating to a brain injury, it is hard to conceive that such a respected, competent physician would have *agreed* that a brain injury existed. Instead, it is much more likely that such a treating physician would have been hesitant to concur with such a finding, reasoning that since his patient had *never* brought up these symptoms to him, it would not be prudent to concur so readily that a brain injury existed from the date of the accident.

Despite the failure of the physicians to properly record these issues and concerns brought up (or, rather, which Claimant and his wife had *attempted* to bring up) at various points, competent experts did recognize that Claimant exhibited classic hallmark symptoms of a brain injury, as noted in the section I.B below.

B. The Single Commissioner erred in failing to find the existence of a compensable brain injury where the record establishes that three out of four opining experts concurred that Claimant did in fact suffer a brain injury as a result of the workplace accident, and where one of those opinions was proffered by one of the foremost experts in the state of South Carolina on closed head injuries and brain injuries.

In support of his claim that he had suffered a compensable permanent physical brain injury as a result of the admitted workplace accident, Claimant produced three opinions from medical professionals, all of which concurred that Claimant had suffered a

physical brain injury as a result of the falling 30-lb. ceiling tile which struck Claimant in the left occipital area of his head.

As Claimant began treatment for his physical injuries, he and his wife both attempted to bring up with the treating physicians their concerns regarding his cognitive deficits. They were told in each instance that the physician either "couldn't" discuss the subject of brain injury or cognitive impairments with the couple, or "wasn't authorized" to do so. (Transcript at pp. 27-28 and p. 62.) Eventually, however, Claimant was referred to Dr. Robert Brabham for a psychological evaluation.

Dr. Brabham saw Claimant on July 20, 2010, and administered a battery of tests. He concluded upon review of Claimant's prior medical records that many of the symptoms Claimant had experienced were classically associated with brain injuries. Dr. Brabham's initial report following the evaluation began with the conclusion he reached after exhaustive review of the Claimant's medical history post-injury: "With the passage of time, now more than 2 years after his injuries, *behavioral and cognitive changes have persisted, as will be noted, sufficient to conclude that he obviously sustained post-concussion injuries, i.e., a physical traumatic brain injury, clearly the result of his on-the-job injuries.*" (*Id.* at p. 174) (emphasis in the original).

Dr. Brabham addressed the role Claimant's physical injuries played in his failed attempts to seek treatment for his cognitive issues: "It appears that the orthopedic injuries and resulting pain symptoms were more immediately obvious and thus received more timely medical attention. However, there are also multiple medical references over an extended period of time confirming that Mr. Baker sustained a (physical) traumatic brain injury." (*Id.* at p.184). Dr. Brabham noted a decline in Claimant's visual acuity, his

frequent reports of ringing in the ears, and his complaints of balance issues “not completely accounted for by orthopedic issues.” (*Id.* at p. 175) These complaints, it should be noted, are reflected in Claimant’s medical records, as Claimant had told his treating physicians all along. More importantly, as Dr. Brabham noted in his report, these complaints are all classic symptoms of a brain injury. (*Id.*) Dr. Brabham recounted that portion of Claimant’s medical history that substantiates Claimant’s claims of brain injury, including reports of neck pain, headaches, need for glasses, and ringing in the ears – all complaints reflected in the medical records of Dr. McCaffrey during visits and examinations on June 16, 2008, June 26, 2008, August 11, 2008, October 2, 2008, and March 16, 2009) (*Id.* at pp. 177-178).

Dr. Brabham administered several tests, noting in his report that Claimant gave consistent good effort during these tests, which included the Wechsler Adult Intelligence Test-Fourth Edition, the Wide Range Achievement Test-Revision 4, and the Beck Depression Inventory-II (*Id.* at p. 184). Dr. Brabham also noted that Claimant has problems with memory and distraction “not better described by any other general medical condition and there is no evidence of any substance abuse which would cause these same symptoms.” (*Id.*)

Calling Claimant “quite compromised” in “attention, concentration, speed of mental processing and multitasking,” (*Id.* at p.185), Dr. Brabham concluded that Claimant has a Class 2 impairment under the CDR, requiring some direction of activities, based on memory loss, moderate difficulties with some activities and limits to social interaction. He also issued his diagnosis of Claimant as Cognitive Disorder secondary to traumatic brain injury. (*Id.* at p. 186).

Based on Dr. Brabham's findings, Claimant sought the opinion of Dr. Randall Waid. Dr. Waid is one of the foremost experts in closed-head injuries in the state of South Carolina. As our Court of Appeals noted in the case of *Means v. Gates*, 348 S.C. 161, 558 S.E.2d 921 (Ct.App. 2001), in holding that the trial court erred in excluding Dr. Waid's expert testimony via taped deposition:

Dr. Waid has a bachelor's degree in general psychology from Temple University, a master's degree in psychology from the University of Richmond, and a doctorate in clinical psychology from the University of North Texas following an internship at the Medical University of South Carolina in Charleston ("MUSC"). Dr. Waid worked as the director of psychological services at a private psychiatric facility in Dallas, Texas before returning to Charleston in 1982 to join MUSC's faculty in the departments of psychiatry and neurology. In 1989, he became the director of MUSC's assessment center, where he ran a clinic providing assessments for conditions such as chronic pain, neurological disorders, and psychiatric disorders. In 1998, Dr. Waid became a clinical associate professor in psychiatry and neurology at MUSC and opened a private practice in Mount Pleasant.

Means, 348 at ___, 558 S.E.2d at 924.

Waid's report states that he administered the following tests to Claimant:

1. Wechsler Memory Scale-III
2. California Verbal Learning Test-II
3. Stroop Test
4. Conners' Continuous Performance Test-II
5. Judgment of Line Orientation Test
6. Wisconsin Card Sorting Test
7. Trail Making Test
8. Controlled Oral Word Association Test
9. Seashore Rhythm Test

10. Speech Sounds Perception Test
11. Tactual Performance Test
12. Sensory Perceptual Examination
13. Behavioral Dyscontrol Scale
14. Test of Memory Malinger
15. Personality Assessment Inventory.

(Claimant's APA p. 192.) In addition, Ms. Baker also completed the family form of the Frontal System Behavior Scale regarding the Claimant. (*Id.*) Dr. Waid noted that Claimant made good effort on all these tests. (*Id.* at pp. 193-196.)

Dr. Waid went on to note that Claimant "experience[d] episodic difficulties understanding instructional sets necessitating repetition [as well as d] difficulties with hearing more affecting the left side." (Claimant's APA p. 193.) Dr. Waid acknowledged previous "educational deficiencies" but concluded that Claimant had a post-injury compromised capacity to pay attention and concentrate, slow mentation, and a significant compromise in memory skills. (*Id.* at 196.) Dr. Waid confirmed Claimant was experiencing tinnitus in left ear, and then stated his belief that Claimant has a cognitive disorder "secondary to the interfering effects of . . . residuals of a mild head injury." (*Id.*)

Dr. Waid finally concluded: "I am in agreement with Dr. Brabham that Mr. Baker is experiencing neurocognitive impairments due to a head injury (physical brain injury) that are contributing to his overall compromise in functioning." (*Id.* at p. 197.)

In addition, Claimant and his wife both testified at length regarding the changes in his abilities, both physical *and* cognitive, since the head injury had occurred. His wife, Mrs. Baker, testified about those changes as follows:

Before and after, well the only way I know to explain it is that he before worked 80 hours a week. He pretty much took care of the home as far as financially. He done all our yard work. I mean, he kept up with everything. He could go to the bank, and, you know, pay bills and things like that. After the injury, he -- I noticed that he seemed like he started forgetting things. He was getting confused. He is not no longer able to physically go outside and do anything. He can't do anything in the house ... I mean, it's just the fact that he is not the same man that he was before the accident mentally or physically.

(Transcript at pp. 25-26.) Additionally, she provided the following information:

I noticed it after the accident. I noticed a change in his memory, and I had, you know, brought it forth to the doctors, but you know, we didn't -- they didn't discuss it. But like if I would send him to go to the grocery store or to the bank to do something, he was always forgetting what I told him to do. Like if I say "put a certain amount of money in the bank," ... if I told him to put \$500 in the bank, he might put \$300 in the bank and bring back the rest of the change. If I tell him -- tell him to go to the grocery store and get something, he might come back with say the gallon of milk but not the loaf of bread, and that's the best example I know to give.

(*Id.* at 27.)

In addition to observable changes in his memory and ability to concentrate, his wife testified she also observed changes in his personality:

Since the accident, he got withdrawn. He acted like he didn't want to participate or have no part of it. Like when family comes around, he doesn't really communicate as far as -- it's like I'm there trying to, you know, perform for everybody, keep everybody active -- keep everything -- I don't know exactly how you want me to put it. It's like -- it's like me, where I did have a husband before, it's like I'm by myself now. It's like I'm leading him around like a child trying to tell him what to do.

(*Id.* at 29.) This testimony corroborates that of the Claimant himself, who testified that he could no longer remember the procedures for some common repairs he had performed for most of his working life, such as tearing down and rebuilding brake drum. (Transcript at p. 60.) In addition, Claimant testified that he had *begun* making mistakes with money management and banking, causing overdrafts. (*Id.*)

This testimony, when viewed in conjunction with his wife's corroborating testimony clearly rebuts the single assumption underlying the *sole* argument made by Defendants' counsel to counter Claimant's substantial and compelling evidence of brain injury. In contrast, Defendants offered absolutely *no* testimonial evidence to contradict the testimony of the Claimant and his wife or the three concurring opinions of Dr. Waid, Dr. Brabham, and Dr. McCaffrey. In fact, Defendants proffered a single report, that of Dr. Deysach, which dissented from the majority opinion of those doctors who examined and treated the Claimant in declining to opine that the brain injury had, in fact, occurred.

As set forth below in section I.C, Dr. Deysach's curiously worded opinion, in fact, is founded upon an assumption regarding Claimant's prior mental and cognitive abilities that is wholly unsupported by the unrefuted evidence in the case. Yet, inexplicably, the Commissioner disregarded the three concurring opinions as well as the testimony of the Claimant and his wife, to conclude that no brain injury existed.

C. The Single Commissioner's apparent reliance on *Crisp v. SouthCo, Inc.* and the opinion of Dr. Deysach was in error, when viewed against the great weight of the substantial and credible evidence contained in the record, including the credible, undisputed testimony of the Claimant and his wife at the hearing below.

In his Decision & Order, Commissioner Lyndon stated:

In addition to the results of the testing performed by Dr. Deysach, Defendants rely on the South Carolina Court of Appeals' decision in *Crisp v. SouthCo., Inc.*, 390 S.C. 340, 701 S.E.2d 762 (Ct. App. 2010) to support their position that there is not substantial evidence in the record to support a finding of a physical brain injury or physical brain damage. ***I agree that Crisp closely parallels this claim.***

(Decision & Order, p. 12 (emphasis added).) As previously stated, Defendants offered no other medical evidence in rebuttal, and presented absolutely no testimony in support of their contention that no brain injury had occurred. Thus, it is clear that the *only* evidence

in support of Defendants' position consisted of Dr. Deysach's report and the Commissioner's misreading of *Crisp*.

Crisp is factually and procedurally distinguishable from the case at hand. Initially, it should be noted that the *Crisp* claimant had not lost consciousness; the evidence in Mr. Baker's case suggests he did lose consciousness when the tile struck him in the head, even if briefly. (Claimant's APA at p. 4.) Additionally, and even more importantly, *Crisp* had a secondary diagnosis that offered a credible alternate explanation for all of his cognitive deficit symptoms: Substance Induced Persisting Dementia. In Claimant's case, there is absolutely no indication of any other similar condition which would explain Claimant's loss of cognitive function post-injury.

Even more crucially, however, is the Commissioner's failure to take into account the procedural posture of *Crisp*, which revolved around a much different standard than that which is before the Hearing Commissioner or the Commission sitting in review.

There, as the Court noted:

Even though the record presents conflicting evidence on the issue of whether *Crisp* suffered a physical brain injury, we conclude the circuit court erred in reversing the Commission. See *Pack v. State Dep't. of Transp.*, 381 S.C. 526, 536, 673 S.E.2d 461, 466 (Ct.App. 2009) (stating where there are conflicts in the evidence over a factual issue, the findings of the Commission are conclusive); *Taylor*, 368 S.C. at 36, 627 S.E.2d at 752 (stating evidence is substantial if, considering the record as a whole, it "would allow reasonable minds to reach the conclusion the administrative agency reached in order to justify its action")

Crisp, 390 S.C. at 346, 701 S.E.2d at 766.

Thus, in *Crisp*, the Court of Appeals was faced with a case in which the Commission had entered one finding, the Circuit Court sitting in review of the Commission's Order had entered the opposite finding, and the Court of Appeals had to

decide which of the rulings had been appropriate, given the standards at play at each respective stage of the proceedings. But, as the Court noted, at the level of review of the Commission's findings and conclusions, the court sitting in review could not substitute its own judgment for that of the Commission, nor could it determine whether the Circuit Court's judgment was correct. Rather, it was required to determine whether substantial evidence existed to support the Commission's findings and conclusions. Since such evidence *did* exist in the record, which contained evidence weighing both in favor of and against the finding of a brain injury, the Court of Appeals was required to uphold the Commission's Order.

However, the present case is quite differently situated. Here, the Commission may disregard in whole or in part the findings and conclusions of the Hearing Commissioner. The Commission may substitute its own findings and conclusions, as it sees fit, in accordance with the weight of the evidence. *Gadson v. Mikasa, Corp.*, 368 S.C. 214, 628 S.E.2d 262 (Ct. App. 2006) (citing *Bass v. Isochem*, 365 S.C. 454, 617 S.E.2d 369 (Ct.App. 2005); *Muir v. C.R. Bard, Inc.*, 336 S.C. 266, 519 S.E.2d 583 (Ct.App. 1999)). This is a very different standard than that at work in *Crisp*. Thus, viewing it as a paradigm for consideration of Claimant's case is inappropriate.

Claimant's case is much closer in terms of the weight of evidence in support of a finding of brain injury to the case of *Pearson v. JPS Converter & Indus. Corp.* 327 S.C. 393, 489 S.E.2d 219 (Ct.App. 1997). In that case, the Court of Appeals affirmed the circuit court's ruling upholding the findings and supporting conclusions of Pearson's total disability and brain injury:

We agree with the circuit court's interpretation that **section 42-9-10 does not require the total and permanent disability to be solely the result of**

physical brain damage – the statute only requires that a claimant be totally and permanently disabled and suffer physical brain damage as a result of the injury. At most, one physician, Dr. Woodward, indicated that he could not determine whether the greater cause of Pearson's disability was his psychological deficits or his organic brain damage.

Pearson, 327 S.C. at 400, 489 S.E.2d at 222. Thus, as the *Pearson* court noted, it is not fatal to Claimant's claim of permanent physical brain damage that he also suffered other physical injuries, as noted by his many treating and evaluating physicians in the medical records submitted to the Commissioner below. All that is required is that Claimant is totally and permanently disabled, as the Commissioner properly found, and that he suffered physical brain damage as a result of the admitted injury, as has been sufficiently proved by Claimant. As such, the Commissioner's findings that Claimant did not suffer physical brain damage are in error and the Commission should issue its own findings that Claimant did, in fact, sustain permanent physical brain damage as a result of his injuries.

As stated above, the Commissioner below essentially relied on two points in support of his decision to find in favor of the Defendants: the opinion in *Crisp* and the report of Dr. Deysach. In order for the Commissioner to find Dr. Deysach's opinion, together with its faulty reading of *Crisp*, as compelling the finding of no brain injury in Claimant's case, he had to either ignore or completely discount the testimony of both Claimant and his wife with respect to his prior level of cognitive functioning, as set forth in section I.B, above. Although it is generally true that Hearing Commissioners are considered to be in the best position to judge initially the credibility of the witnesses testifying at the hearing stage, matters of witness credibility are ultimately reserved to the appellate panel or Full Commission sitting in review of Workers' Compensation cases. *Shealy v. Aiken County*, 341 S.C. 448, 454, 535 S.E.2d 438, 442 (2000).

Dr. Deysach's report found cognitive deficits but oddly then claimed that these

deficits were purely attributable to conditions that preexisted the injury. (Defendant's APA p. 7.) However, in order to find this conclusion credible, the Commissioner had to completely ignore the testimony of both Claimant and his wife, who both testified that Claimant exhibited significantly more deficits in cognitive processes after being struck in the head by the heavy ceiling tile. Oddly, Dr. Deysach seemed to be reluctant to conclude the Claimant had a brain injury because, in his view, telling Claimant he had a brain injury would lead Claimant to conclude he had a brain injury -- a piece of circular logic that defies explanation:

To his determinant (sic), a conclusion of this sort is likely to suggest to him that he is "damaged" beyond the orthopedic injuries and chronic pain he reports from those injuries.

(Defendant's APA p. 8.) This sentence appears in the same paragraph as Deysach's admission that the Claimant clearly "did suffer an injury to the head with brief and mild post-concussive symptoms." (*Id.*) Thus, Dr. Deysach appears to base his opinion, at least to some significant degree, on a reluctance to call the injury Claimant suffered "brain damage" because he did not want the Claimant to *think* he was brain damaged. This reasoning renders the entire opinion somewhat suspect. When viewed in contrast to the well-reasoned reports from Claimant's proffered experts, especially Dr. Waid, the opinion of Dr. Deysach is insufficient to overcome the weight of the evidence supporting Claimant's contention that he is physically and permanently brain damaged as a result of the admitted accident.

As no contradictory testimonial evidence was offered by the Defendants in this case to rebut the Claimant's testimony that he had suffered a diminution in cognitive abilities, a claim completely supported by the testimony of the Claimant's wife, it was

error for the Commissioner to overlook that testimony when weighing the credibility and persuasiveness of Dr. Deysach's opinion and report. When that testimony is considered alongside the Deysach report, it becomes clear that the assumptions made by Dr. Deysach were simply inaccurate. As his opinion rests wholly on those assumptions – that the Claimant was *always* cognitively impaired to the *same degree* as he is after the injury – either the opinion or the testimony must be deemed unreliable and unpersuasive. Because the testimony of Claimant and his wife is credible overall, and more importantly, because it is shored up and completely supported by three out of the four opinions on the brain injury issue contained in the record, it was error for the Commissioner to give more credence to the lone opinion of Dr. Deysach than to the testimony and the three concurring opinions.

Thus, the Claimant requests that the Commission issue its own finding on the issue of the existence of a brain injury that comports with the great weight of the credible and substantial evidence produced by Claimant and contained in the record.

II. THE COMMISSIONER BELOW ERRED IN HIS FAILURE TO CONCLUDE AS A MATTER OF LAW THAT CLAIMANT WAS ENTITLED TO LIFETIME BENEFITS AS A RESULT OF THE COMPENSABLE PERMANENT PHYSICAL BRAIN INJURY THAT CLAIMANT SUFFERED AS A RESULT OF THE WORKPLACE ACCIDENT.

The Hearing Commissioner below should have likewise concluded as a matter of law that Claimant was entitled to lifetime benefits under the Worker's Compensation Act provisions as a result of the fact that he suffered a compensable permanent physical brain injury caused by the ceiling tile which struck his head.

Under the provisions of § 42-9-10 (“Amount of compensation for total disability; what constitutes total disability”) of the South Carolina Code of Laws, claimants for Worker’s Compensation benefits are limited to recovery of compensation for no more than five hundred weeks total. S.C. Code Ann. § 42-9-10(A) (2010 Supp.) However, an exception to the five hundred week limitation on recovery is provided in subsection (C) to that statute:

(C) Notwithstanding the five-hundred-week limitation prescribed in this section or elsewhere in this title, any person determined to be totally and permanently disabled who as a result of a compensable injury . . . has suffered physical brain damage is not subject to the five-hundred-week limitation and shall receive the benefits for life.

S.C. Code Ann. § 42-9-10(C) (2010 Supp.)

As stated above, the Commissioner justified his decision against finding a brain injury, and thus granting lifetime benefits to the Claimant, upon a faulty reading of *Crisp v. SouthCo, Inc, supra*. This case was brought up repeatedly by Defendants’ legal counsel at the hearing below and characterized as necessitating a conclusion and factual finding that no compensable brain injury existed in *Claimant’s* case. The Commissioner (and the Defendants’) reliance on the *Crisp* case is wholly misplaced, as set forth in detail above.

Likewise, when viewed as a whole, the evidence submitted to the Commissioner below clearly establishes the existence of permanent physical brain damage caused by a traumatic brain injury caused during Claimant’s workplace accident. Three out of four medical experts agreed that such a brain injury had in fact occurred, causing a diminution in Claimant’s previously existing cognitive abilities, specifically in the areas of memory and concentration. The records from treating physicians following Claimant’s injuries frequently note that Claimant complained of symptoms commonly associated with

traumatic brain injuries, such as ringing in the ears and headaches. Further, the testimony of both Claimant and his wife corroborated the claim of a brain injury, with specific incidents of Claimant's decreased ability to remember simple instructions and requests and to concentrate on relatively easy tasks.

Further, the Defendants offered no contradictory testimony or documentary evidence, with the sole exception of the Deysach report. Yet that report rested on an assumption that, if deemed credible, would necessitate disregarding the entire testimony of Claimant and his wife on the issue of how his cognitive abilities had decreased following the head injury. It was error for the Commissioner to overlook that testimony when weighing the credibility and persuasiveness of Dr. Deysach's opinion and report. Because the testimony is credible overall, and more importantly, because it is shored up and completely supported by three out of the four expert opinions on the brain injury issue contained in the record, it was error for the Commissioner to give more credence to the lone opinion of Dr. Deysach. It simply cannot be logically claimed that this single opinion, given the weight of the testimony and the qualifications of Dr. Waid, outweighed the great weight of the contrary evidence submitted by the Claimant.

Thus, the Claimant requests that the Commission issue its own legal conclusion on the issue of lifetime benefits for Claimant's brain damage that comports with the great weight of the credible and substantial evidence produced by Claimant and contained in the record.

CONCLUSION

For the foregoing reasons, the Order of the Commissioner below should be

REVERSED and the Commission should issue a new Order, with a finding of fact that Claimant suffered compensable permanent physical brain damage as a result of the workplace accident of May 6, 2008, and a corresponding conclusion of law that as a result of that injury to the brain, he is therefore entitled to lifetime benefits.

RANKIN & RANKIN, P.A.

BY:

Luke A. Rankin
Attorney for Employee/Claimant - Appellant
201 Beatty Street
Post Office Box 919
Conway, SC 29528-0919
(843) 248-2405

May ____, 2011

STATE OF SOUTH CAROLINA)
)
COUNTY OF HORRY)

BEFORE THE S.C. WORKERS'
COMPENSATION COMMISSION

BOBBY BAKER,)
)
Employee/Claimant,)
)
vs.)
)
HILTON HOTELS CORP.,)
)
Employer,)
)
and)
)
SPECIALTY RISK SERVICES,)
)
Carrier/Defendants.)
)

W.C.C. FILE NO. 0810190

RESPONDENTS' BRIEF

STATEMENT OF THE CASE

This appeal stems from an admitted injury to Claimant's back only. (Decision & Order p. 2; Hearing Tr. p. 15). Claimant was injured after a piece of ceiling tile fell and struck him on his head during the course and scope of his employment with Hilton Hotels Corporation. After the injury, Claimant received comprehensive medical treatment by several authorized treating physicians including Dr. McCaffrey of Strand Regional Specialty Associates of Pain, Spine & Sports Medicine. Dr. McCaffrey placed Claimant at maximum medical improvement on March 11, 2009 with a finding of permanent and total disability secondary to his workers' compensation injury. Dr. McCaffrey referred Claimant to Long Term Pain Management with Dr. Kang. Claimant began treating with Dr. Kang on November 4, 2009 and continues to do so today. Despite this, Dr. Kang placed Claimant at maximum medical improvement on June 8, 2010 with an 18% lumbar spine impairment and a sedentary type activity level restriction.

Claimant filed a Form 50 Request for Hearing on July 7, 2010 alleging injuries to his head,

spine, left leg and right leg. He alleged he was permanently and totally disabled as a result of his work related injury and also alleged he sustained physical brain damage pursuant to S.C. Code Ann. §42-9-10(c). This claim was heard before the hearing commissioner on January 4, 2011.¹ Subsequently, the hearing commissioner issued a Decision. & Order dated March 2, 2011, which awarded Claimant permanent and total disability benefits pursuant to §42-9-30(21) but denied Claimant's claim for a lifetime award based on the finding of physical brain damage.

ISSUES ON APPEAL

- I. WHETHER THE HEARING COMMISSIONER ERRED IN FINDING CLAIMANT DID NOT SUFFER A PHYSICAL BRAIN INJURY OR ANY RESULTING PHYSICAL BRAIN DAMAGE BASED UPON THE GREATER WEIGHT OF THE EVIDENCE.
- II. WHETHER THE HEARING COMMISSIONER ERRED IN FINDING CLAIMANT WAS NOT ENTITLED TO LIFE TIME BENEFITS AS THE GREATER WEIGHT OF EVIDENCE DID NOT SUPPORT A FINDING OF PHYSICAL BRAIN DAMAGE.

STANDARD OF REVIEW

The statute empowers the Full Commission to make its own findings of fact and to reach its own conclusions of law consistent with or inconsistent with those of the Hearing Commissioner. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 186, 414 S.E.2d 162, 163 (1992) (citing Green v. Raybestos-Manhattan, Inc., 250 S.C. 58, 156 S.E.2d 318 (1967)); see also S.C. Code Ann. Section 42-17-50. It is logical for the Full Commission, which did not have the benefit of observing the witnesses, to give weight to the Hearing Commissioner's opinion, but the Full Commission may disagree with his findings based on the credibility of witnesses. Green at 64, 156 S.E.2d at 321. The Commission must consider all of the evidence in the record when

¹ This claim was originally set for a hearing on October 12, 2010; however, it was continued so the parties could perform additional discovery. This initial hearing date is significant because the expert report of Dr. L. Randolph Waid, which is so heavily relied upon by the Claimant, was completed less than two weeks prior to the original hearing date but over two years after the date of injury.

developing findings of fact. Hendricks v. Pickens County, 335 S.C. 405, 517 S.E.2d 698 (Ct. App. 1999). An award cannot, however, be based upon mere possibilities, probabilities, surmises or conjectures. Broughton v. South Carolina Game and Fish Dept., 219 S.C. 50, 64 S.E. 2d 152 (1951).

ARGUMENT

I. THE HEARING COMMISSIONER DID NOT ERR IN DENYING CLAIMANT'S PHYSICAL BRAIN DAMAGE CLAIM AS IT WAS NOT SUPPORTED BY A GREATER WEIGHT OF THE EVIDENCE.

The Hearing Commissioner properly denied Claimant's allegation of a physical brain injury or resulting physical brain damage as this claim was not supported by the greater weight of the evidence. As stated in Claimant's brief, it is axiomatic in workers' compensation cases in South Carolina that Claimant bear the burden of proof to establish the existence of a compensable injury. Herndon v. Morgan Mills, 246 S.C. 201, 143 S.E.2d 376 (1965). In this case, the Claimant submitted 197 pages of medical evidence as well as his own testimony that of his wife. Based on all of the evidence submitted as a whole Claimant's allegations of physical brain damage was not supported by a greater weight or preponderance of the evidence.

A. The Hearing Commissioner properly determined the record lacked sufficient evidence to support a finding of physical brain damage.

At the hearing, Claimant testified he could not remember exactly what happened to him on the date of injury. All he remembered was waking up on the floor of the hotel room he was inspecting. (Hearing Tr. p. 47, ll. 17-24; p. 69 ll. 24-70; p. 8). Medical records from the emergency room at Grand Strand Regional Medical Center on the date of injury show a diagnosis of a scalp laceration and head contusion for which Claimant received wound clips. (Claimant's APA p. 1). An x-ray of his cervical spine was read as "no acute fracture" by the radiologist and Claimant was

discharged home with instructions to follow up with his primary care physician within the next week. (Id.). From May 6, 2008 through June 16, 2008 Claimant received medical care at both Doctors' Care and Grand Regional Medical Center with complaints of "lower back discomfort and received diagnosis of back pain and low back strain." (Defendants' APA's pp. 32-33; p. 35, p. 49).

Claimant had an MRI of the lumbar spine performed on June 23, 2008, which revealed degenerative disc and facet joint disease with bilateral annular tears at L4-5 and T11-12. (Defendants' APA p. 51).

Claimant was referred to Dr. McCaffrey at Strand Regional Associates on June 26, 2008. Prior to meeting with Dr. McCaffrey, Claimant completed a medical questionnaire wherein he indicated he "never" suffered from recurrent headaches, migraine headaches, fainting, dizziness or memory loss." (Claimant's APA, pp. 11-14). In his first meeting with the Claimant, Dr. McCaffrey noted,

"[h]e suffered a very brief loss of conscious[ness] with a laceration to the occipital area requiring 12 stitches at Grand Strand Regional Medical Center. He went to Doctor's Care the next day and was told to go back to work. Unfortunately, he developed a bad upper respiratory infection. He was seen by his primary care physician and was in bed for two to three days after this accident. On 06/14/2008, he developed severe low back pain. He was seen at Grand Strand Regional Medical Center and given intravenous medication."

(Claimant's APA, p.4). Claimant was diagnosed as having "low back pain with right leg radiation" and was referred for an EMG of the right lower extremity. Claimant was also diagnosed with a "closed-head injury with a left occipital laceration." Dr. McCaffrey noted that Claimant's laceration was completely healed and Claimant was having "no residual symptoms from this." (Claimant's APA, p. 6). In the "Mental Status" of his neurological evaluation, Dr. McCaffrey noted that Claimant was,

"Oriented to person, place, and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify

objects. Patient has no difficulty in discussing current events."

(Claimant's APA, p. 6). Claimant continued to treat with Dr. McCaffrey from June 26, 2008 through March 11, 2009 when he was placed at maximum medical improvement with a finding of permanent and total disability "in reference to his low back pain, neck pain, and headaches." Claimant's mental status was assessed at each and every visit and was noted to be the same. (Claimant's APA, pp. 4-54). Dr. McCaffrey went on to complete an "Attending Physician's Statement of Disability" wherein he noted Claimant had a Class 5 Physical Impairment (severe limitation) and a Class 1 Mental/Nervous Impairment (no limitations). (Claimant's APA, p. 59).

On March 22, 2010, one year after Claimant's last visit, Dr. McCaffrey completed a medical questionnaire wherein he stated he agreed with the certified disability examiner's impairment ratings of 14% to the lumbar spine and 5% impairment to sexual dysfunction. On October 12, 2010 (the day of the originally scheduled hearing and over eighteen months after Claimant's last visit) Dr. McCaffrey filled out a second questionnaire from Claimant's attorney wherein he checked the line for "YES" when it asked whether he agreed Claimant sustained a permanent physical brain injury. (Claimant's APAs' pp. 61-62). It should be noted these last two questionnaires were sent along with records of others "experts" not authorized by the employer or carrier. It should also be noted Dr. McCaffrey's response to the brain injury questionnaire is in direct contrast to the ten visits over the course of nine months wherein Dr. McCaffrey noted claimant was "oriented to person, place and time. No difficulty with short or long term memory.

Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty I discussing current events." (Claimant's APA's pp. 4-54.)

After Claimant's last visit with Dr. McCaffrey in March 2009, he began treatment for long term pain management with Dr. Kang starting November 4, 2009 through the present. Dr. Kang

diagnosed Claimant with lumbar degenerative disc disease with lumbar facet syndrome and recommended a repeat radio frequency ablation and medical management of Claimant's pain medications. (Claimant's APA, p. 133). Claimant continues to receive medical treatment from Dr. Kang. The last medical record from Dr. Kang is dated November 24, 2010. Dr. Kang placed Claimant at maximum medical improvement on June 8, 2010 with an 18% impairment rating to the lumbar spine. Dr. Kang gave Claimant clearance for sedentary type activity. In all medical records from November 4, 2009 through November 24, 2010, it was noted that Claimant "shows no signs of cognitive impairment." (Claimant's APA, pp. 133 - 160).

In addition to Drs. McCaffrey and Kang, with whom Claimant treated consecutively for over two years prior to any mention of a physical brain injury, Claimant also treated with Dr. Rosenberg at Next Step Pain Management, Dr. Jeffrey C. Wilkins, Dr. William S. Edwards, Dr. John D. Steichen. Not one of these treating physicians noted the occurrence of or any problems with Claimant's cognitive abilities or functioning which would result in treatment for a potential brain injury. Based on the lack of medical evidence in the treating physicians' records, the Hearing Commissioner properly determined Claimant did not meet his burden of proving he sustained physical brain damage by a preponderance of the evidence.

B. Substantial evidence exists to support the Hearing Commissioner's determination that Claimant's did not sustain physical brain damage.

More important than the *absence* of treatment notes regarding physical brain damage or cognitive limitations is the *presence* of actual statements to the contrary. Each and every one of Claimant's treating physicians, from the emergency room physicians to Claimant's long-term pain management physician, reported normal cognitive functioning throughout the course of Claimant's medical treatment. It wasn't until Dr. Kang released Claimant at maximum medical improvement

with an 18% impairment rating to the lumbar spine and a sedentary work restriction that Claimant made an appointment to see Dr. Brabham – over two years after the accident.

Claimant and his wife testified they attempted to bring up Claimant's decline in cognitive functioning on numerous occasions, but were rebuffed by the treating physicians. This is inconceivable on many grounds. First, as indicated above, the vast majority of Claimant's medical treatment notes specifically refer to normal cognitive functions and abilities. To assert that attempts were made to discuss cognitive limitations with the numerous treating physicians is to assert that all of the treating physicians *lied* in their medical narratives. Claimant was specifically asked about this assertion at the hearing, to which he replied, "That could go a lot of different ways." (Hearing Tr. p. 82, ll. 10-18).

Second, Claimant was initially transported to the emergency room by a co-worker on the date of his accident. There were no case workers involved and no adjusters. Only the emergency room physicians had contact with Claimant regarding the extent of his injuries. When Claimant followed up with Doctors' Care later that day and several times later for follow up visits, again there were no adjusters or case managers involved with the claim. Claimant and his wife, who testified she attended 90-95% of his medical visits, would have had ample time and opportunity to discuss all of Claimant's complaints including any decline in cognitive functioning. Claimant filled out medical questionnaires and had lengthy discussions prior to all of his initial visits with every specialist to whom he was referred. The initial medical questionnaire for the visit with Dr.

McCaffrey was discussed above; however, Claimant actually filled out a questionnaire prior to each visit with Dr. McCaffrey wherein he was specifically asked whether he had any specific questions for the doctor. In most of the cases, Claimant left this particular question blank; however, on January 15, 2009, Claimant wrote "about my pain". (Claimant's APA p. 51).

Claimant treated with Dr. Rosenberg from September 21, 2008 through August 4, 2009 wherein on multiple occasions, Dr. Rosenberg noted, "The patient is alert, oriented, cooperative and follows commands well. Speech is clear and language is normal. Abstract function is normal. Attention and memory are normal." (Claimant's APA's pp. 63-106). In addition, Dr. Rosenberg noted at each visit a long discussion was had with Claimant concerning his current situation. Additional notes regarding a review of Claimant's symptoms range from back pain, hemorrhoids, headaches, skin rash, decrease visual activity requiring glasses, constipation and swelling. (Claimant's APA's p. 81).

At the hearing, Claimant testified doctors told him, "We can't discuss it. We are only allowed to discuss your back. That's all the insurance company is allowing." (Hearing Tr. p. 92, ll. 6-10.) This testimony is not supported by the medical evidence. The variety of complaints discussed with Dr. Rosenberg makes it highly unlikely Claimant was told not to discuss any one particular complaint. In the same line of questioning, Claimant testified that the doctors and the case manager used the term, "They was not authorized to do anything with my head was the word." However, Claimant later acknowledged that Dr. McCaffrey gave him "some pills" for his headaches. (Hearing Tr. p. 93, ll. 15-24.) Even the Hearing Commissioner tried to rehabilitate Claimant's testimony by asking exactly what Claimant said to his various doctors:

COMMISSIONER: I believe her — Ms. Taylor's question was did you talk about having anything like memory problems other than headaches; any problems that would be associated with your ability to reason or anything of that nature other than headaches? I mean, doctors generally write down what you say whether they are authorized to or not. I'm just — I was curious to know why in every case.

CLAIMANT: I don't know. I'll be honest, I just don't know, because I tried.

COMMISSIONER: You are sure in every case you said you were having what, and tell me what you told them you had.

CLAIMANT: I'm having real bad headaches.

COMMISSIONER: I know that's in some of the records.

(Hearing Tr. p. 92, ll.11-24).

Clearly, the Hearing Commissioner considered all of the evidence as a whole when determining Claimant did not meet his burden of proving a physical brain injury by a greater weight of the evidence. As such the Hearing Commissioner properly denied Claimant's physical brain damage claim.

- C. When reviewed as a whole, the Hearing Commissioner properly determined the conflicting expert reports did not support a finding of physical brain damage.

In an effort to overcome two years of medical treatment without reference to cognitive limitations or resulting physical brain damage, Claimant obtained vocational and psychological evaluations performed by Robert E. Brabham, Ph.D. and L. Randolph Waid, Ph.D. both reports of which are contradictory at best given Claimant's reported history. Both Doctors Brabham and Waid reported Claimant's history of academic difficulties. Specifically, Dr. Brabham noted,

"He has a limited educational background, having completed high school through the 9th grade. He quit school during the 10th grade and went to work. Thus, at the age of 52, he remains a high school drop out. He noted a history of academic difficulties, failing the 1st grade and 'barely passing all others.' He acknowledged he was 'good with my hands' but described himself as having been 'retarded in the books.' He also noted he had been unable to handle the paperwork or financial aspects of his auto mechanic business in the past."

(Claimant's APA pp. 176-177).

In his examination with Dr. Waid, Claimant reported "he has always been mechanical and good with his hands but not a good book learner." (Claimant's APA p. 192). Dr. Waid went on to note Claimant was limited in his educational skills, which was confirmed via evaluation by Dr. Brabham who administered the wide range achievement test-4 revealing Mr. Bakers' reading/word

recognition abilities to be at the 4.6 grade level with arithmetic at the 2.9 grade level and spelling at the 5.5 grade level. In his Summary/Case Discussion, Dr. Waid opined,

"The current neuropsychological evaluation was revealing of an individual who has a history of educational deficiencies ... I believe it evident that the primary obstacle to Mr. Baker's ability to return successfully to role functioning are the residuals from the orthopedic injury with resultant chronic pain, somatic symptoms, and balance/dyscoordination difficulties."

(Claimant's APA p. 196).

Claimant was evaluated by Robert E. Deysach, Ph.D. on December 4, 2010 at the request of the Employer/Carrier. On the Wechsler Abbreviated Scale of Intelligence (WASI), Claimant was noted to have a Full-2 estimated IQ of 62, which places him in the "Mildly Handicapped" range. (Defendants' APA, p.4). Dr. Deysach agreed with Dr. Waid that the "primary obstacles" of Claimant's inability to return to a competitive job market are the "residuals from the orthopedic injury." (Defendants' APA, p.7). Of importance, Dr. Deysach noted cognitive deficits were documented but "the data indicate that these deficits are basically developmental (i.e., existing before the accident) rather than the result of physical brain damage from the accident."

Specifically, Dr. Deysach noted,

"In other words, up to the present, the patient has been able to compensate for his intellectual shortcomings by his physical competencies and a strong work ethic (e.g., working two full time jobs before his accident). The accident and his failure to return to productivity has made more salient to him and his family that he has significant deficits in the area of language and math (i.e., skills critical for activities of daily living)."

(Defendants' APA, p.7). Lastly, Dr. Deysach noted it was reasonable to conclude Claimant

did suffer an injury to the head with brief and mild-post concussive symptoms but "the data do not appear to support the presence of an acquired brain injury." (Defendants' APA, p. 8).

All three experts agree Claimant has significant pre-morbid or developmental

cognitive/educational deficiencies and that Claimant's physical limitations secondary to his orthopaedic injury are the greatest factors prohibiting Claimant from returning to work. Despite this, only Dr. Deysach reaches the most logical conclusion in finding that although Claimant did suffer an injury to the head, he did not sustain physical brain damage. The conclusions of Dr. Brabham and Dr. Waid do not rely on the medical evidence or even the testing results (most of which point to developmental deficiencies), but instead rely on the subjective opinion of the Claimant and his wife who both acknowledge Claimant's pre-injury cognitive deficiencies. In a workers' compensation action, the existence of any conflicting opinions between the doctors is a matter left to the Commission. Harbin v. Owens-Corning Fiberglass, 316 S.C. 423, 450 S.E.2d 112 (Ct. App. 1994). As such, the Hearing Commissioner properly weighed all of the evidence and properly determined Claimant did not meet his burden of proving he sustained physical brain damage.

D. The Hearing Commissioner properly relied on the Crisp case in addition to the evidence as a whole in finding Claimant did not meet his burden of proving physical brain damage.

Given the factual background of this claim and that of the claim in Crisp v. South Co., 390 S.C. 340, 701 S.E.2d 762 (Ct. App. 2010), the hearing Commissioner was correct to find that Crisp closely parallels this claim. Claimant Crisp was struck in the head, neck, back and right upper extremity by a bobcat bucket during the course of his employment. He was admitted to the hospital where he was treated for abrasions and bruises behind the back of his head and neck as well as injuries to his back and right hand. He sought additional medical treatment from several physicians regarding his headaches, neck and lower back pain and was diagnosed with cervical muscle strain, lumbar strain and fractures to his right hand. An MRI scan of Crisp's brain did not reveal any abnormalities. Id. at 341.

Crisp then went to see Dr. Robert Moss, a psychologist, who diagnosed him with a traumatic brain injury. Claimant was then evaluated by Dr. Thomas Collings, a neurologist, who diagnosed him with a closed head injury but noted the head injury appeared to be "very minor," and that Crisp did not sustain a significant head injury based on his medical records and the low frequency of headache complaints. Crisp was then seen by Dr. David Price, a psychologist, who concluded there was no credible evidence Crisp sustained a brain injury. Id. at 342.

The hearing commissioner in the Crisp case concluded Crisp sustained a head injury resulting in cognitive disorders to his brain but not a physical brain injury. This holding was affirmed by the full commission, but reversed by the Circuit Court. In reversing the Circuit Court's Order, the South Carolina Court of Appeals ultimately upheld the conclusion of the Commission by holding,

"To the contrary, we conclude the record is replete with substantial evidence to support the Commission's finding that Crisp did not sustain a physical brain injury. . . . The medical records of the several physicians who treated Crisp following the accident support reversal of the Circuit Court's decision. The hospital's physicians did not note any symptoms commonly attendant to a physical brain injury during Crisp's treatment. The physicians who evaluated Crisp following surgery did not diagnose Crisp with a physical brain injury. In fact, [the] MRI scan did not reveal any abnormalities suggestive of a physical brain injury and [Dr. Kopera] specifically opined Crisp was neurologically intact."

Id. at 345.

When compared to our claim, the underlying facts of both cases are nearly identical. Claimant was struck in the head by a piece of ceiling tile during his employment. He was admitted to Grand Strand Regional Medical Center and was treated for a scalp laceration and a head contusion for which he received wound clips. Claimant had an x-ray of his cervical spine, which was normal. Claimant sought medical treatment from several physicians regarding his lower back pain as well as headaches. Dr. McCaffrey evaluated Claimant and diagnosed him as

having low back pain with right leg radiation. Claimant also treated with Drs. Rosenberg and Kang for low back and right lower extremity pain. Claimant was evaluated by Dr. Brabham who diagnosed Claimant with a traumatic brain injury. This report was agreed to by Dr. Waid, who noted in his multi-axial assessment that Claimant had a "mild head injury" (Claimant's APA p. 196). Finally, Claimant was evaluated by Dr. Deysach who opined that although Claimant did sustain an injury to his head, it did not amount to a finding of a physical brain injury.

The time period between the date of injury to the first neuropsychological testing in the Crisp claim was approximately 21 months -- almost two years. In our claim, the time period between the date of injury to the first neuropsychological testing was approximately 26 months -- just over two years. Both records were void of any neurological or cognitive deficiencies, with the exception of headaches, for approximately two years. Both cases have a flurry of psychological testing and new complaints of cognitive limitations just prior to the hearing date. In both cases, the hearing commissioner looks at all of the medical evidence and lack of medical evidence as a whole in finding there was not a substantial evidence in the record to support a finding of a physical brain injury or resulting physical brain damage. The procedural posture of the two case is irrelevant. Evidence is substantial if, considering the record as a whole, it "would allow reasonable minds to reach the conclusion the administrative agency reached in order to justify its actions." Taylor v. S.C. Dept. of Motor Vehicles, 368 S.C. 33, 36, 627 S.E.2d 751, 752 (Ct. App. 2006). Based on the above, the hearing commissioner did not err in finding that Crisp closely parallels this case and that Claimant did not meet his burden of proving he sustained a physical brain injury.

II. THE HEARING COMMISSIONER DID NOT ERR IN FINDING CLAIMANT WAS NOT ENTITLED TO LIFE TIME BENEFITS AS THE GREATER WEIGHT OF EVIDENCE DID NOT SUPPORT A FINDING OF PHYSICAL BRAIN DAMAGE.

The Hearing Commissioner properly denied Claimant's physical brain damage claim as it was not supported by a greater weight or preponderance of the evidence. As such, the Hearing Commissioner properly determined Claimant was not entitled to lifetime benefits pursuant to S.C. Code Ann. 42-9-10(C).

In order to receive lifetime benefits pursuant to the Act, any person determined to be totally and permanently disabled who as a result of a compensable injury has suffered physical brain damage shall receive benefits for life. S.C. Code Ann. §42-9-10(C) (2010 Supp.). As Claimant failed to meet his burden of establishing a claim of physical brain damage by a preponderance of the evidence, the Hearing Commissioner properly found he is not entitled to lifetime benefits under the Act.

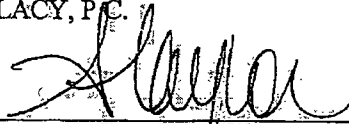
CONCLUSION

Based on the foregoing arguments, the Decision and Order of the Hearing Commissioner should be AFFIRMED.

Respectfully submitted,

COLLINS & LACY, P.C.

BY:



Aisha G. Taylor, Attorney
Post Office Box 12487
Columbia, South Carolina 29211
(803) 256-2660
Attorneys for Employer/Carrier

Columbia, South Carolina
June 7, 2011

CERTIFICATE OF SERVICE

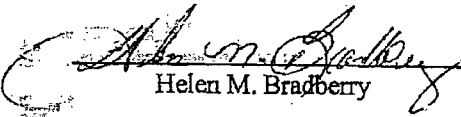
I, the undersigned, of the Law Offices of Collins & Lacy, P.C., attorneys for the defendant do hereby certify that I have served all counsel of record in this action with a copy of the pleading herein below specified by mailing a copy of same in the United States mail, with sufficient postage affixed thereto and return address clearly marked on the date indicated below:

COUNSEL SERVED:

Luke A. Rankin, Esquire
Rankin & Rankin
PO Box 851
Conway, South Carolina 29528-0851

PLEADINGS:

Respondents' Brief


Helen M. Bradberry

Columbia, South Carolina
June 7, 2011

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO: 0810190

Bobby Baker,

**CLAIMANT/
APPELLANT,**

VS.

**HILTON HOTELS
CORPORATION,**

EMPLOYER,

and

**ACE AMERICAN INSURANCE
COMPANY,**

**CARRIER,
DEFENDANTS/
RESPONDENTS.**

CLAIMANT'S REPLY BRIEF

The Claimant, in reply to the Defendants' brief to the Commission on appeal in the above-captioned case, would submit and argue as follows:

ARGUMENT

- A. The existence of a physical brain injury was proven by the great weight of the credible and reliable evidence before the Commissioner.

Defendants' brief to the Commission claims that the admitted injury was to Claimant's back only. It is specious to claim Claimant was only injured in his back, given that the very nature of the incident involved a heavy ceiling tile hitting Claimant's head. The ER records submitted below clearly show that Claimant received a scalp laceration from the workplace accident.

It is simply not true that "Claimant's allegations of physical brain damage was [sic] not supported by a greater weight or preponderance of the evidence." (Def. Brief, p. 3.) As set forth in great detail in Claimant's initial brief, the Claimant submitted numerous medical records, including the consensus among three doctors – one of whom has been cited with approval by this state's Court of Appeals in the field of brain injury analysis and diagnosis (*Means v. Gates*, 348 S.C. 161, 558 S.E.2d 921 (Ct.App. 2001)) – that Claimant did, in fact, suffer physical brain damage as a result of the workplace accident.

Defendants mention in their brief that the records Claimant submitted from his medical providers stress the physical injury to Claimant's back. This may be true, but this fact alone is insufficient to support the assumption that there is, necessarily, no brain injury as well. Claimant and his wife both testified at the hearing that they made numerous attempts to discuss the cognitive deficits both had observed in Claimant after the accident, but in each case the discussion of brain injury was shut down by the providers. (Transcript at pp. 27-28 and p. 62.) They were repeatedly told by those physicians that they "couldn't talk about that" or "weren't authorized to discuss" brain injuries. As stated in Claimant's initial brief, neither Claimant nor his wife is knowledgeable about the finer points of law and procedure that govern Worker's Compensation cases. As such, they understandably trusted their physicians, and when those trusted doctors told Claimant and his wife that they *could not discuss brain injuries* with them, Claimant and his wife responded accordingly by turning their attention to the other significant physical injuries Claimant had suffered.

Both Claimant and his wife were cross-examined at length on this point by

Defendants' counsel and (in Claimant's testimony) by the Commissioner himself. Claimant and his wife both reasserted that they had tried to bring up Claimant's decline in cognitive functioning, but had been rebuffed at each turn by the treating physicians.

Defendants' position appears to be that, if the medical records do not mention a particular event or discussion, that this event or discussion did not take place. This is faulty logic, and unsupported by the evidence. The lack of a reference in a medical record simply means that Claimant must prove the fact to be asserted by other means. Claimant argues that he did, in fact, meet that burden of proof, by the presentation of the concurring opinions of Drs. Waid, McCaffrey, and Brabham, and the testimony of Claimant and his wife as to the very specific and distressing ways in which the accident had caused serious cognitive difficulties - difficulties which did not exist prior to the accident.

Moreover, the very fact that Dr. McCaffrey agreed with the diagnosis of a physical brain injury corroborates the Claimant's and his wife's testimony on this point. If the Defendants' contention that no such reports of cognitive deficits were made is correct, then Dr. McCaffrey would have no basis in fact for putting his agreement with the diagnosis of brain injury on the record. At a minimum, Dr. McCaffrey would have risked his future credibility, if not his medical license itself, by making a diagnosis for which he had no factual foundation. The fact that Dr. McCaffrey *did* agree with the diagnosis on the record and to a reasonable degree of medical certainty supports a reasonable inference that he was aware of Claimant's complaints of decreased cognitive abilities and processes - that, in fact, Claimant and his wife had brought up these concerns to him in the past. Had they not done so, Dr. McCaffrey would have had no

factual foundation to support his conclusion. It strains credulity to assert a physician of Dr. McCaffrey's experience and stature would have made such a finding without any reason to believe it was true.

In point of fact, however, the record *does* reflect symptoms of brain injury. This point was noted by Dr. Brabham in his report. (Claimant's APA pp. 177-178.) Claimant's tinnitus appeared only after the accident. (*Id.* at pp. 5 - 64) Likewise, Claimant complained of visual acuity diminishment. (*Id.* at 64.) As Dr. Brabham points out, these facts are symptomatic of a brain injury. (*Id.* at 178.)

Defendants, as well as the Commissioner below, place undue stress on the fact that Claimant was not intellectually gifted or academically successful prior to the accident. The Claimant's testimony, supported by that of his wife, clearly established that there were numerous tasks and activities that were accessible to him before the accident, but which remain out of his reach now. It is the *diminishment* in those cognitive faculties which is the essential inquiry in a physical brain injury case — a focus that was given superficial acknowledgment in Dr. Deysach's report, but which was not, in fact, considered fully therein.

Claimant's wife testified at length regarding the changes in personality, affect, and demeanor she had personally observed in Claimant post-trauma. (Transcript at 29.) This testimony corroborates that of the Claimant himself, who testified that he could no longer remember the procedures for some common repairs he had performed for most of his working life, such as tearing down and rebuilding brake drum. (*Id.* at p. 60.) In addition, Claimant testified that he had *begun* making mistakes with money management and banking, causing overdrafts. (*Id.*)

Dr. Deysach's report stressed Claimant's past academic difficulties. This fact alone is irrelevant to the question of whether Claimant has suffered a diminishment in his cognitive faculties. It is crucial to remember that Claimant used to run his own business, together with his wife, as well as to consider the fact that Claimant can no longer perform those automotive repair tasks, for instance, that he was previously able to accomplish routinely. His failure at these tasks was due not to his back injury, as his testimony made clear, but rather to his brain injury and resulting cognitive deficits. In other words, he can no longer perform these tasks, not because he is physically unable to do so, but because he can no longer *remember* the processes involved. This is a clear indication of physical brain injury, one that was in fact considered by the doctors who concurred that a brain injury had, in fact, occurred.

Further, Dr. Deysach's report itself is suspect, given his strange assertion that he was reluctant to conclude a physical brain injury existed because he did not want the Claimant to believe he suffered a physical brain injury:

To his determinant (sic), a conclusion of this sort is likely to suggest to him that he is "damaged" beyond the orthopedic injuries and chronic pain he reports from those injuries.

(Defendant's APA p. 8.) As Claimant pointed out in his initial brief, this strange assertion follows Deysach's admission that the Claimant clearly "did suffer an injury to the head with brief and mild post-concussive symptoms." (*Id.*) Thus, Dr. Deysach appears to base his opinion, at least to some significant degree, on a reluctance to call the injury Claimant suffered "brain damage" because he did not want the Claimant to *think* he was brain damaged. This sort of circular logic should alert a cautious reader as to the credibility of his findings. Contrasted with the well-reasoned reports from Claimant's proffered

experts, especially Dr. Waid, Dr. Deysach's conclusory report cannot be said to be so reliable as to overcome the consensus of three physicians, one of whom is considered one of the state's leading experts on brain injury, that Claimant did in fact sustain a physical brain injury.

The full consideration of *all* the evidence and facts in the reports of Waid and Brabham, together with McCaffrey's concurrence, should have led the Commissioner to weigh them more favorably, as opposed to the less-than-comprehensive and oddly-worded report of Deysach. The Commissioner's failure to reach that conclusion, in light of all the evidence available to him, was legal error, and should be reversed by the Commission.

- B. The Commissioner's reliance on the *Crisp* case was inappropriate and misplaced, resulting effectively in Claimant's being held to an inappropriate and higher burden of proof.

In his Decision & Order, Commissioner Lyndon stated:

In addition to the results of the testing performed by Dr. Deysach, Defendants rely on the South Carolina Court of Appeals' decision in *Crisp v. SouthCo., Inc.*, 390 S.C. 340, 701 S.E.2d 762 (Ct. App. 2010) to support their position that there is not substantial evidence in the record to support a finding of a physical brain injury or physical brain damage. *I agree that Crisp closely parallels this claim.*

(Decision & Order, p. 12 (emphasis added).)

Despite Defendants' continued insistence to the contrary, the *Crisp* case involved very different facts that bore directly on its outcome, specifically including the presence of addiction and abuse of controlled substances. In *Crisp*, the addiction presented a competing or conflicting diagnosis of substance-induced dementia, a factual background completely inapplicable to Claimant's case.

Additionally, as stated by the Claimant in his initial brief, the Defendants and the

Commissioner misread the *Crisp* case. The result is that the Commissioner held Claimant a burden of proof not in fact applicable to him by law at this stage of the proceedings.

In *Crisp*, as the Claimant previously illustrated, the issue was whether there was any evidence to support the Commission's findings and conclusions. The Court held that given the conflicting evidence on the brain injury question, the appropriate conclusion was to support the Commission's findings, thus overruling the Circuit Court's reversal of the Commission on that point. This case is at a completely different stage of Worker's Compensation proceedings. From this point, the Commission may disregard in whole or in part the findings and conclusions of the Hearing Commissioner below, and may in fact substitute its own findings and conclusions, as it sees fit, in accordance with the weight of the evidence. *Gadson v. Mikasa, Corp.*, 368 S.C. 214, 628 S.E.2d 262 (Ct. App. 2006) (citing *Bass v. Isochem*, 365 S.C. 454, 617 S.E.2d 369 (Ct.App. 2005); *Muir v. C.R. Bard, Inc.*, 336 S.C. 266, 519 S.E.2d 583 (Ct.App. 1999)). This is a very different standard than that at work in *Crisp*. Thus, viewing it as a paradigm for consideration of Claimant's case is inappropriate.

Additionally, once the superficial factual similarities between the two cases are put aside, it becomes clear that the different standard and the presence of the addiction issues in *Crisp* necessitate a finding that the *Crisp* case does not and should not control the outcome of Claimant's case. Thus, the Commissioner's reliance on *Crisp* in ruling that Claimant had not proven the existence of a physical brain injury was legal error, and should be corrected by the Commission on appeal.

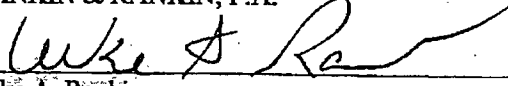
CONCLUSION

For the foregoing reasons, the Order of the Commissioner below should be

REVERSED and the Commission should issue a new Order, with a finding of fact that Claimant suffered a compensable traumatic brain injury as a result of the workplace accident of May 6, 2008, and a corresponding conclusion of law that as a result of that brain injury, he is therefore entitled to lifetime benefits.

RANKIN & RANKIN, P.A.

BY:


Luke A. Rankin

Attorney for Employee/Claimant - Appellant

201 Beatty Street

Post Office Box 919

Conway, SC 29528-0919

(843) 248-2405

June 16, 2011

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

T. SCOTT BECK, COMMISSIONER, CHAIR
DERRICK L. WILLIAMS, COMMISSIONER

W.C.C. FILE NO.:0810190

Bobby Baker, ...Employee/Claimant/Appellant,

vs.

Hilton Hotels Corporation Employer,

AND

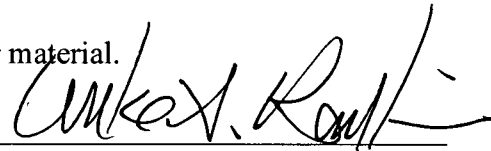
ACE American Insurance Company Carrier/Defendants.

OF WHOM

Hilton Hotels Corporation and ACE American Insurance Company are Respondents.

CERTIFICATE OF COUNSEL

The undersigned certified that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.



Luke Rankin
Rankin & Rankin
Post Office Box 851
Conway, South Carolina 29528-0851
(843) 248-2405
Attorneys for Appellant

Dated: 11/19/12
Conway, South Carolina

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

T. SCOTT BECK, COMMISSIONER, CHAIR
DERRICK L. WILLIAMS, COMMISSIONER

W.C.C. FILE NO.:0810190

Bobby Baker Employee/Claimant/Appellant,

vs.

Hilton Hotels Corporation..... Employer,

AND

ACE American Insurance Company.....Carrier/Defendants.

OF WHOM

Hilton Hotels Corporation and
ACE American Insurance Company are..... Respondents.

PROOF OF SERVICE

I, RACHEL H. ALLEN, an employee of Rankin & Rankin, attorneys for Bobby Baker in the above-entitled action, certify that I have served the Record on Appeal, Certificate of Counsel, and Proof of Service on all parties to this matter by depositing a copy in the United States Mail, first class postage prepaid on the 20TH DAY OF NOVEMBER, 2012.

Other Counsel of Record:

Aisha G. Taylor
Collins & Lacy, P.C.
1330 Lady Street 6th Floor

DECEMBER

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SOUTH CAROLINA COURT OF APPEALS

Columbia, South Carolina 29211
(803) 256-2660
Attorneys for Respondents

Rachel H. Allen

Conway, South Carolina