Medical Chronology/Summary

Confidential and privileged information

Usage guideline/Instructions

***Verbatim summary:** All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

***Case synopsis/Flow of events:** For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

***Injury report:** Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

***Comments:** We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: **"**Comments*".**

Indecipherable notes/date:** Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes" in heading reference.

***Patient's History:** Pre-existing history of the patient has been included in the history section.

***Snapshot inclusion:** If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

***De-Duplication:** Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on **Motor vehicle collision** on **03/23/YYYY**, the injuries and clinical condition of **XXXX** as a result of accident, treatments rendered for the complaints and progress of the condition.*
- *Initial and final therapy evaluation has been summarized in detail. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*
- *Prior visits for other medical conditions have been included in brief for reference.*

Injury Report:

DESCRIPTION	DETAILS
Prior injury details	*12/27/YYYY-Low back pain- Lifting concrete bird bath* *07/12/YYYY: Slip and fall- Chest wall pain* *06/05/YYYY: Trip and fall- Left shoulder injury, Left humeral neck fracture* *02/14/YYYY- Motor vehicle accident- Neck pain- Cervical sprain, Mild C5-6 degenerative disk disease, Left cubital tunnel syndrome, Left elbow medial epicondylitis*
Date of injury	MM/DD/YYYY
Description of injury	She was involved in a motor vehicle collision. She was at a complete stop with her head turned to the left checking for traffic when an automobile rear-ended her. She states that her head was turned so when she was hit it caused her neck to jerk. The airbags were not deployed. Immediately she states that she experienced neck pain. She also complains of a left aided headache, left ear pain but denies dizziness
Injuries as a result of accident	• Closed injury of head • Injury of neck • Posttraumatic headache • Left apical radiation fibrosis and of left upper lung • Cervicalgia • Cervical radiculopathy • Displacement of cervical intervertebral disc without myelopathy: Other cervical disc displacement, unspecified cervical region
Treatments rendered	• Pain medications • Medrol Dosepak • Physical therapy: 04/05/YYYY-10/18/YYYY • Modification of pillow arrangement
Condition of the patient as per the last available record	As of 05/13/YYYY, She stated that she had constant neck pain that radiated to both shoulders and right elbow, she was unable to have therapy due to increase pain, and she wanted to discuss Celebrex and another referral for therapy. Her pain level was rated 7-9/10 with a sharp and aching quality. She said it improves with rest, heat or ice and sitting makes her pain worse.

Patient History

Past Medical History: History of adverse reactions to anesthesia. History of chemotherapy to breast cancer and osteopenia. *Pdf ref: 286.* History of menopause, depression, stress at work. *Pdf ref: 22*

Surgical History: History of tylectomy, elbow surgery**.** *Pdf ref: 142.* History of tonsillectomy/adenoids, Appendectomy. *Pdf ref: 286*

Family History: History of Malignant hyperthermia in brother, history of stroke in paternal grandfather and history of hypertensive disorder in paternal uncle. *Pdf ref: 286*. History of mother died of septic shock, Father died in Accident in his 40's, history of brother dies of pancreatic cancer at 45 years, Brother died in motor vehicle collision in 20's. *Pdf ref: 22*

Social History: History of former smoker and occasional alcohol intake. *Pdf ref: 286.* History of 3/wine with moderate alcohol use. *Pdf ref: 22*

Allergy: History of allergic to Demerol and Percocet. *Pdf ref: 285*

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
Prior medical records				
12/27/YYYY	Hospital/ Provider	**Office visit:** **History of present illness**: This 50 year old right handed woman comes for severe low back pain present over the past week after picking up a concrete bird bath. Aggravated further by continuing yard work with raking. She has not really had prior back problems and she has been in a fair bit of misery radiating into the buttocks. Taking Advil and limping around on crutches. No bowel or bladder dysfunction. No lasting numbness or radicular type complaints and her general health has been notable for breast cancer treated five years ago with surgery, chemotherapy, and radiation and no known residual disease. Baseline medications are Femara, Fosamax, and the more recent Advil. She is intolerant of Demerol or Percocet, Enjoys social alcohol is not a smoker. Denies other relevant put history or family history or other surgery. **Physical examination:** She is 5'9, about 175 pounds. In significant discomfort. Guards lumbar motion and moves very slowly. There is marked tenderness in the lower lumbar spine extending into the buttocks. Tension signs are negative. Hip motion is well preserved, although reproduce her back pain. Reflexes are absent and symmetrical at the knees, active and symmetrical at the ankles. Good distal strength. Normal pulses and normal subjective sensation. **Imaging:** X-rays of the lumbar spine in two view, obtained in the office today and reviewed by me demonstrate a curvature on the AP which may be postural. A small spina bifida occult at S1, but generally well preserved disk spaces with no erosions or fractures**.** **Impression:** Acute lumbar strain **Disposition:** We have considered the possibility of a bulging or herniated disk, but I think there is room for conservative care here.	217, 611	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		I have recommended rest for a couple *of* day, heat or ice, whichever feels better, Good supportive shoes, avoiding bending, stooping, lifting. We will change medications to Celebrex, Flexeril, and Darvocet with precautions and add some formal physical therapy but if not satisfactorily better over the coming weeks, lumbar MRI would be appropriate**.** *Related records: pdf ref: 604-610, 599, 613-616, 619*		
01/04/YYYY	Hospital/ Provider	**Initial physical therapy evaluation:** *(Poor quality records)* **Subjective** **Mechanism of injury:** Insidious **Date of accident:** 12/22/YYYY **Current history:** Patient lifted concrete bird bath and tuned ___ afterwards pain _____ **Objective**: **Gait**: __ gait **Range of motion** Flexion: 20, painful Extension **Assessment:** • Pain • Decreased function, strength, ROM • Poor posture • Not independent with HEP • Out of work **Plan**: • Passive ROM/ stabilization • Electrical stimulation • Therapeutic exercises • HEP/Education • Return to work *Related records: pdf ref:600*	596-597, 594	N/A
01/06/YYYY - 01/12/YYYY	Hospital/ Provider	**Summary of interim physical therapy visits:** *(Poor quality records)* **Date of visits:** *01/06/YYYY, 01/08/YYYY, 01/10/YYYY, 01/12/YYYY* Patient states she still, having lot of pain on sitting and is most comfortable in supine position **Objective:**	592, 598, 586, 583	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Area treated: Lumbar spine Hot/ cold pack Ultrasound Therapeutic exercises **Assessment: _____** Patient tolerated the exercises well **Plan:** Continue with current plan of care ** Reviewer's Comments: Only the initial and final visits have been elaborated. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.**		
01/18/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness**: Patient returns a month into her episode reporting the severe pain has backed off a bit, Therapy has been somewhat helpful. Celebrex has been somewhat helpful. but i:he continues to have severe pain when sitting and feels ready to advance to MRI **Physical examination:** She continues to guard lumbar motion severely. Tenderness is maximal in the lower lumbar spine and right buttock. She still has pain on tension signs and other than symmetrical hyporeflexia, no focal deficits. **Imaging**: X-rays are not repeated. **Impression:** Lumbar strain with partial response to conservative care. Possible bulging or herniated disc. **Disposition:** She may continue that therapy and the Celebrex, We will advance to lumbar MRI with definitive recommendations thereafter.	216, 578	N/A
01/19/YYYY	Hospital/ Provider	**Final physical therapy visit:** *(Poor quality records)* **Subjective:** Patient has better ____ **Objective:** **Area treated:** Lumbar spine Hot/ cold pack Ultrasound Therapeutic exercises **Assessment: _____** **Plan:** Continue with current plan of care.	575	N/A
01/20/YYYY	Hospital/	**MRI of lumbar spine without contrast:**	574	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
	Provider	**History:** Lumbar radiculopathy **Findings:** The conus terminates normally behind L1 with normal signal and _____. There is disc desiccation at all levels with loss of disc space height at L1-2, L4-5 and L5-S1 The vertebral body heights and remainder of the disc space heights are well maintained as well as alignment **L1-2:** Minimal disc bulge. No significant central canal or neural foraminal narrowing. Mild facet arthropathy **L2-3:** Facet arthropathy. Otherwise unremarkable **L3-4:** Facet arthropathy. Otherwise unremarkable **L4-5:** Broad-based concentric disc bulge with facet arthropathy. No significant central canal narrowing. There is mild to moderate right neural foraminal narrowing and left neural foraminal narrowing. Please clinically correlate for possible bilateral L4 nerve root radiculopathy **L5-S1:** Broad-based concentric disc bulge with facet arthropathy. No significant central canal narrowing **Impression:** • Multilevel degenerative disc disease as described most significant at L4-5 with possible bilateral nerve root encroachment. Please clinically co-relate as the ___appears to be preserved bilaterally on axial T1 imaging • Multilevel facet arthropathy		
01/25/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness**: Patient returns reporting slow gradual progress. She has been unable to really perform any of her normal activities. Even getting dressed or feeding the dogs will aggravate her. She has not been back to work and although it is office type duties it aggravates her when she sits for a long time **Physical examination:** Physical exam reveals she ambulates smoothly but guard's lumbar motion still. Tension signs cause her back pain but no leg symptoms and there are no neurologic deficits with symmetrical hyporeflexia but normal subjective sensation and good distal strength **Imaging**: Lumbar MRI since last visit demonstrates multilevel	572	N/A

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		degenerative changes with minimal risk bulging. Multilevel facet arthropathy but no clear but stenosis. There may be some foraminal stenosis but certainly no obviously crushed nerves. **Disposition:** We have reviewed the implications of her scan in some detail and I have referred her to Dr. Sean or chambers for consideration of injection therapy, either epidural and or facet injections. I do not consider her totally disabled and she should be safe to work as long as there is no heavy bending, stooping and or lifting. *Related records: Pdf ref: 573*		
01/31/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of present illness:** Patient is a 51 year old woman who lifted a concrete bird bath on 12/18/YYYY and developed back pain. Her symptoms are worse when sitting and improve when lying down. She has been treated with a short course of rehabilitation as well as oral NSAIDS and Darvocet. Overall she has improved, But she is still having low back pain. There is no pain, numbness or tingling in either lower extremity. Bowel and bladder function are normal. **Physical examination:** Lumbosacral posture is normal when standing. Motion is full with forward flexion, extension and bilateral side bending. Back pain increases at the end range of forward flexion. Root tension signs are negative seated and supine. Strength is 5/5 through the lower extremity major motor groups. Sensory exam is intact to light touch in L2 through S1 dermatome on both sides. Patellar and Achilles reflexes are 2+ and symmetrical. Hip joint range of motion is full and without pain on both sides. Patrick's test is negative. In the prone position mild tenderness is present in the lumbosacral paraspinals to palpation. Upon inspection there is no evidence of skin changes or gross skeletal deformity **Radiographs:** A lumbar MRI on 01/YYYY indicates multilevel degenerative disk disease at L1-2, L4-5 and L5-S1. Most significant level appears to be L4-5. There is right greater than left foraminal encroachment secondary t broad based disk bulge and facet joint arthropathy. There is facet joint arthropathy also at L1-2, L4-5 and L5-S1. **Impression**: Multilevel lumbar degenerative disk disease Multilevel lumbar spondylosis	569-570	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Recommendations: • She is going to return for rehabilitation services to the lumbar spine. Her previous visits so rehabilitation were prior to Definitive diagnosis was made and therefore she was approached in a general manner in terms of rehabilitation efforts. She was given a prescription today and interventions were fined tuned based on MRI findings • Continue with Celebrex and a refill was written for her to use 200mg , ne PO qd or bid as needed , # 60 without refills • Recheck in one month *Related records: Pdf ref: 565-568, 571*		
03/09/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of present illness:** Patient returns today in follow up doing much better after working with Jim Lewis at physiotherapy and Associates in Alpharetta. She is especially pain free. She has times where the pain increases and this responds to exercise. She sits quite a bit at work and need to remind herself to get up periodically. She is using the Celebrex very rarely now. She is independent with her home program. **Physical examination:** Exam reveals normal posture, full painless motion of the lumbosacral spine in all directions. Root tension signs are negative in both legs. Strength and sensation are normal in both lower extremities. The patella and Achilles reflexes are unobtainable in both legs **Impression**: lumbosacral spondylosis lumbar sprain **Recommendations:** • She is for the most part pain free at this time and independent with her home program • She will be discharged from routine follow up and is certainly welcome to follow up on an as needed basis as symptoms warrant • She asked if she has any exacerbation could she simply return to see Jim for one or two visit for rehabilitation to get things back on track and tis would be appropriate if her symptoms have not changed significantly *Related records: Pdf ref: 561-562*	560	N/A
04/15/YYYY	Hospital/ Provider	**Mammogram- bilateral:**	214	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Comparison: 03/20/YYYY and 03/17/YYYY **Findings:** Post lumpectomy changes in the medial left with a moderate amount or fibro glandular density in both breasts, and the occasional punctate benign calcification in the left are stable, No suspicious mass, distortion, or micro calcification cluster is identified to suggest malignancy. **Impression:** No change to suggest malignancy or recurrence.		
01/06/YYYY	Hospital/ Provider	**Bone densitometry:** **History:** 53 year old who is post-menopausal and takes bisphosphonates. The patient has a history of breast cancer **Comparison:** 10/17/YYYY and 02/11/2004 **Findings:** The T score of the lumbar spine us -0.9, previously -0.8 and -1.1. The T-score of the total proximal femur is -1.5, previously -1.3 and -1.5. the T-score of the femoral neck is -1.8, previously -1.6 **Impression:** Osteopenia	197-212	N/A
03/24/YYYY	Hospital/ Provider	**Office Visit:** **HPI:** follow up on bronchitis **Assessment:** Acute bronchitis **Plan:** Ambien 10mg 1 tab QHS/ HS, 30 tab, 03/24/YYYY, no refill. Active Follow up in two weeks	191-192	N/A
03/24/YYYY	Hospital/ Provider	**X-Ray of chest:** **History:** 54-year-old female with cough. History of left breast cancer. status post radial ion to the left chest **Comparison:** The 2006 chest radiograph is not available for direct comparison. This will be requested. Once it becomes available, an addendum will be added to this report. **Findings**: The cardiac silhouette is normal In size. There are no mediastinal or hilar contour abnormalities. Surgical clips project over the left axilla. There is pleural parenchymal thickening seen at the left lung apex which is likely related to prior radiation. On the lateral view, there is a 1.8 cm nodular opacity which projects over the upper lobes near the apices. No clear correlate is iden1ilied on the frontal view. Negative for focal consolidation, edema, pleural effusion and pneumothorax. Mild degenerative	190	N/A

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		changes are noted in the spine. **Impression:** 1 .8 cm nodular opacity seen on the lateral view only. Recommend comparison to the 2006 examination. If this finding represents as significant change, recommend CT of the chest to evaluate for a parenchymal nodule.		
03/31/YYYY	Hospital/ Provider	**Progress Notes:** **Chief complaint:** She presents to the clinic for follow-up of Malignant Neoplasm Breast Nos- 1749. Under management according to NCCN and ASCO guidelines The patient presents for re-evaluation of therapy and/or disease related problems. **Assess:** Stage IIA left breast cancer**.** **Plan:** s/p -4 yrs. of Tamoxifen and 5 yrs. Femara. **Assess:** Osteopenia **Plan:** Continue Fosamax, calcium, Vit D. **Plan:** RTC in one year for tabs and to see Dr. Galleshaw	188-189	N/A
04/20/YYYY	Hospital/ Provider	**Digital screening mammogram with CAD:** **Clinical history:** No current breast symptoms reported. History of breast cancer on the left with lumpectomy radiation and chemotherapy **Impression:** Parenchymal changes left breast consistent with history of left breast cancer compared to the prior study, there has been no significant interval change	186-187	N/A
09/14/YYYY	Hospital/ Provider	**Follow-up visit:** **HPI:** The patient is a 55 year old female who presents for follow-up of hypertension. Overall the patient is doing well. The patient blood pressure has been well-controlled. The patient has been compliant with their medications and there have been no side effects. **Assessment and plan:** Hypertension **Plan:** • Well controlled • Continue current meds • Check lytes	106-107	N/A
09/14/YYYY	Hospital/ Provider	**Follow-up visit:** **Assessment and plan:** Influenza, need for prophylactic vaccine	105	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Plan: immunization: Flu vaccine		
09/22/YYYY	Hospital/ Provider	**X-Ray of chest:** Heart normal, Lungs well expanded and clear. History/ comments noted. No prior films for review. 1.8 x 4.5 cm density extreme left apex; no associated calcification or rib erosion/periosteal reaction. Possible additional vaguer, subtle density beneath medial aspect left clavicle and some upward retraction of left hilum. No effusion, other peripheral nodules, or effusion. Concern for Pan coast among other etiologies; cross sectional evaluation planned; discussed via telephone with Dr. Pepper 9/25/10 at 10:50 a.m.	184	N/A
10/21/YYYY	Hospital/ Provider	**Follow-up visit:** **History:** Patient is a 55 Yo female who comes in for evaluation of a sinus infection that she has had for a couple of weeks. She has had facial pressure, pain, nasal congestion, and headache. She has a history of sinus infections in the past. She is SIP surgery, chemotherapy and radiation for breast cancer a couple of years ago. She has drainage down her throat and a cough. She drinks water all night long and goes through several bottles a night, but wakes up with a dry throat in the morning. She drinks a lot of water during the day. She is on Lisinopril for high blood pressure. She will take a social glass of wine. She denies tobacco use. She is allergic to Demerol and other narcotic medications. **Examination:** A comprehensive head and neck examination was performed. **Nose:** Shows a deviated nasal septum antero inferiorly rightward. There is no evidence of masses, polyps, or infection. **Ears:** TMs and canals are clear**.** **OC/OP:** Clear. Tonsils are surgically absent**.** **Neck:** Benign without adenopathy **Impression:** • Deviated nasal septum. • Probable chronic sinusitis. **Plan:** She has been taking Augmentin without significant improvement but I will have her Continue this and add a Medrol Dosepak. Sample of Nasacort. CT sinuses in 2-3 weeks.	183	N/A

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		Follow-up with me after the CT scan. I will discuss septoplasty down the line.		
10/28/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of Present Illness:** **Patient's words:** Patient here for nasal congestion, fatigue for 2 weeks Patient complains of about 10 days of nasal congestion, green drainage down the throat, slightly productive cough. Started after she cleaned out a box in the garage. Felt achy all over when it began. Took Amoxicillin 875 mg BID x 7 days (had it at home already but saw ENT, Dr. Robb, who examined her and recommended Mucinex DM and continuing antibiotic, which she finished 10/25/10) Nasal congestion better now but still persists. Clear mucus only. Cough minimal. Slight ear fullness today. No sinus pain or headache. No fever/chills. Patient has not been taking OTC cold meds since then, except Afrin 1 spray every other day or so. Low energy for 2 weeks. Had cold sore 4-5 days ago; now resolved. Used to take Zovirax 400 mg BID for a few days with cold sore outbreak. Wants refill**.** **Assessment & Plan**: **URI/Upper respiratory infections** Feel bacterial infection has been treated. No antibiotic necessary. Not taking OTC meds to help symptoms of URI, so suggested Mucinex regular strength 2 tabs BID with plenty of fluids, prn congestion. Will give sample of Astepro nasal spray, 1 spray in each nostril q day-BID prn allergy/nasal congestion. Call in 3-5 days if symptoms worsen or persist. BP slightly elevated today--think probably related to caffeine consumption. Pt. advised to avoid decongestants. **Herpes simplex, uncomplicated** Treatment outbreaks of cold sores with Zovirax.	103-104	N/A
02/10/YYYY	Hospital/ Provider	**Follow-up Visit:** **Office visit:** Bonnie comes in for evaluation of an acute sinus infection. She was taking Mucinex and her throat was very sore. She had facial pressure, her teeth hurt and she has had facial pressure and pain, malaise, cough, and nasal congestion. She has had a cough to the point where her stomach hurts, She has had a fever to 100-dcgrees. She had something like this in October, 2010. We called in Cipro on February 7, 2011. I added a Medrol Dosepak yesterday or the day before, but she didn't take it because the pharmacist told her it can increase the effects of tendon damage or rupture. She has a history of left breast cancer S/P surgery and radiation.	182	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Impression: Acute pan sinusitis**.**		
02/22/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** **Patient words:** On 2/4 she woke up with rhinitis and sinus pressure. She saw Dr. Robb, she took Cipro and steroids. She is still feeling congested. There is a lot of dust in her house with remodeling going on at home and she feels this is worsening her congestion also. The yellow mucus she had initially has improved. She took Mucinex also for a while and she stopped that. She is still having fatigue, congestion, and dry throat She has had more allergies over the past few years. She also has a new dog and she might be allergic to the dog. Assessment: Sinusitis, chronic nec	101-102	N/A
03/08/YYYY	Hospital/ Provider	**Telephone Conversation:** **Assessment & Plan:** Acute sinusitis, unspecified **Current Plans:** Augmentin 875-12SMG, 1 Tablet two times daily, #20, 10 days starting 03/08/YYYY, No Refill. Active.	100	N/A
03/30/YYYY	Hospital/ Provider	**Progress Notes:** **Chief complaint:** Patient presents to the clinic for follow-up of Malign neoplasm Breast Nos 1749 Stage II N1 M0 The patient presents for reevaluation or therapy and/or disease related problems. **HPI:** She feels well. She completed 5 years of Femara in 11/09 after taking Tamoxifen tor 4 years. She's frustrated that she's gained weight. She's scheduled for her annual mammogram next month. She's been inconsistent in taking Fosamax for the osteopenia noted on her BMD 1/09. **Active problems**: • Stage II A left breast cancer • Osteopenia	180-181	N/A
04/18/YYYY	Hospital/ Provider	**Mammogram- Bilateral:** **Comparison:** 4/16/09, 4/15/08. Parenchyma is moderate in amount and density with post-lumpectomy distortion in the lower inner left. Occasional benign appearing calcification In each breast. No suspicious mass, distortion or micro calcification cluster is identified to suggest malignancy. **Impression:** Stable mammogram. Annual follow-up**.**	178	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
04/18/YYYY	Hospital/ Provider	**Correspondence to Dr. Kara pepper:** **Dear Kara:** I had the pleasure of seeing Bonnie Koeplin in the office in follow up. As you know she is now eleven years status- post left lumpectomy and axillary dissection. On physical examination today, no suspicious or dominant masses were noted. A bilateral mammogram was performed and this showed no evidence of malignancy. I will sec Bonnie in follow up in one year end will keep you apprised of her situation.	179	N/A
07/01/YYYY	Hospital/ Provider	**Follow-up Visit :** **History of present illness:** **Patient words:** CPE The patient is a 59 year old female who comes in today for a complete physical exam. This is a nice patient who feels well with minor complaints. Energy level is described as good. Toe patient's stress level is described as an average **Assessment**: • Routine medical exam • Hypertension • Palpitation • Osteopenia unspecified • Fatigue	95-99	N/A
07/13/YYYY	Hospital/ Provider	**Telephone encounter:** **Assessment & Plan:** Unspecified Diagnosis **Current Plan:** Ultram 50MG, 1-2 Tablet every 8 hours, #30, 07/13/YYYY, No Refill. Discontinued. Mobic 15MG, 1 Tablet daily, #15, 15 days startling 07/13/YYYY, No Refill. Active.	92	N/A
07/13/YYYY	Hospital/ Provider	**History and physical:** **History of present illness:** **Patient words:** Back injury last night slipped on dog's sleeping bag in bathroom landed on R rib on side of bathtub did not hit her head no blood in her urine worried that she fracture her ribs feels her ribs popping in and out of place **Assessment & Plan:** Chest wall pain	93-94	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Impression: s/p fall no fracture will treat pain		
07/13/YYYY	Hospital/ Provider	**X-Ray of chest:** **Findings:** Heart normal. Lungs well expanded and clear. Ribs and osseous structures intact; no effusion or ptx. No contusion or infiltrate. No acute process.	176	N/A
07/15/YYYY	Hospital/ Provider	**Follow-up Visit:** **Assessment & Plan:** Unspecified Diagnosis **Current Plan:** Tylenol with Codeine #3 300-30MG, 1 Tablet every eight hours, as needed, #30, 07/15/YYYY, No Refill. Active.	91	N/A
10/19/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of present illness:** **Patient words:** Patient here for influenza today **Assessment & Plan:** Influenza, need for prophylactic vaccine	90	N/A
06/05/YYYY	Hospital/ Provider	**Follow-up visit:** **History:** This is a 56 year old female right hander with complaints related to the left shoulder. Last evening she was walking her dog, tripped and fell directly onto the left shoulder. She had immediate pain and was taken to North Fulton, x-rays were taken out she did not bring these. She is having significant pain. She has been pretty nauseous from the pain meds. She was given some nausea medication, which she did not take. **Physical examination:** Exam today shows a well-developed and well-nourished female in some distress, oriented x3, respirations are unlabored. The Jen shoulder shows significant soft tissue swelling. Her distal neurovascular is intact. Elbow and wrist are benign. The right foot shows a little bit of tenderness on the dorsum with some ecchymosis. No instability. No mid foot tenderness. No calf tenderness. Negative Homans **X-ray:** X-rays, two views or the humerus, AP and Y view ordered, taken, and interpreted shows a humeral neck fracture with about 20 degree of angulation on the AP and about 20° on the lateral **Impression:** Left humeral neck fracture	446-447, 552-554, 556-557, 4-5	$7.94

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Plan: We have gone through the options. At this point. I think this alignment would be acceptable if it stays. She is going to use ice on her shoulder, take her pain medication, and we will re-x-ray her in a week		
06/12/YYYY	Hospital/ Provider	**Follow-up visit:** **History:** She returns for evaluation of her left shoulder proximal humerus fracture. She is doing much better. The pain is much less. She is a little concerned because she had a lymph node dissection on this shoulder for breast cancer many years ago though no recent difficulty. **Physical examination:** Exam today of' the left shoulder shows ecchymosis proximally. No evidence of distal lymphedema. Distal neurovascularly intact. **X-ray:** X-rays. 2 views of the left shoulder, AP and Y views, show a 3-part proximal humerus fracture with a non-displaced neck and mild displacement of the greater tuberosity. **Impression:** Left proximal humerus fracture in acceptable position at this point. **Plan**: Discussed things with her. She is going to continue icing and we will see her back in a few weeks with repeat x-rays.	444-445, 546-547	N/A
06/19/YYYY	Hospital/ Provider	**Correspondence:** **To whom it may concern,** Patient has been a patient of ours since June 5, 2012 and she is currently being treated for a fractured left shoulder. She is not allowed to drive. She is using a sling as needed for support. She is taking pain medication and needs ice therapy several times a day. The patient may work from home, utilizing her right hand, predominantly for computer and telephone work. She has a follow up appointment with us on June 26, 2012. Thank you for consideration in regards to her injury	545	N/A
06/26/YYYY	Hospital/ Provider	**Follow-up visit:** **History:** She returns for follow-up of her left shoulder fracture. She is having some discomfort also in her elbow. That was not x-rayed and she did hit it. The pain is improved. **Physical examination:** Exam today of the left shoulder shows she still has pain with passive motion, even some simple pendulum. She has expected ecchymosis. The elbow has some ecchymosis but full motion and no instability.	443, 543-544	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		XR: X-rays. 2 views of the humerus, AP internal and external rotation views show the proximal humerus fracture in acceptable position with a little bit or anterior and valgus angulation. X-rays. 3 views of the elbow, ordered, taken and interpreted arc negative for fracture. **Impression:** Left proximal humerus fracture and elbow contusion. **Plan:** Next week, she will be 4 weeks out. I am a little bit worried about her moving too slow. We are going to start some gentle passive motion and sec her back in a few weeks. *Related records: Pdf ref: referral reports:539-542*		
07/05/YYYY	Hospital/ Provider	**Initial physical therapy evaluation:** *(Poor quality records)* **Subjective** **Mechanism of injury:** Insidious **Date of accident:** 06/04___ **Current history:** Status post she fell down walking her dog **Chief complaint**: Left shoulder pain **Objective**: **Pain scale**: 6 at rest, 4 at worst/10, Constant, achy **Gait**: __ gait **Range of motion** Flexion: 20, painful Extension **Assessment:** • Pain • Decreased strength, ROM • Not independent with HEP **Plan**: • Passive ROM/ stabilization • Therapeutic exercises • HEP/Education Frequency of 2 times a week for 4 weeks	442, 535-538	N/A
07/17/YYYY	Hospital/ Provider	**Follow-up visit:** **History:** Six to seven weeks out from her left proximal humerus	439, 531-533	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		fracture. She is still having a fair amount of' discomfort. She is still wearing her sling intermittently. It hurts a lot doing exercises. **Physical examination:** Exam today or the shoulder shows limited motion in all directions. She has tenderness to extremely light touch around the shoulder. Her distal neurovascular is intact. **X-ray:** X-rays. 2 views of the left humerus, ordered, taken, and interpreted, shows the proximal humerus fracture in acceptable position. **Plan:** She is having much more pain than l would expect. She is sensitive to light touch. I am worried about an RSD type of pattern developing or an arthrofibrosis. I am going to give her Mobic with the appropriate GI precautions. Continue rehabilitation, work on range of motion. She might need MRI or CT if not progressing.		
08/14/YYYY	Hospital/ Provider	**Follow-up visit:** **History:** Follow-up for her kit proximal humerus fracture. She is about 10 weeks out. She is making progress in rehabilitation; still a fair amount of pain and adhesive capsulitis. **Physical examination:** Exam today of the shoulder shows limited motion in all directions although some improvement from the last visit. No real weakness and no atrophy. No warmth or erythema and neurovascularly intact. **X-ray:** X-rays, 2 views of the left shoulder, ordered, taken, and interpreted show that the fracture is pretty well healed with minimal angulation. **Impression:** Adhesive capsulitis with healing left proximal humerus fracture**.** **Plan:** Continue rehabilitation its long as she is improving. Sec back in a month.	431, 525-527	N/A
10/02/YYYY	Hospital/ Provider	**Follow-up Visit :** **History of present illness:** **Patient words:** CPE The patient is a 59 year old female who comes in today for a complete physical exam. This is a nice patient who feels well with minor complaints. Energy level is described as good. Toe patient's stress level is described as an average **Assessment**: • Routine medical exam • Hypertension	85-89	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		• Influenza, need for prophylactic vaccine		
10/05/YYYY	Hospital/ Provider	**Follow-up Visit:** **History:** She re-turns status post kit greater tuberosity fracture. Left shoulder with adhesive capsulitis. She is improving pain-wise, therapy-wise, and strength-wise. **Physical examination:** Exam today of the shoulder shows she can abduct to about 80, externally rotate to 20, internal rotation to her belt line, strength is good, no atrophy, docs not really have signs of impingement. **X-ray:** X-rays, 2 views of the left shoulder, ordered, taken, and interpreted, shows the greater tuberosity fracture is healed. **Impression:** Adhesive capsulitis status post greater tuberosity fracture**.** **Plan:** She is making progress. Continue rehabilitation. See back in six weeks	422, 521, 519-520	N/A
07/09/YYYY - 11/08/YYYY	Hospital/ Provider	**Summary of interim physical therapy visit:** **Date of visits:** *07/09/YYYY, 07/13/YYYY, 07/18/YYYY, 07/23/YYYY, 07/26/YYYY, 07/31/YYYY, 08/03/YYYY, 08/06/YYYY, 08/09/YYYY, 08/15/YYYY, 08/20/YYYY, 08/29/YYYY, 09/06/YYYY, 09/12/YYYY, 09/21/YYYY, 09/26/YYYY, 10/03/YYYY, 10/08/YYYY, 10/10/YYYY, 11/08/YYYY* **Diagnosis:** Left shoulder proximal humerus fracture **PT diagnosis:** Left shoulder pain, weakness stiffness **Subjective:** Patient states overall better. Still weak with lifting **Objective:** Area Treated: Left shoulder Hot Pack x 10 min Pre Rx Cold pack Therapeutic exercise Manual therapy Ultrasound **Assessment:** Patient is progressing appropriately towards goals and has been encouraged to continue HEP. **Plan:** Progress as tolerated, instructed to continue HEP ** Reviewer's Comments: Only the initial and final visits have been*	417-418, 420-421, 423-430, 433-438, 440-441, 517, 522, 529, 534	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		*elaborated. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.**		
11/19/YYYY	Hospital/ Provider	**Final physical therapy visit:** **Diagnosis:** Left shoulder proximal humerus fracture **PT diagnosis:** Left shoulder pain, weakness stiffness **Subjective:** Patient states overall better. Only has time for ultrasound today due to work, she has to return hack this evening **Objective:** Area Treated: Left shoulder Hot Pack x 10 min Pre Rx Ultrasound **Assessment:** Patient is progressing appropriately towards goals and has been encouraged to continue HEP. **Plan:** Progress as tolerated, instructed to continue HEP	415-416	N/A
11/24/YYYY	Hospital/ Provider	**Physical Therapy visits:** No show. Cancelled appointment	419	N/A
11/30/YYYY	Hospital/ Provider	**Physical Therapy visit:** No show. Cancelled appointment	414	N/A
12/05/YYYY	Hospital/ Provider	**Physical Therapy visit:** No show. Cancelled appointment	413	N/A
12/07/YYYY	Hospital/ Provider	**Follow-up visit:** **History:** Follow-up for left proximal humerus fracture and adhesive capsulitis. She is dramatically improved, She says the pain is pretty much gone, still some occasional aching. The motion is improved. She had to lay off rehabilitation services for the last couple of weeks but wants to keep going as she feels like she is making good progress. **Physical examination:** Exam today shows her abduction is 10 about 110°, external rotation is to 30”. Internal rotation past the borderline and strength is good. **X-ray:** We did not repeat her x-rays. **Impression:** Proximal humerus fracture with adhesive capsulitis and excellent progress in rehabilitation**.** **Plan:** She is continuing to improve and as long as she docs that	412, 511-512, 457	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		we will continue her rehabilitation.		
12/18/YYYY	Hospital/ Provider	**Telephone Conversation:** **Assessment & Plan:** Unspecified Diagnosis **Current Plans:** Started Amoxicillin 500MG, 2 (two) Tablet two times daily, #40, 10 days starting 12/18/YYYY, No Refill.	84	N/A
12/28/YYYY	Hospital/ Provider	**Follow-up Visit :** **History of present illness:** **Patient words:** F/U sinus infection. Sick for about 2 weeks sinus congestion, thick yellow mucous, teeth pain called in last week, got amoxil, but was taking 500 bid taking appropriate OTC meds has marginally gotten better **Assessment & Plan:** Acute sinusitis, unspecified	82-83	N/A
10/22/YYYY	Hospital/ Provider	**Follow-up Visit :** **History of present illness:** **Patient words:** Patient here for influenza today **Assessment & Plan:** Influenza, need for prophylactic vaccine	80-81	N/A
01/02/YYYY	Hospital/ Provider	**Addendum report:** **Assessment**: UTI, unspecified **Current Plans:** • Started Cipro 250MG, 1 (one) Tablet two times daily, #10, 5 days starting 01/02/YYYY, No Refill.	79	N/A
01/17/YYYY	Hospital/ Provider	**Follow-up Visit :** **History of present illness:** **Patient words:** CPE The patient is a 59 year old female who comes in today for a complete physical exam. This is a nice patient who feels well with minor complaints. Energy level is described as good. Toe patient's stress level is described as an average **Assessment**: • Routine medical exam • Hypertension • Breast cancer	74-78	N/A
01/17/YYYY	Hospital/ Provider	**Telephone Conversation:** **Assessment**: Stress at work **Current Plans:** Started Xanax 0.5MG, 1 (one) Tablet daily as	73	N/A

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		needed, #30, 01/17/YYYY, No Refill.		
03/12/YYYY	Hospital/ Provider	**Telephone Conversation:** **Assessment**: UTI, unspecified **Current Plans:** Started Macrobid 100MG, 1 (one) Capsule two times daily, #10, 6 days starting 03/12/YYYY, No Refill.	72	N/A
02/03/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** **Patient words:** CPE The patient is a 59 year old female who comes in today for a complete physical exam. This is a nice patient who feels well with minor complaints. Energy level is described as good. Toe patient's stress level is described as an average. **Assessment**: • Routine medical exam • Hypertension • Stress at work • Need for shingles vaccine	66-71	N/A
05/01/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** **Patient words:** Allergy sneezing watery eyes fatigue "feels off" going on for a month, traveled to Germany during this time and symptoms did not improve wanted to check with me to see what she could take **Assessment:** Allergic rhinitis, cause unspecified	64-65	N/A
05/27/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** **Patient words:** f/u on most recent sinus infection Sin signs and symptoms since beginning of May was seen on May 1, dx with allergic rhinitis treated with flonase and decongestant didn't' get better now has R sided facial pressure, Rear won't pop tried steroids but they made her agitated took an old course of amoxil for 5 days, didn't help not drinking wine anymore, has lost 6# since she was last seen tried Mucinex and ocean spray- feels no better today No fever	62-63	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Assessment& Plan: Acute sinusitis, unspecified		
10/02/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** **Patient words:** Here for influenza vaccine **Assessment:** Influenza vaccination administered at current visit	61	N/A
01/14/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of present illness:** **Patient words:** Patient of Dr Pepper goes by "Bonnie" h/o breast CA. C/o vague mild R sided ABD pain lasting 1-3 hours, up to 3 days per week since 10/15. Worse if full after eating large meal and possibly after higher carb or higher fat meal. Similar to when had duodenal ulcer in 20's. Quit EtOH beginning 1/16, previously 2-3 glasses EtOH 3-4 days per week x 1 yr. No NSAIDS. No n/v, f/c, change in weight, night sweats, LAD, ABD mass. **Assessment and plan:** • Abdominal pain, unspecified abdominal location • Stress at work • Allergic rhinitis, unspecified allergic rhinitis type	59-60	N/A
03/25/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of present illness:** **Patient words:** The patient is a 60 year old female who presents for a nurse visit. The patient states the following (CPE labs for 3/29/YYYY OV) **Assessment and plan:** Routine medical exam **Impression:** The patient was counselled on appropriate sunscreen use and seatbelt safety. She was advised to participate in weight-bearing exercise most days of the week and perform monthly self-breast exams. She should consume 1200mg of calcium daily as part of a well-balanced diet. *Related records: pdf ref: 172-173*	57-58	N/A
03/29/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of present illness:** **Patient words:** CPE Toe patient is a 60 year old female who comes in today for a complete physical exam. This is a nice patient who feels well with minor complaints. Energy level is described as good. Toe patient's stress level is described as an average.	53-56	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Additional reason for visit: Hypertension Follow-Up is described as the following: Overall the patient is doing well. The patient Checking Pressure blood pressure has been well-controlled. The patient has been compliant with their medications and there have been no side effects. **Assessment & Plan**: • Routine medical exam • Hypertension • Osteopenia • Stress at work • GERD without esophagitis		
05/02/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of Present Illness:** **Patient words:** Started Last wed. started with chills then got sore throat Sinus Pressure, and congestion. Jaw pain Tickle in throat. Slight cough taking nasal spray took amoxil last night a during this am **Assessment & Plan**: Acute sinusitis, unspecified **Impression**: will change meds to Augmentin continue decongestant and delsym call if not improving **Current Plans**: Restarted Augmentin 875-125MG, 1 Tablet two times daily, #20, 10 days starting 05/02/YYYY, and No Refill.	51-52	N/A
06/03/YYYY	Hospital/ Provider	**Telephone Conversation:** **Assessment & Plan:** Upper respiratory infection **Current Plans:** Started Levaquin 500MG, 1 (one) Tablet daily, #10, 10 days starting 06/03/YYYY, No Refill.	50	N/A
07/28/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of present illness:** **Patient words:** C/o knee right/side swollen started within a week of being on Levaquin has been doing on for months now R knee hurts to drive walk dog	48-49	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		knee is swollen sore, clicks **Physical exam** The physical exam findings are as follows: **Musculoskeletal** **Knee** **Swelling – Right –** Generalized swelling **Movements – Right –** Range of motion decreased (flex ID 110 deg). **Deformities:** **Right –** No deformities **Other Characteristics – Right –** Moderate effusion and Warm. No Erythema or Crepitus. Note: joint line tenderness **Assessment & Plan**: **Knee pain** **Impression**: Acute knee pain after Levaquin x-ray shows mild OA(Osteoarthritis) without trauma declines aspiration or injection today will treat with ice, rest, elevation, NSAIDS can send to ortho if not improving **Knee swelling** **Current Plans:** Knee x-ray, 2 views –right **Anxiety disorder, unspecified** **Current Plans:** Continued Xanax 0.5MG, 1 (one) Tablet daily as needed, #30		
07/28/YYYY	Hospital/ Provider	**X-Ray of right knee:** **Findings:** Joint spaces are within normal limits. No fracture. No dislocation. No radiopaque foreign body. No significant effusion. **Impression:** Unremarkable exam	170-171	N/A
07/29/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of Present Illness:** **Patient words:** knee pain was seen yesterday for knee pain she used Voltaren gel yesterday, can't tell if it's working yet wants to have her knee drained today **Physical exam** The physical exam findings are as follows: **Musculoskeletal** **Knee** **Swelling – Right –** Generalized swelling	46-47	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Movements – Right – Range of motion decreased (flex ID 110 deg). **Deformities:** **Right –** No deformities **Other Characteristics – Right –** Moderate effusion and Warm. No Erythema or Crepitus. Note: joint line tenderness **Assessment & Plan**: **Knee pain** **Impression**: Acute knee pain after Levaquin x-ray shows mild OA(Osteoarthritis) without trauma will treat with ice, rest, elevation, NSAIDS can send to ortho if not improving **Knee swelling** **Impression**: Right knee joint injection: after verbal informed consent obtained, patient placed in prone position. Knee was prepped in sterile fashion. Ethyl chloride was applied for local analgesia. Joint space was entered with inf lateral approach. 10cc sero sanguinous fluid aspirated. 80mg DepoMedrol injected with 1 cc 1 % lidocaine. The patient tolerated the procedure well with no known complications		
08/23/YYYY	Hospital/ Provider	**Follow-up visit:** **History:** The patient returns after a long absence; now 61, a right-handed marketer for right knee pain and swelling in recent weeks with no one particular injury, although it may have been from helping a friend lift some heavy items a few months ago. She had aspiration/injection by her primary doctor Dr. Pepper but reports it was minimally helpful and she is quite frustrated. **Physical examination:** On exam she is 5 feet 9 inches, 170 pounds, hobbling around on the right knee with significant localized medial joint line tenderness, none laterally. There is mild patellar crepitus and lots of pain with end flexion. No instability. Calf is soft. Skin, pulses, and distal neurologic status are intact. **X-ray:** X-rays of the right knee in four views ordered, obtained, and interpreted by me in the office today demonstrate at most subtle medial compartment narrowing but generally clean**.** **Reviewers comment: The above mentioned original report of X-ray report of right knee is unavailable for review** **Impression:** Right knee pain despite conservative efforts, occult medial meniscus tear versus arthritis**.** **Disposition:** MRI right knee with definitive recommendations to	168-169, 411, 620-621	$296.55

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		follow. We will offer her a patellar sleeve for as needed use. We have discussed general knee care. She does not want medications. *Related records: pdf ref: 480-481, 498-510*		
08/23/YYYY	Hospital/ Provider	**Progress Notes:** This patient was issued the following equipment, medium hinged knee brace as prescribed by Dr. Rosenstein. The patient was measured and fitted for the equipment, and instructed in the proper donning, doffing, use and care of the equipment. Then was no difficulty in applying the product correctly. The patient acknowledged understanding of the instructions provided.	410, 621	$140.00
09/08/YYYY	Hospital/ Provider	**MRI of right knee:** **History:** Right knee pain and swelling**.** **Findings:** There is a small effusion with small caudally, dissecting Baker's cyst. Intact, medial and lateral menisci. The Cruciate and collateral ligaments are intact with preserved quadriceps and patellar tendons. Mild infra patellar bursitis noted. There is moderate chondromalacia with cartilaginous attenuation and irregularity involving the medial patellar facet. Preserved remaining patellar and trochlear cartilage thickness. Mild chondromalacia and cartilaginous attenuation affects the posterior paramedian aspect of the articular surface of the medial femoral condyle with subcortical degenerative cystic changes and reactive marrow edema. Moderate chondromalacia affects the periphery of the poster superior articular surface of the medial femoral condyle with subcortical degenerative cystic changes and reactive marrow edema. Unremarkable lateral compartment. No stress fracture is seen. There is a prominent medial plica. **Impression:** • Intact medial and lateral menisci • Intact cruciate and collateral ligaments and extensor mechanism • Moderate chondromalacia of the medial patellar facet as well as the poster superior articular surface of the medial femoral condyle with subcortical degenerative cystic changes and reactive marrow edema of the latter • No stress fracture detected • Prominent medial plica	372, 621	$1135.00
09/13/YYYY	Hospital/ Provider	**Follow-up visit:** **History:** The patient returns reporting her knee is feeling better. She has had MRI since I have seen her.	409, 167, 622	$125.00

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		Physical examination: On exam she still has some mild localized medial joint line tenderness but it is much improved. She is no longer hobbling. She has some baseline patellar crepitus but minimal effusion. No obvious Baker cyst or fullness posteriorly. No instability. Calf is soft. Skin and pulses are intact**.** **X-ray:** MRI of the right knee since I have seen her is useful in demonstrating no evidence of internal derangement. She does have some chondromalacia both medially and in the patello femoral joint. **Impression:** Early osteoarthritis right knee, back to baseline, feeling well clinically. **Disposition:** Implications discussed in some detail. She looks so good there is no reason to be aggressive. I have recommended rehab services, knee friendly lifestyle, and ice. She prefers no meds, We could consider hyaluronic acids in the future and handouts are given. She likes this plan. *Related records: Pdf ref: 490-493*		
09/21/YYYY	Hospital/ Provider	**Physical therapy visit:** *(Poor quality record)* **Mechanism of injury:** Insidious- unspecified **Current history:** Shoulder unspecified, Left knee plan with ____ **Location of pain:** Left knee cap **Assessment:** Decreased strength, pain, Not independent with HEP, decreased function **Plan**: therapeutic exercises HEP/education	483-484, 489, 622	$188.00
10/28/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** **Patient words:** Here for influenza vaccine **Assessment:** Influenza vaccination administered at current visit	45	N/A
11/10/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** **Patient words**: Fullness in chest, thinks its gas from raw kale intermittent she just got a nuteribullet and was making large kale smoothies she felt a pressure sensation in her chest burping makes it better	43-44	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Stopped smoothies 4 days ago and symptoms are improving. **Assessment**: Dyspepsia **Impression**: She is improving Will give her course of omeprazole for 2 weeks, she has some at home		
02/16/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** The patient is a 61 year old female who presents with neck pain. This condition occurred following a specific injury. The injury occurred 2 day(s) ago. The injury resulted from a motor vehicle accident 2/14/17 she as driving down a small 2 lane country road in Forsyth co. A tractor trailer was in front of her. The truck came to a complete stop and then started to reverse in the road. She states that she stopped as well and started to honk her horn vigorously as she noticed the reverse lights come on the truck. The truck ran into her VW beetle and started to push it down the road. She was retrained, denies head trauma or airbag deployment. No changes in bowels or bladder. Started ID develop muscle pain later that night and it worsened as the days have progressed.). Symptoms include neck stiffness, crepitus (feels/hearins and intermittent 'popping 'sound with cervical rotation), tenderness, impaired range of motion and shoulder pain. Symptoms are located in the left posterior neck and right posterior neck. The pain radiates to the left trapezius, left shoulder, right trapezius and right shoulder. The patient describes the pain as aching and burning. Onset was hour(s) after the injury. The symptoms occur constantly. The patient describes symptoms as moderate in severity and worsening. Symptoms are exacerbated by neck movement. Symptoms are not relieved by ice. Associated symptoms include headache, while associated symptoms do not include upper extremity paresthesias, upper extremity weakness, tinnitus, impaired memory or impaired vision. Current treatment includes ice. The patient is currently able to do activities of daily living without limitations. Note for "Neck pain": Patient also states that she has been anxious about this event "I can still see the underbelly of the truck as it was coming towards me". **Review of system**: **Musculoskeletal**: Present myalgia **Psychiatric**: present- Anxiety (Flash backs of the accident) **Physical exam:** **Cervical spine**: Movements painful, Mildly tender (Bilateral lateral neck as well as bilateral traps) **Assessment & Plan:** Neck pain	40-42	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Impression: Suspect muscle tension/strain. Has good ROM of cervical and lumbar spine. TTP of bilateral lateral neck muscles as well as bilateral trap Do not suspect spinal involvement but will obtain cervical x-rays given the history of an audible popping sound. Advised on NSAIDS and muscle relaxers. Patient states she does not tolerate either very well. Advised to cut dose in half and only use muscle relaxer in the evenings ID prevent drowsiness next AM. Take meloxicam with food. Also advise on ice 15 mins TID for 2 days and then introduce moist heat---soaking in warm Epsom salt Patient asked about massage–advised her to hold off for now and try next week if still in pain. If pain last for longer than 3-4 weeks, will refer to physical therapy **Current Plans** Started Meloxicam 15MG, 1 (one) Tablet daily, #30, 30 days starting 02/16/YYYY, No Refill. Started Cyclobenzaprine Hcl 10MG, 1/2-1 Tablet at bedtime as needed for muscle pain, #30, 02/16/YYYY, No Refill. **Motor vehicle accident** **Impression:** 2/14/17 tractor trailer reversed into her VW beetle at a steppe position. She states that she was restrained and airbags did not deploy and she did not obtain a head trauma nor other injuries. Neck pain started that night. Suspect muscle strain. See above. **Anxiety disorder, unspecified** **Impression:** having flash backs of accident. Having a difficult time sleeping. Request a refill on xanax. **Current Plans** Continued Xanax 0.5MG, 1 (one) Tablet daily as needed, #30 **Addendum Note:** LM for patient on voicemail to f/u on OV and symptoms. Requested that they call the office back with an update on how they are doing. **Addendum Note:** • Informed patient that her c-spine x-ray shows mild degenerative changes with no acute bony abnormality • Patient states that she is still in a lot of pain and the ‘popping” in her neck has worsened has not used meloxicam–states she uses this in the past and it torn her stomach up • Has an appointment to see ortho • Will change to Celebrex in the mean time		
02/16/YYYY	Hospital/	**X-Ray of cervical spine:**	166	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
	Provider	The cervical vertebral body heights are well-maintained. Minimal loss of disc space at C5-6. Cervical vertebral body heights are well-maintained. Alignment is within normal limits. Prevertebral soft tissues unremarkable. Degenerative changes of the uncovertebral joints at C5-6 and C6-C7. Lateral masses of C1 and C2 are in alignment. The odontoid is within normal limits. **Impression**: Mild degenerative changes with no acute bony abnormality.		
02/20/YYYY	Hospital/ Provider	**Telephone Conversation:** **Assessment:** Neck pain **Impression:** Did not tolerate meloxicam. Will try Celebrex	39	N/A
02/22/YYYY	Hospital/ Provider	**Follow-up visit:** **HPI:** Patient is a 61 y/o woman who is here with a chief complaint of right side cervical pain. She was involved in a motor vehicle accident in which she was sitting in her vehicle at a standstill and a tractor trailer hacked up onto the front of her vehicle. Her car was wedged under the back of the truck. Since that time she has had localized pain over the right lateral epicondyle, as well as right side cervical pain. Prior to this accident she had not had any cervical spine problems. Her pain level is rated 7/10. She is bothered by "clicking" on the right side of her neck and it is constant each time she moves her head. She feels better when sitting, standing or walking and keep her head upright. She feds worse when lying down, morning and night. She has been taking Advil, but prefers not to use any stronger medications. She has not had rehabilitation services and there is no history of prior spine surgery or spinal injection procedures. **PE:** Exam shows patient alert and oriented x3. She ambulates independently and her gait is normal. Cervical posture is normal. Range of motion is decreased toward end ranges of rotation toward the right more so than toward the left. Spurling test is negative on both sides. Strength is 5/5 through the upper extremity major motor groups. The biceps, triceps and brachioradialis reflexes arc trace bilaterally. Sensation is intact to light touch without extremity edema noted. There is myofascial tenderness along the upper to mid-cervical paraspinals on the right side. No left paraspinal muscle tenderness noted in the cervical region. There is diffuse tenderness through the trapezius muscles on both sides. **X-ray:** X-rays ordered, performed and interpreted by me in the office today four views of the cervical spine reveal normal	407-408, 482, 623	$397.17

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		vertebral body alignment with mild narrowing of the C5-6 intervertebral disk space. **Reviewer comment : The original report of X-ray of cervical spine is unavailable for review** **Impression:** • Cervical sprain • Mild C5-6 degenerative disk disease **Result:** **I**. X-ray and exam findings discussed, as well as appropriate treatment. Rehab services on the cervical spine was recommended for son tissue and joint mobilization, ROM and HEP. 2. She has some difficulty with prescription NSAIDs. She has Voltaren gel so she was encouraged to use this on an as needed basis. 3. She says she has used Celebrex in the past for previous issue and her primary care physician is already looking into obtaining prior authorization. She will let us know if the prescription needs to be written through our office or if it will be handled by her PCP. 4. Recheck in 4-6 weeks. *Related records: pdf ref: 482, 476-479*		
02/24/YYYY	Hospital/ Provider	**Initial physical therapy evaluation:** *(Hand written notes)* **Diagnosis:** Cervical sprain, Mild C5-6 degenerative disc disease **Mechanism of injury:** Motor vehicle collision **Date of accident**: 02/14/YYYY **Current history**: Semi backed over car. Immediate right cervical pain, no previous problem **Location**: Cervical region- Bilateral **Chief complaint**: Pain/clicking- catch/ release, fatigue **Symptoms** : Movement **Current function**: limited as below **Frequency**: 1-2 times/ week for 4-6 weeks **Plan of care**: Home exercise program, Therapeutic exercises, body mechanics, ____	406, 471-472, 623-624	$251.85

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
03/01/YYYY	Hospital/ Provider	**Follow-up visit:** Missed appointment: No show.	405	N/A
03/22/YYYY	Hospital/ Provider	**Follow-up visit:** **Assessment:** • Routine medical exam **Impression:** Age appropriate cancer screening, cardiovascular risk factors and risk stratification, vaccines, diet, exercise, and anticipatory guidance discussed.	38	N/A
03/30/YYYY	Hospital/ Provider	**Follow-up visit:** **Patient words:** Physical exam a semi backed into her car (VW bug) she is reliving the accident she has appointment to see therapist in 2 weeks No SI/HI. The patient is a 61 year old female who comes in today for a complete physical exam. This is a nice patient who feels well with minor complaints. Energy level is described as good. The patient's stress level is described as an average**.** **Additional reasons for visit:** Hypertension follow-Up: is described as the following: Overall the patient is doing well. Toe patientr2 2 Checking Pressure blood pressure has been well-controlled. The patient has been compliant with their medications and there have been no side effects. **Assessment:** • Routine medical exam • Hypertension • Osteopenia • Gastroesophageal reflux disease without esophagitis • Hyperlipidemia	35-37, 629	$169.00
03/06/YYYY - 03/31/YYYY	Hospital/ Provider	**Summary of interim physical therapy visits:** **Date of visits:** *03/06/YYYY, 03/10/YYYY, 03/14/YYYY, 03/17/YYYY, 03/22/YYYY, 03/24/YYYY, 03/28/YYYY, 03/31/YYYY* **Subjective:** **03/06/YYYY:** Patient states she is very stiff and sore **03/10/YYYY:** Patient states she felt significantly better last visits	396-404, 624-629	$809.10

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		but things stiffened back up **03/14/YYYY:** Patient states her neck is doing better, having back issues today (Slept wrong) **03/17/YYYY:** Patient states her neck is doing better, tractions is helping **03/22/YYYY:** Patient states heart and traction are really helping **03/24/YYYY:** Patient states heart and traction are really helping , low back hurting **03/28/YYYY:** Patient her low back is very painful today, requesting g mechanical traction only **03/31/YYYY:** Patient again states her low back is very painful and is requesting heat and mechanical traction only **Objective:** Area Treated: Cervical Moist heat x 10 min Pre Rx Mechanical traction x 15 minutes. HEP instruction **Assessment:** Patient tolerated treatment Fair. Mechanical traction only today 20 patient's request. Patient is progressing appropriately towards goals. Functional deficits arc secondary to pain, weakness. Loss of ROM, at this lime. **Plan:** Continue with the current plan or care. Progress as tolerated ** Reviewer's Comments: Only the initial and final visits have been elaborated. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.**		
04/04/YYYY	Hospital/ Provider	**Final physical therapy visit:** **Subjective:** Patient states her hack is a little belier hut having increased left arm symptoms. Requests MH and traction only. Patient states she is doing her exercises at home. **Objective:** Area Treated: Cervical Moist heat x 10 min Pre Rx Mechanical traction x 15 minutes. HEP instruction **Assessment:** Patient tolerated treatment Fair. Mechanical traction only today 20	395, 630	$40.00

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		patient's request. Patient is progressing appropriately towards goals. Functional deficits arc secondary to pain, weakness. Loss of ROM, at this lime. **Plan:** Continue with the current plan or care. Progress as tolerated.		
04/05/YYYY	Hospital/ Provider	**Follow-up visit:** **HPI:** Patient returns today for reevaluation or cervical pain and upper extremity pain following an MVA which occurred on 02/14/YYYY. She has been working with a rehab therapist and her symptoms have improved, hut not resolved. Heat and traction seem to be the most helpful at this point. She is independent with the exercise program otherwise. She is also having a lot of tightness and muscular pain through the shoulder blades on both sides and she has abnormal sensation in the fourth and fifth fingers and along the ulnar border of her left hand. **Physical examination:** Exam shows patient alert and oriented x3. She ambulates independently and has a normal gait. Cervical range of motion is mildly reduced at the end ranges of rotation. Spurling test is equivocal on the left; negative on the right. There are no focal motor. Sensory or reflex deficits in either arm. There is a mildly positive Tinel sign over the left cubital tunnel. **X-ray:** Cervical spine x-ray, 02/22/YYYY: Mild narrowing of the C5-6 intervertebral disk space. **Impression:** 1. Cervical sprain secondary to motor vehicle accident on 02/14/YYYY – improving. 2. Left upper extremity pain, cervical radiculitis versus cubital tunnel syndrome or both. **Result:** 1. Treatment options discussed and she will discontinue structured rehabilitation services but continue the exercise program on her own. 2. She has a chiropractor that has seen her periodically over the years and massage therapy is available through their office with a referral. This would be medically appropriate for her to receive therapeutic massage treatment in the cervical and periscapular region. 3. Reevaluate in 4-5 weeks. 4. Left upper extremity EMG/NCS and/or cervical MRI would be our next steps if her symptoms do not continue to improve. 5. She was also given a prescription to obtain a supine cervical home traction unit.	394, 630	$134.12

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
04/24/YYYY	Hospital/ Provider	**Telephone Conversation:** **Message:** Left voice message asking patient to call and schedule EMG/ NCS Spoke to patient and scheduled EMG/NCS with Dr. chambers 05/16	392-393	N/A
04/24/YYYY	Hospital/ Provider	**Follow-up visit:** **HPI:** She follows up today for continued pain in the left shoulder and arm and she is concerned because she is having numbness in the fourth and filth fingers of her left hand. **Physical examination:** Exam shows patient alert and oriented x 3. She ambulates independently and has a normal gait. Tinel test is positive over the left cubital tunnel. Sensation is altered in the fifth finger and the ulnar hat r of the ring linger of her ten hand. There is also decreased cervical range of motion with left side cervical pain noted during rotation and side bending. No focal motor deficits arc present in either upper extremity. Reflexes arc equal in both upper extremities. **Impression:** l. Left cubital tunnel syndrome. 2. Cervical pain with left upper extremity radiculitis. **Result:** 1. Proceed with cervical MRI 2. Proceed with left upper extremity EMG/NCS. 3. She is in the process of obtaining a home traction unit through her rehab therapist. 4. Additional recommendations pending outcome of above studies.	391, 631	$164.12
05/16/YYYY	Hospital/ Provider	**EMG/Nerve Conduction Study:** **Patient Complaints:** Numbness and tingling in the left forearm and hand **Patient History:** Patient is a 61 year old woman who was involved in an MVA on 2/14/YYYY and subsequently developed cervical pain with left arm pain and paresthesias. The paresthesias involve the 5th finger and only the ulnar side of the 4th finger. She also has cervical pain and radicular symptoms which have improved but not resolved with rehabilitation services. NSAIDS and oral steroids. **Impression:** The above electro diagnostic study reveals evidence of left ulnar neuropathy at the elbow. Ulnar inching technique localizes the compression at and just above the left cubital tunnel.	385-389, 631	$365.00

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		There is also left carpal tunnel syndrome (median nerve entrapment at wrist) affecting sensory components. Patient docs not display symptoms of carpal tunnel syndrome at this time. There is no electro diagnostic evidence of cervical radiculopathy in the left upper limb. **Recommendations**: She will be referred to one of our hand and upper extremity physicians for evaluation and treatment for these findings		
05/23/YYYY	Hospital/ Provider	**MRI of cervical spine without contrast:** **History:** Neck pain/radicular symptoms since motor vehicle accident February 2017. **Comparison:** None **Findings:** Limited images or the cervico medullary junction am normal. Cervical cord is normal in course and Caliber. No cord edema. 2 mm retrolisthesis C5 relative to C6 associated with mild disk space narrowing. Disk dehydration present at remaining cervical levels with intact disk heights. No evidence of fracture **C2·3:** No disk bulge. Patent central canal and neural foramina **C3-4:** No disk bulge. Patent central canal and neural foramina **C4-5:** Mild disk space narrowing. No disk bulge, Patent central canal and neural foramina. **C5-6:** Grade 1 retrolisthesis with mild disk space narrowing. Uncovertebral hypertrophy and broad-based posterior osteophyte disk complex with effacement of the ventral thecal sac. Mild facet hypertrophy. Moderate to severe left and moderate right foraminal narrowing. **C6-7:** No disk bulge. Patent central canal and neural foramina **C7-T1:** No disk bulge. Mild facet hypertrophy. Patent central canal and neural foramina **Impression:** 1. C5-6: Grade 1 retrolisthesis with mild disk space n; mowing Broad-based posterior disk osteophyte complex and mild facet hypertrophy resulting in moderate to severe left and moderate right foraminal narrowing. Mild central canal stenosis. Full details throughout the cervical levels as described above. 2. Prominent asymmetric oft apical pleural thickening. Correlation with CT chest recommended to exclude a neoplasm	369, 632	$1225.00

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
05/31/YYYY	Hospital/ Provider	**Follow up visit:** **HPI:** She follows up today to review the findings of a cervical MRI scan. She continues to haw cervical pain extending into the trapezius and periscapular region on both sides, left greater than right. Additionally, she continues to have symptoms of left ulnar neuropathy. She had an EMG/NCS performed by me on 05/16/YYYY which revealed ulnar neuropathy at the elbow. She has already been scheduled to sec Dr. Frank Joseph for evaluation and treatment. **Physical examination:** Limited exam is remarkable for cervical range of motion that is decreased toward end range of rotation. No focal motor deficit is noted with manual muscle testing. **X-ray:** Cervical MRI. 05/23/YYYY, was reviewed personally by me. Images were shown to and discussed with the patient and reveal a grade I retrolisthesis of C5 on C6 with mild narrowing of the disk space. There is a broad-based disk osteophytic complex that effaces the thecal sac and contributes to left greater than right foraminal stenosis. The other levels arc normal in appearance. **Electro diagnostic studies:** Left upper extremity EMG/NCS.05/16/YYYY: Len ulnar neuropathy at the elbow. There is also left carpal tunnel syndrome affecting sensory components. Patient docs not display symptoms of carpal tunnel syndrome. No electro diagnostic evidence of cervical radiculopathy. **Impression:** • C5-6 disk osteophyte complex with left greater than right foraminal stenosis. • Left cubital tunnel syndrome-symptomatic. • Left carpal tunnel syndrome – asymptomatic. **Result:** Options for treatment were discussed. Cervical epidural steroid injection was recommended. Patient declined and says that she would like to just monitor the symptoms for another few weeks and she will call if she should decide to pursue more aggressive care. She is already scheduled to sec Dr. Frank Joseph on 06/06(2017 for evaluation and treatment of left cubital tunnel syndrome, Follow up prn.	384,458-460, 632	$164.12
06/06/YYYY	Hospital/ Provider	**Progress Notes:** This patient was issued the following equipment, Heel Bo, as prescribed by Dr. Joseph. The patient was measured and fitted for	380	$15.00

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		the equipment, and instructed in the proper donning, doffing, use and care or the equipment, Then: was no difficulty in applying the product correctly, The patient acknowledged understanding of the instructions provided.		
06/06/YYYY	Hospital/ Provider	**Follow-up visit:** **Diagnosis:** MVA 02/14/YYYY**.** • Cervical C5-C6 disk osteophytic complex left greater than right with right foraminal stenosis, • Left cubital tunnel syndrome with positive EMG and NCV studies**.** **History:** The patient is being seen today at the request of Dr. Chambers regarding increasing ulnar paresthesias following an MVA on 02/14/YYYY. The patient is working with difficulty. The patient complains of numbness of the ring and little fingers with increasing weakness. An ESI has been recommended by Dr. Chambers, but deferred by the patient who has started cervical traction. **Physical examination:** The patient has a normal station and gait with normal respirations. Exam of the left elbow demonstrates FROM with a positive Tinel, a negative Tinel over the carpal canal, a negative Phalen's test, and a negative Finkelstein test bilaterally. DF/PF is symmetric at 70/85. GS: R 30 kg, L 16 kg. The patient is noted to be healthy. Alert and oriented x3 with normal affect. Flexor and extensor tendons arc intact. Radial pulse is 3+ and symmetric. Digits arc warm and pink. Negative scaphoid shift test. Carpus is well-aligned clinically. DRUJ is stable and non-tender. **Imaging:** X-rays were ordered, performed and interpreted by myself. Three views of the left elbow are negative for Fracture or STC. **Reviewers comment: The above mentioned original x-ray report of left elbow is unavailable for review** **Lab:** EMG and NCV studies arc positive for left cubital tunnel syndrome. **Plan:** Therapeutic options were reviewed. The need for activity	381-383, 633	$258.12

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		modification was reviewed. The patient was lit with an elbow pad. The patient will initiate a towel wrapping program. The patient will RTC in six weeks for reevaluation. The possibility of cubital tunnel decompression was discussed in detail with literature and the nature of surgery was reviewed. *Related records: Pdf ref: 452-456*		
06/07/YYYY	Hospital/ Provider	**Referral Report:** Patient requested a new physical therapy order. Per Venyette Charles. A new order was written. Patient was called and informed.	379	N/A
06/21/YYYY	Hospital/ Provider	**Bilateral digital diagnostic mammogram with CAD:** **Clinical History:** Personal history of left breast cancer, Left lumpectomy in 2010. Comparison is made to exams dated: 6/17/YYYY ultrasound, 6/17/YYYY mammogram, 6/8/YYYY, mammogram, 5/8/YYYY mammogram, and 5/9/YYYY mammogram, 05/11/YYYY mammogram – Breast Care Specialists, L.L.C. Both breasts are heterogeneously dense, which may obscure small masses. Current study was evaluated with a Computer Aided Detection (CAD) system. The left breast is smaller than the right due to lumpectomy. There are post-op and radiation changes. Skin thickening, and skin retraction in the left breast n the medial aspect that correlate with surgical site. There also is a benign appearing calcification in the left breast. No significant masses, calcifications, or other findings are seen in either breast **Benign:** There is no mammographic evidence of malignancy. Ultrasound of both breasts: 6121/YYYY comparison is made to exams dated: 6/17/YYYY ultrasound, 6/17/YYYY mammogram, 6/812015 mammogram, 5/812014 mammogram, 5/9/YYYY mammogram, and 5/11/YYYY mammogram. Breast Care Specialists, L.L.C. Real-time ultrasound of both breasts was performed. No abnormalities were seen sonographically in either breast. **Impression:** Negative – follow-up recommended There is no sonographic evidence or malignancy. A follow-up mammogram in 12 months is recommended.	159-160	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
08/01/YYYY	Hospital/ Provider	**Follow-up visit:** **Diagnosis:** MVA 02/YYYY. 1. Left cubital tunnel syndrome with positive EMG and NCV studies. 2. Left elbow medial epicondylitis. 3. Cervical C5-C6 disk complex. **History:** The patient presents for follow-up with increasing pain, aching and paresthesias, The patient is working with difficulty and would like to proceed with surgery. Discomfort is 6-8/10. **Physical examination**: The patient has a normal station and gait with normal respirations. Exam of the left elbow demonstrates medial epicondylar swelling and tenderness with a positive Tinel over the cubital canal. The lateral epicondylar area is non-tender. Mobile wad is non-tender. There is a negative Phalen's test bilaterally and a negative Finkelstein test bilaterally. DF/PF is symmetric al 70/80. GS: R 30 kg, L 18 kg. The patient is noted to be healthy. Alert and oriented x3 with normal affect. Flexor and extensor tendons arc intact. Radial pulse is 3+ and symmetric. Digits are warm and pink. Negative scaphoid shin test. Carpus is well-aligned clinically, DRUJ is stable and non-tender**.** **Plan:** Natural history was reviewed. The patient will continue with the towel wrapping program. Anticipate the need for left cubital tunnel release with associated medial epicondylar repair as an outpatient. The nature of surgery was reviewed. Anticipate two to four weeks off of work following surgery.	376-378, 634	$164.12
08/28/YYYY	Hospital/ Provider	**Follow-up visit:** **Diagnosis:** MVA 02/YYYY. I. Left cubital tunnel syndrome with positive EMG and NCV studies. 2. Left elbow medial epicondylitis. 3. Cervical C5-C6 disk complex. **History:** The patient presents for follow-up with increasing pain, aching and paresthesias, The patient is working with difficulty and would like to proceed with surgery. Discomfort is 6-8/10. **Physical examination**: The patient has a normal station and gait with normal respirations. Exam of the left elbow demonstrates medial epicondylar swelling	374-375, 634	$164.12

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		and tenderness with a positive Tinel over the cubital canal. The lateral epicondylar area is non-tender. Mobile wad is non-tender. There is a negative Phalen's test bilaterally and a negative Finkelstein test bilaterally. DF/PF is symmetric al 70/80. GS: R 30 kg, L 16 kg. The patient is noted to be healthy. Alert and oriented x3 with normal affect. Flexor and extensor tendons arc intact. Radial pulse is 3+ and symmetric. Digits are warm and pink. Negative scaphoid shin test. Carpus is well-aligned clinically, DRUJ is stable and non-tender. **Plan:** Therapeutic options were reviewed. The patient ha, foiled standard conservative evaluation and care. The decision was made today to proceed with a left cubital tunnel release with a medial epicondylar repair us an outpatient. Morbidity and mortality were reviewed. Anticipate two to four weeks off or work following surgery. We will schedule. H and P was completed.		
09/22/YYYY	Hospital/ Provider	**History and physical:** *(Illegible record)* **Chief complaint:** Left cubital tunnel and medial epicondylitis **Present illness:** left carpel tunnel/ left medial epicondylitis **Physical exam:** Left elbow positive Tinel, __ pain **Impression**: left elbow pain____ *Related records: pdf ref: 252*	251	N/A
09/29/YYYY	Hospital/ Provider	**Operative report of carpel tunnel release- left:** **Physical Exam** Patient is a 62-year-old female. **Surgeon:** Frank R. Joseph M.D. **Pre-op diagnosis:** • Left Cubital Tunnel. Syndrome • Left medial epicondylitis **Post-op Diagnosis:** The same **Procedure Performed:** Left Cubital Tunnel release Medial epicondylar repair **Anesthesia: General**	306-308	$6181.97

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		Operative Note: The patient was taken to the operating room where a standard briefing and timeout was performed. Patient was given appropriate IV preoperative antibiotics. Anesthesia was performed without complications. Standard prep and drape Left The extremity was exsanguinated and the tourniquet was inflated to 250 mmHg. Using 3.5 loupe magnification. Followed by 5.0 loupe magnification. A 6 cm longitudinal, medial incision was made just inferior to the medial epicondyle on the left. Subcutaneous tissue was carefully transected. Multiple branches or the medial ante brachial cutaneous nerve were identified and mobilized with a vessel loop. A proximal to distal dissection of the ulnar nerve was performed, The nerve was noted to be compressed and hyperemic at its apex at Osborne's ligament. The FCU muscle and fascia were appropriately split. Motor branches were identified and protected. Proximal brachial fascia was split A 4 cm section of the medial intramuscular septum was identified and excised, All potential bleeders were etectrocauterized. At this point it was felt that the nerve had been completely decompressed and was stable. No masses or anatomic anomalies were encountered. The motor branches were noted to be intact. The medial epicondylar area was identified. Split longitudinally scar tissue was excised, bone was soaped to a bleeding surface and a formal repair was performed with interrupted 4-0 Vicryl The area was aggressively irrigated with normal saline. Subcutaneous tissue was infiltrated with 025% Marcaine with epinephrine. Subcutaneous tissue was closed in layers with 2·0 and 4-0 Vicryl followed by a standard skin closure and compressive dressing. The tourniquet was released. The patient tolerated the procedure well and was transferred to the recovery room in stable condition Return to Office: Frank Joseph, MD for Recheck at St. Joseph's on 10/10/YYYY at 08:45 AM *Related records: pdf ref: 347-349, 251-254, 355-356*		
10/04/YYYY	Hospital/ Provider	**Follow-up Visit:** **HPI** Patient is status post left cubital tunnel release with medial epicondylar repair 9/29/YYYY Patient returns with some aching and inability to change her dressing **Physical Exam** Patient is a 62-ycar-old female. The patient is noted to be alert and oriented x3 with normal mood. Station and affect. Normal gait. Pulses are +3 and symmetric.	304-306	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Digits are warm and pink. Carpus is well aligned clinically. DRUJ is stable and non-tender, Normal skin texture. No skin ulcers are noted. No evidence of infection. Excellent healing of incision dressing is dry and intact removed no its infection **Assessment/ Plan** Diagnosis and pathophysiology was reviewed at length with the patient. Activity levels were discussed in detail. Follow-up care was reviewed. Appropriate OTC NSAID use was reviewed Dressing changed by myself. Area redressed. Rx of Ambien 5 mg patient will RTC 1 week for reevaluation. Possible rehab 125. Lesion of ulnar nerve – Left: Lesion of ulnar nerve. Left upper limb Ambien 5 mg tablet – Take 1 tablet al bed lime as needed post-surgery Qty: 12 tablet(s) Refills: 0 Return to Office: • Frank Joseph, MD tor Recheck at Roswell on 10/11/YYYY at 0945 AM *Related records: Pdf ref: 344-346*		
10/11/YYYY	Hospital/ Provider	**Follow-up visit:** **Chief Complaint:** **Diagnosis:** Left cubital tunnel release 09/29/YYYY. **HPI:** The patient relates some aching and stiffness. Working but on a limited basis. Current level of discomfort is 2-4/10. **Physical Exam** Patient is a 62-yoar-old female. Excellent healing. Trace swelling. No evidence of infection. Range of motion of left elbow is 30/90. The patient is noted to be healthy, alert and oriented x3 with normal affect. Flexor and extensor tendons are intact, 3+ symmetric radial pulses. Digits are warm and pink. Negative scaphoid shift test. Carpus is well-aligned clinically. DRUJ is stable and non-tender**.** **Assessment/ Plan** Suture end trimmed. Light dressing. Patient strongly encouraged to increase mobilization of the elbow. We will initiate rehab. The patient will RTO 2 weeks for reevaluation. OTC NSAIDs. The patient again is working on a limited basis. 125. Lesion of ulnar nerve: Lesion of ulnar nerve. Left	303-304	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		upper limb • Physical therapy elbow referral· Schedule Within: provider's discretion Side: LEFT Evaluate & Treat: yes Visits per Week: 3 Number of Weeks; 4 Total# of Visits: 12 **Return to Office** • Rakhi Sujeet Gaonkar, OT for Rehab New Patient at Rehab Roswell on 10/16/YYYY at 11:00 AM • Frank Joseph, MD for Recheck at Roswell on 10/30/YYYY at 10:00 AM *Related records: Pdf ref: 341-343*		
10/16/YYYY	Hospital/ Provider	**Occupational Therapy visit:** **Chief Complaint:** Left elbow problem evaluation **Physical Therapy Episodes** **Episode:** Left elbow pain 10/16/17 **HPI:** **Location:** Left **Quality:** Aching; stabbing; hypersensitivity along the surgical incision **Severity:** Pain level 8/10 **Aggravating Factors:** Lifting; gripping: grasping 62 y/o female with s/p left cubital tunnel release done on 9/29/17 .Discharge sutures to 10/4/17 and ref to therapy **PMH:** MVA post Chest injury and complains with L SF, RF , dec sensation **Occupational history:** Event planner , computer work **Hobbies:** Gardening **Physical Exam:** Patient is a 62-year-old female **Elbow-R L** Ext/flex 0/147,-47/118 **Wrist-R L** Flexion: 0/65 0/40 Extension: 0/65 0/60 RD: 0/40 0/15 UD: 0/55 0/40	295-298, 636-637	$246.33

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Forearm R L Pron: 0/60 0/65 Sup: 0/75 0/35 **Finger IF SF** MP 0/60 0/70 PIP 0/80 12/80 DIP 0/70 0/78 R 50 # ,40# 45# LNT Pinch: R L Lat 16# 2 pt 10# 3 jaw 9# **Edema:** **R elbow:** 26.7 cms **L elbow:** 27.0 cms **Sensations:** Numbness in the L SF, RF burning in the elbow **Procedure :Manual Therapy: 15 minutes** The patient received manual therapy consisting of PROM, gentle passive stretches to the wrist **OT evaluation low complex** Occupational therapy low complex evaluation performed **Assessment/Plan:** **Assessment** Rehab Potential: Good Patients presents with the following problems that require skilled rehabilitation: • Pain. • Decreased ROM • Decreased Strength. • Decreased ADL Function. **Plan**: Treatment Frequency/Duration: 3 visit(s)/week for 4 week(s). • Treatment Plan to include but not limited to: Education & HEP • Therapeutic Exercise • Manual Therapy & Joint Mobilization • Modalities 1. Pain in elbow: Pain in left elbow		

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		2. Cubital tunnel syndrome: Lesion of ulnar nerve, left upper limb **Return to office:** • Rakhi Sujeet Gaonkar. OT for Rehab Follow Up at Rehab Roswell on 10/26/YYYY at 12:30 PM • Rakhi Sujeet Gaonkar. OT for Rehab New Patient at Rehab Roswell on 10/30/YYYY at 09:00 AM • Frank Joseph, MD for Recheck at Roswell on 10/30/YYYY at 10:00 AM		
10/26/YYYY	Hospital/ Provider	**Occupational Therapy visit:** **Chief Complaint:** Elbow Problem Daily **Physical Therapy Episodes** **Episode:** Left elbow pain 10/16/17 **HPI:** **Location:** Left **Quality:** Aching; stabbing; hypersensitivity along the surgical incision **Severity:** Pain level 8/10 **Aggravating Factors:** Lifting; gripping: grasping 62 y/o female with s/p left cubital tunnel release done on 9/29/17 .Discharge sutures to 10/4/17 and ref to therapy **PMH:** MVA post Chest injury and complains with L SF, RF , dec sensation **Occupational history:** Event planner , computer work **Hobbies:** Gardening **Physical Exam:** Patient is a 62-year-old female **Elbow-R L** Ext/flex 0/147,-47/118 **Wrist-R L** Flexion: 0/65 0/40 Extension: 0/65 0/60 RD: 0/40 0/15 UD: 0/55 0/40 **Forearm R L** Pron: 0/60 0/65 Sup: 0/75 0/35 **Finger IF SF** MP 0/60 0/70	292-295, 637	$95.33

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		PIP 0/80 12/80 DIP 0/70 0/78 R 50 # ,40# 45# LNT Pinch: R L Lat 16# 2 pt 10# 3 jaw 9# **Edema:** **R elbow:** 26.7 cms **L elbow:** 27.0 cms **Sensations:** Numbness in the L SF, RF burning in the elbow **Procedure :Manual Therapy: 20 minutes** The patient received manual therapy consisting of gentle passive stretches to the elbow and the wrist in supine position, scar massage, desensitization **Hot/Cold Pack: 10 minutes** Treatment of Moist Heat was applied during post –treatment for the above noted minutes. Pre and post skin checks performed with no adverse reaction. **Assessment/Plan:** **Assessment** Patient continues to present with hypersensitivity along surgical incision .Fair tolerance to passive stretches to the elbow and the wrist. Surgical incision is healing well but presents with scar tissue. **Plan** Next visit will focus on desensitization and rom to benefit the patient's functional limitations noted today. 1. Pain in elbow: Pain in left elbow 2. Cubital tunnel syndrome: Lesion of ulnar nerve, loft upper limb **Return to Office** • Frank Joseph, MD for Recheck at Roswell on 10/30/YYYY at 10:00 AM • Rakhi Sujeet Gaonkar. OT for Rehab New Patient al Rehab Roswell on 11/01/YYYY at 01:30 PM		
10/30/YYYY	Hospital/ Provider	**Follow-up visit:** **Chief complaint:** None recorded	290-292	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		HPI: **Diagnosis:** Cubital tunnel release 09/29/17. **History:** Moderate aching. Some incisional hypersensitivity**.** **Physical exam:** Patient is a 62-year-old female. Incision is well healed. There is no focal Tinel, but the incision is tender. Patient lacks 10 degrees of extension with full flexion. No instability or evidence of infection. Normal station, gait, and respirations. The patient s noted to be healthy, alert and oriented x3 with normal affect. Flexor and extensor tendons are intact, 3+ symmetric radial pulses. Digits are warm and pink. Negative scaphoid shift test. Carpus is well-aligned clinically, DRUJ is stable and non-tender **Assessment/Plan:** Patient will continue with rehab to include desensitization. Rx of Voltaren gel. Patient is working. RTO 6 weeks for reevaluation. OTC NSAIDs. Lesion of ulnar nerve: Lesion or ulnar nerve, left upper limb **Return to Office** • Rakhi Sujeet Gaonkar, OT for Rehab Follow Up at Rehab Roswell on 11/01/YYYY at 01:30 PM • Frank Joseph. MD for Recheck at Roswell on 12/11/YYYY at 10: 15 AM *Related records: Pdf ref:338-340*		
12/11/YYYY	Hospital/ Provider	**Follow-up visit:** **Chief complaint:** Follow up: lesion of ulnar nerve 0/10 Left side occasional pain right elbow pain now hurting **HPI:** Diagnosis: MVA 02/14/YYYY. 1. Left cubital tunnel release 09129/YYYY. 2. Right lateral epicondylitis, new diagnosis. **History:** The patient presents for follow-up. Left elbow is feeling better. Paresthesias arc improving. The patient relates persistent right elbow pain since the day of the injury and is now requesting evaluation and care. The patient relates difficulty gripping and lifting. The patient is working. **Physical Exam**	287-290, 637	$258.12

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Patient is a 62-vear-old female. Normal station, gait, and respirations. Left elbow is well healed with minimal swelling. Negative Tinel. FROM. No instability. Exam of right elbow demonstrates classic lateral epicondylar tenderness with swelling. Mobile wad is non-tender. FROM. Negative Tinel over the cubital canal. Negative Phalen's test bilaterally. Negative Tinel bilaterally. Negative Finkelstein test bilaterally. The patient is noted to be healthy, alert and oriented x3 with normal affect. Flexor and extensor tendons are intact. 3+ symmetric radial pulses. Digits are warm and pink. Negative scaphoid shift test. Carpus is well-aligned clinically. DRUJ is stable and non-tender. **Imaging:** X-rays were ordered, performed, and interpreted by me. Three views of the right elbow are negative for OA or STC. Some slight osteopenia is noted. **Reviewers comment: The above mentioned original X-ray report of right elbow is unavailable for review** **Assessment/Plan** Natural history reviewed. Pros and cons of injection or MRI discussed. Patient encouraged to start using Voltaren gel on the right. RTC in 6 weeks for reevaluation. Should right elbow continue to be symptomatic. Would be inclined to proceed with MRI and/or injection. Possibility of rehabilitation was specifically discussed on the right but deferred per patient. 1. Lesion of ulnar nerve: Lesion of ulnar nerve, left upper limb 2. Lateral epicondylitis – Right: Lateral epicondylitis. Right elbow 3. Pain in elbow: Pain in right elbow **Return to Office:** Frank Joseph. MD for Recheck at Roswell on 02/05/YYYY at 10:15 AM *Related records: Pdf ref: 335-337*		
01/08/YYYY	Hospital/ Provider	**Follow-up Visit:** **History of present illness:** **Patient words:** sinus infection**?** Patient mentioned that there is pressure in her face, and discomfort in her right ear. The patient is a 62 year old female who presents with sinusitis. Feeling well until symptoms started 2 days ago sinus congestion; right sided sinus pressure without much mucus production	33-34	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		right ear pain/pressure symptoms worsening, chilled **Assessment & Plan:** Acute maxillary sinusitis**,** Hypertension **Impression:** 62 y/o female with right sided sinus congestion/pressure, right ear pressure x 2 days – symptoms worsening, not much mucus production. Afebrile, right sided sinus tenderness to palpation; congestion; lungs CTAB Suspect viral etiology. Explained to patient that most upper respiratory, throat**,** and sinus infections are viral in etiology and typically should resolve in 7-10 days, maximum of 14 days. Antibiotics do not help with viral infections and may lead to antibiotic resistance if overused, thus will hold antibiotic treatment at this time. Augmentin written for if symptoms continue to worsen (patient requests for abx) Encouraged patient to use symptomatic therapy including Mucinex, Tylenol or Advil, fluids, and rest. Patient to call back if not improving or any concerning symptoms.		
Summary of Post motor vehicle collision ***Date of collision: 03/23/YYYY***				
03/23/YYYY	Hospital/ Provider	**Emergency room visit:** **Arrival time:** 17:05 hours **Triage:** Less urgent **Vital signs:** **Pulse:** 92 beats/ minute **Respiration:** 16 breaths/ minute **Blood pressure:** 165/85mmhg **SpO2:** 97% **Pain:** 6/10 **GCS**: 15 **Chief complaint:** Motor vehicle collision **Mode of arrival:** Transported by EMS- Gwinnett County **Reviewers comment: The above mentioned EMS report of Gwinnett County is unavailable for review** **Onset of symptoms**: 30 minutes ago Patient reports to emergency department complains of neck tightness and left ear pain after being rear ended in MVA,. Patient	140-146	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		reports she was restrained driver, no LOC, no Airbag deployment. Nursing assessment: **General Presentation:** Appears in no acute distress. Fully verbal**.** **HEENT:** Eyes, ears and nose without visible drainage or Injury. Swallowing without difficulty **Pulmonary:** Bilateral breath sounds clear. Respirations regular end unlaboured. Mucous membranes and nail beds pink. **Circulatory/Cardiac:** Pulse present and regular. Capillary refill less than 2 seconds **Neurologic:** Alert end oriented· person, place, and time. Speech clear. Responds to commands. Moves all extremities **Skin/Soft Tissue:** Skin is warm, dry and intact with normal color and turgor. There is pain noted over the C spine and posterior neck. Neurovascular exam intact**.** **Musculoskeletal/ Extremities:** ROM intact for al extremities, no muscle weakness. Normal ambulatory status. **Nursing Notes:** Patient ambulated to the bathroom with steed and even gait Patient received Ativan in CT room for anxiety. Good airway Patient given crackers and water. Tolerating well **Clinician history of present illness:** **Summary** The patient is a 62 year old female who presents to the ED today for a MVA. Today the patient was a restrained driver when she was rear ended. Immediately she states that she experienced neck pain, she states that her head was turned so when she was hit it caused her neck to jerk. The airbags were not deployed. She complains of a left aided headache, left ear pain but denies dizziness. She has a medical history of hypertension and breast cancer; she is now cancer free and received chemotherapy and radiation for 1 year. She has a surgical history that consists of left breast lumpectomy, appendectomy, tonsillectomy, and left elbow surgery. No other associating symptoms and modifying factors were reported upon examination. No history to suggest any head injury. This is note job related problem. History comes from patient. Have reviewed and agree with RN note. Able to get a good history. Presenting problem started hour(s) ago.		

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Patient problems: • Benign hypertension • Anxiety • Status post MVA • Closed Injury of head • Posttraumatic headache • Injury of neck **Review of systems:** He has headache. Has neck pain. No fever. No double vision **Reviewers comment: The diagnostic reports are elaborated in detail below** **Primary diagnosis**: • Status post MVA • Closed injury of head • Injury of neck • Posttraumatic headache • Left apical radiation fibrosis and of left upper lung **Disposition:** **Decision**: Discharge **Condition at discharge**: Stable Patient ambulated out of ED without difficulty Discharge to home. Patient left via private vehicle as a passenger **Discharge prescriptions:** • Cyclobenzaprine tablet 10 mg 1 tablet(s) By Mouth Every 8 Hours • Tramadol tablet 60 mg 1 tablet(s) By Mouth Every 8 Hours • Zofran ODT tablet, disintegrating 4 mg 1 tablet(s) Orally Every 8 Hours *Related records: Pdf ref: 147-150*		
03/23/YYYY	Hospital/ Provider	**CT of Angio Neck with-without contrast & post:** **Indication:** MVA; head and neck injury; left-sided headache and neck pain; opacified left lung apex; history of breast cancer **Findings:** The imaged intracranial contents are normal. The imaged paranasal sinuses and mastoid air cells are clear. No lesions are present within the mucosal space. The	151-152	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		parapharyngeal fat is symmetric. No masses are appreciated within the carotid, parotid, masticator spaces. The tonsils are symmetric. There is no evidence of a mass within the floor the mouth or the mobile tongue. The submandibular glands are symmetric. There is no significant adenopathy. There is a smooth appearance to the epiglottis and aryepiglottic folds. There is no evidence of a mass in the region the true vocal cords. The laryngeal cartilages are intact. The thyroid gland is grossly normal. Posterior left lung apex demonstrates consolidation with air bronchograms. This may be due to inclusion within radiation field. CT angiography demonstrates a normal variant branching pattern to the great vessels. Left vertebral artery directly arises from the aortic arch. Origin of the left subclavian artery demonstrates nonspecific mild wall thickening. There is no evidence of the stenosis at their origins. There is no evidence of a stenosis at the origin of the vertebral arteries and there is antegrade flow bilaterally. The common carotid arteries are of normal caliber. There is no evidence of a significant stenosis in either carotid bifurcation. There is enhancement in the distal vertebral arteries. There is enhancement of visualized portions of basilar artery. **Impression:** 1. Posterior left apical consolidation, possibly secondary to radiation therapy. Comparison with prior outside facility chest radiograph is recommended to assess chronicity. Follow-up to complete resolution is otherwise recommended. 2. Nonspecific mild thickening of the wall involving left subclavian artery origin. 3. Otherwise, normal CTA of the neck vessels.		
03/23/YYYY	Hospital/ Provider	**CT of cervical spine:** **History:** MVA/ injury **Comparison:** None **Findings:** All 7 cervical vertebrae are visualized and aligned. No fracture or subluxation. Prevertebral soft tissue is normal. Degenerative changes are present including spur and ossicle formation at the anterior atlantoaxial joint. There is disc space narrowing at C5-6. Alignment is straightened.	153-154	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		There is opacification of the left lung apex. Minimal aerated lung is observed anteriorly. **Impression:** l. No acute fracture or subluxation. 2. Mild degenerative changes. 3. Straight alignment which may be secondary muscle spasm, positioning or soft tissue injury. 4. Opacification of the left lung apex. Chest x-ray or CT cheat may evaluate further. Clinical correlation is recommended. If clinical suspicion persists, MRI may be more sensitive.		
03/23/YYYY	Hospital/ Provider	**CT of chest with contrast:** **History:** MVA/ left apical CAP on chest x-ray **Comparison:** None **Findings:** Lower neck showed no acute abnormalities **Lung and Pleura:** Consolidation with air bronchograms and straight margin posterior left lung apex most likely arises from lying within radiation field. No pleural effusion. Tracheobronchial tree showed no acute abnormalities. Mediastinal and hilar structures: have normal contour. No abnormal masses or inflammatory changes. No significant lymphadenopathy. Heart/Great Vessels: Normal heart size and contour. No pericardial effusion. Normal great vessels. Coronary Artery Calcification: None. Cheat wall: Normal. The visuali2ed upper abdomen showed no focal abnormality though the upper abdomen was not specifically evaluated on this cheat study. No musculoskeletal abnormalities. **Impression:** 1. Consolidation with air bronchograms and straight margin and posterior left lung apex is most likely due to previous radiation. 2. No pleural fluid	155-156	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		3. No evidence of acute vessel, organ, or bone injury**.**		
03/23/YYYY	Hospital/ Provider	**CT of head without contrast:** **History:** MVA/ injury **Comparison:** None **Findings:** The ventricles are normal in size and configuration. No focal intra parenchymal lesions are present. No acute hemorrhage. There is no evidence of midline shift or mass effect. No extra-axial fluid collections are present. The visualized paranasal sinuses and mastoid air cells are clear. The intraorbital contents are grossly normal in appearance. No hemorrhage, mass lesion, or acute infarction is demonstrated. There is hyperostosis frontalis interna. **Impression:** 1. No acute findings on non-contrast CT scan of the head. If patient develops a persistent neurologic deficit, further evaluation with MRI with diffusion weighted imaging may be of assistance.	157	N/A
03/23/YYYY	Hospital/ Provider	**X-Ray of chest:** **History:** MVA/ Abnormal CT left lung apex **Comparison:** None **Findings:** There is a homogeneous left apical cap which could represent sub pleural hematoma or chronic pleural and parenchymal scarring. No pneumothorax. Lungs are otherwise clear. Cardio mediastinal silhouette appears unremarkable. **Impression:** 1. There is a homogeneous left apical cap which could represent sub pleural hematoma or chronic pleural and parenchymal scarring. No pneumothorax.	158	N/A
03/29/YYYY	Hospital/ Provider	**Office visit:** **Chief complaint:** HTN follow up, Request refill of Xanax for anxiety- helps sleep The patient is a 62 year old female who presents for follow-up of hypertension. And has not been checking blood pressures. The patient has been compliant with their medications and there have	31-32	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		been no side effects. There has been no associated chest pain, headache or edema. Note for "Hypertension Follow-Up": 195/110 at Gwinnett Medical ER 6 days ago; 147/110 upon discharge per patient **Assessment & Plan:** Hypertension **Impression:** Within normal limits today on Lisinopril-HCTZ suspect anxiety highly contributes to her BP elevations Encourage regular exercise of at least 30 minutes three times/week, weight 105.5, and low salt diet (1,500mg/day). Advice limited alcohol intake. Patient is to monitor BP readings outside the office with arm cuff and call if> 140/90 consistently. **Reviewers comment: Since this visits is unrelated it's not elaborated in detail**		
03/29/YYYY	Hospital/ Provider	**Follow-up visit:** **Chief Complaint:** Neck/C-spine problem Rear ended on 03/23/18, Neck pain with clicking, stiffness **HPI:** Patient is a 62-year-old woman who is well known to me but is being seen today for a new problem. She was involved in a motor vehicle collision on 3/23/YYYY. She was at a complete stop with her head turned to the left checking for traffic when an automobile rear-ended her. She was taken by ambulance to Gwinnett medical where she was evaluated with CT scan and given prescription medications and eventually released. She has continued to have constant pain in the neck with a clicking sensation. She is not having numbness or tingling down the arms. She rales her pain level 7 out of 10. Aching in quality. **Reviewed Problems** • Lesion or ulnar nerve-Onset: 05/31/YYYY • Displacement of cervical intervertebral disc – Onset: 05/31/YYYY • Cervical disc disorder – Onset: 02/22/YYYY • Neck pain – Onset: 04/05/YYYY • Closed fracture of surgical neck of humerus Onset: 06/05/YYYY • Neck sprain· Onset: 02/22/YYYY **Review of system:** Positive for anxiety and fatigue **Physical Exam** Patient is 62·year·old female**.** **General Appearance**: Patient appears their stated age. Alert and oriented x 3. Affect is appropriate**.** **Cervical exam:** Inspection shows head held in a normal posture.	285-287, 638	$394.77

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		There are no obvious skin changes, atrophy, or asymmetry. Palpation shows tenderness to palpation of the paraspinals, Range of motion shows normal motion inflexion, extension and decreased toward end ranges of rotation and bilateral side bending. **Upper extremity exam**: Inspection shows no evidence of significant skin changes, atrophy, or asymmetry. Palpation shows no tenderness. Range of Mot on shows normal motion of the shoulders, elbows, and wrists. Stability: No evidence of ligamentous laxity/instability. No crepitus noted. Strength: Manual muscle testing shows 5/5 strength throughout the major muscle groups of the upper extremities. **Neurological** Sensation is intact to light touch throughout the upper extremities. Deep tendon reflexes: 2 + biceps, 2·+ brachioradialis, and 2t- triceps bilaterally. **Provocative Maneuvers**: Spurling's is negative bilaterally. **Cardiovascular**: Distal pulses are palpable. **Lymph Node**: No palpable lymphadenopathy **Assessment/ Plan** **Imaging**: 4 views of the cervical spine ordered, performed and interpreted by me today shows normal vertebral body alignment with mildly diminished cervical lordosis. There is narrowing of the disc space al C5-6. **Reviewers comment: The original X-ray report of cervical spine is unavailable for review** **Assessment**: 1. Acute cervical sprain secondary to rear end motor vehicle collision on 3/23/18. Patient was doing well prior to the accident and not experiencing any of her current symptoms. 2. Mild degenerative disc disease at C5-6 **Recommendations**: 1. X-ray and exam findings were discussed and her symptoms appear to be myofascial in nature, She has a massage therapist that she has worked within the past and she like to try this to see if this can ease her symptoms. She also attended rehabilitation services for the cervical spine previously so she understands how to perform the exercises independently. 2. I will provide her a referral for rehabilitation services in the event the treatment outlined above is not completely effective 3. Medrol Dosepak to be taken as directed 4. Recheck in 6 weeks. Sooner if needed		

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Neck pain: Cervicalgia Cervical spine 4 views **Acute cervical sprain: Sprain of ligaments of cervical spine. Initial encounter** Physical therapy neck referral – Schedule Within: provider's discretion Evaluate & Treat: Cervical spine Visits per Week: 1-2 Number of Weeks: 6 Total# of Visits: 12 Exercises: Stretching, ROM. Flexibility, Strengthening as Modalities: Yes, as needed. Include dry needling as appropriate. HEP appropriate Manual Therapy: Joint and Soft tissue mobilization techniques. And traction • Medrol (Pak) 4 mg tablets in a dose pack – Take as directed on patient instruction card Qty: 1 dose-pack(s) of 21 Refills: Return to office to see Krystal Chambers, MD at St. Joseph's on or around 05/10/YYYY *Related records: Pdf ref: 243-246, 332-334*		
04/05/YYYY	Hospital/ Provider	**Initial physical therapy visit:** **Chief Complaint:** Neck/Cervical Problem Evaluation **Physical Therapy Episodes:** **Episode:** Neck pain S/P MVA/pain/dec ROM 4/5/18 **HPI:** Patient was in MVA 2 weeks ago, hit from behind with left side of her head hilting the headrest. Immediate pain and to the ER. She was seen here last year for cervical issues but had been doing very well and had stayed consistent with HEP, History of breast CA, 2000. General health is good. Pain is constant. Achy at 8/10. Pain is across upper back into cervical paraspinals, jaw and right SCM with no UE symptoms, Pain will decrease slightly with neat and ice. **Physical Exam** Patient is a 62-year-old female, Severe loss of cervical extension. Moderate loss of flexion and bilateral rotation. Some centralization with retractions. Tight and tender throughout upper back**.** **Strength:** WNL (Within normal limits) **Exercise**	282-285, 638-639	$320.85

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		MVA with cervical pain: 1 of 60 Cervical rotation x 10 Shrugs x 10 Retractions supine x 10 **Procedure Documentation** **Therapeutic Exercise:** 20 minutes The patient performed therapeutic exercise to develop strength. ROM and flexibility. See exercise log for specific information. **Hot/Cold Pack**: 10 minutes Treatment of Cold Pack was applied during post –treatment for the above noted minutes. **PT Eval Low Complex:** Physical Therapy Low Complex Evaluation performed. **Cervical Cold Pack:** Cervical Cold Pack was supplied to the patient for home use. **Oversize Cold Pack:** Oversize Cold Pack was supplied to the patient for home use. **Assessment:** **Rehab Potential:** Good **Patients presents with the following problems that require skilled rehabilitation:** • Pain. • Decreased ROM. • Decreased Strength. • Decreased ADL Function. **Plan:** Patient is scheduling dry needling for next week**.** **Treatment Frequency/Duration:** 2 visit(s)/week for 6 week(s). **Treatment Plan to include but not limited to:** • Education & HEP • Therapeutic Exercise • Manual Therapy & Joint Mobilization • Modalities **Return to Office** • Jonathan Koontz, PT for Rehab Dry Needling at Rehab Roswell on 04/10/YYYY at 10:00 AM • To see Krystal Chambers. MD at St. Joseph's on or around 05/10/YYYY		

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		• Krystal Chambers, MD for Recheck at SL Joseph's on 05/10/YYYY at 01:15 PM		
04/12/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** **Patient words:** Patient is here for CPE. The patient is a 62 year old female who presents for a physical exam. General health: feels well with no complaints (seen 3 weeks ago after MVA and BP was elevated in ambulance. BP since has been ok. Patient feeling fine since then. Saw Dr. Chambers with Resurgens for f/u neck-referred to PT and did dry needling and she is doing well.). The patient's appetite is normal. Nutrition: normal/adequate. **Additional reasons for visit:** Breast cancer is described as the following: Note for "Breast cancer": left lumpectomy with Dr Amerson 2000, chemo (Adriamycin and Cytoxin) and radiation with Dr bowen 3 years Tamoxifen, then changed to Femara Mammogram/ultrasound yearly June. **Assessment & Plan:** Routine medical exam **Impression:** CBC/comp normal with Dr bowen a few weeks ago chest x-ray with Gwinnett medical utd mammogram/pap/colonoscopy/dexa **Reviewers comment: Since this visits is unrelated it's not elaborated in detail**	27-30	N/A
05/10/YYYY	Hospital/ Provider	**Follow-up visit:** **Chief Complaint:** Neck/C-spine problem **History:** Has had about 6-8 sessions of PT. she feels the traction and dry needling helps. The dry needling hurts at the time but does relax the area afterwards. She is unable to sleep at night and wonders if there are some suggestions for that. The MDP was picked up but she has not taken it due to an upcoming physical and her concern about false-positives. **HPI:** Pain is mostly constant (7-8/10) in neck area that radiates into upper back with not radiating symptoms into the arms. She mentioned that she feels Knots in her neck at times. Dry needling helps, ice, rest and heat helps ease the discomfort. Turning her head and lying down makes it worse. **Reviewed Problems** • Lesion or ulnar nerve-Onset: 05/31/YYYY	276-279, 639	$164.12

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		• Displacement of cervical intervertebral disc – Onset: 05/31/YYYY • Cervical disc disorder – Onset: 02/22/YYYY • Neck pain – Onset: 04/05/YYYY • Closed fracture of surgical neck of humerus · Onset: 06/05/YYYY • Neck sprain· Onset: 02/22/YYYY **HPI:** Patient follows up today for pain in cervical spine extending in her trapezius muscles on both sides and up her neck. She is not having any pain numbness or tingling down the arms. The symptoms came about after being involved in a motor vehicle accident on 3/23/YYYY. She did not take the oral steroids because she had a pending physical. She had a couple sessions of rehabilitation services. Dry needling helped her periscapular and trapezius pain but did not help the upper cervical pain. The upper cervical muscular pain responded better to manual Traction/manipulation. **Review of system:** Positive for anxiety and fatigue **Physical Exam** Patient is 62·year·old female**.** Exam shows a normal cervical posture. Range or motion is decreased with rotation bilaterally. There are no focal motor deficits with manual muscle testing in either upper extremity. The reflexes are trace to 1+ in both upper extremities and equal. There is diffuse myofascial tenderness in the cervical paraspinals and upper trapezius muscles on both sides **Assessment/ Plan** **Imaging:** 4 views of the cervical spine ordered, performed and interpreted by me today shows normal vertebral body alignment with mildly diminished cervical lordosis There is narrowing of the disc space at C5-6. **Assessment:** 1. Acute cervical sprain secondary to rear end motor vehicle collision on 3/23/18. Patient was doing well prior to the accident and not experiencing any of her current symptoms. 2. Mild degenerative disc disease at C5-6 **Recommendations:** 1. Patient is continuing to have symptoms but has had limited rehabilitation visits. I like for her to continue working with a rehab therapist 1-2 times weekly over the next 6 weeks 2. She will go ahead with the Medrol Dosepak as previously recommended 3. We talked about modifications to her pillow arrangement 4. She will try melatonin for sleep 5. Recheck		

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		in 4-6 weeks, Patient left today after all concerns and questions were addressed **Pain in cervical spine: Cervicalgia** Physical therapy neck referral – Schedule Within: provider's discretion Evaluate & Treat: Cervical spine Visits per Week: 1-2 Number of Weeks: 6 Total# of Visits: 12 Exercises: Stretching, ROM. Flexibility, Strengthening as appropriate. HEP Modalities: Yes, as needed. Include dry needling as. Appropriate Manual Therapy: Joint and Soft tissue mobilization techniques and traction Return to office to see Krystal Chambers, MD at St. Joseph's on or around 05/10/YYYY Krystal chambers, MD for recheck at St. Joseph's on 06/28/YYYY at 01:15 pm *Related records: Pdf ref:241, 328-330*		
06/11/YYYY	Hospital/ Provider	**Bilateral digital diagnostic mammogram with CAD:** **Clinical History:** Left lumpectomy in 2010. Comparison is made to exams dated: 6/21/YYYY ultrasound, 6/21/YYYY mammogram, 6/17/YYYY mammogram, 6/8/YYYY, mammogram, 5/8/YYYY mammogram, and 5/9/YYYY mammogram • Breast Care Specialists, L.L.C. Both breasts are heterogeneously dense, which may obscure small masses. Current study was evaluated with a Computer Aided Detection (CAD) system. The patient is status post lumpectomy of the left breast at 9 o'clock. No significant masses, calcifications, or other findings are seen in either breast. **Impression:** Benign There is no mammographic evidence of malignancy or recurrence. A follow-up mammogram in 12 months is recommended.	137	N/A
06/11/YYYY	Hospital/	**Ultrasound of both breasts:**	138	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
	Provider	**Clinical history:** Left lumpectomy in 2010. Comparison is made to exams dated: 6/21/YYYY ultrasound, 6121/YYYY mammogram, 6/17 /YYYY mammogram, 6/812015, mammogram, 5/8/YYYY mammogram, and 5/9/YYYY mammogram – Breast Care Specialists, L.L.C. Ultrasound of both breasts was performed. The patient is status post lumpectomy of the left breast at 9 o'clock. Normal appearing fibro glandular elements and fatty lobulations are shown throughout. No solid or cystic mass, shadowing focus or echo texture alteration is identified. **Impression:** Benign – follow-up recommended There is no sonographic evidence of malignancy. A follow-up mammogram in 12 months is recommended**.**		
07/30/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief Complaint:** Neck/C-spine problem Neck aches comes and goes. Unable to start therapy, due to cost. Neck is better after using special pillow. **HPI:** Patient follows up today for reevaluation of cervical spine pain which came about following a move vehicle accident. She was unable to start therapy due to cost. Her cervical symptoms are actually somewhat better and she attributes this to using a cervical pillow. Her pain is not gone but rather She experiences a constant lower level or cervical pain. She is not having numbness or tingling in the arms. **Physical Exam** Patient is a 63-year-old female. Cervical posture is normal with full motion. Pain at the end ranges of rotation and sidebendinq, There are no obvious motor deficits in the upper extremities. **Assessment/ Plan:** **Imaging:** 4 views of the cervical spine ordered. Performed and interpreted by me today shows normal vertebral body alignment with mildly diminished cervical lordosis, There is narrowing of the disc space at C5-6. **Assessment:** 1. Acute cervical sprain secondary to rear end motor vehicle collision on 3/23/18. Patient was doing well prior to the accident	274-276, 639	$98.4808

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		and not experiencing any of her current symptoms. She has been unable to proceed with rehabilitation services due to cost. She reports having some difficulty getting the insurance company for the driver at fault to cover her expenses. She is in the process of getting a new attorney. 2. Mild degenerative disc disease at C5-6 **Recommendations:** 1. New orders for rehabilitation services were provided 2. No medication prescriptions were needed today 3. Reevaluate 4-6 weeks after she starts rehab services 4. Patient expressed understanding and left today after all concerns were addressed **Neck pain: Cervicalgia** Physical therapy neck referral – Schedule Within: provider's discretion Evaluate & Treat: Cervical spine Visits per Week: 1-2 Number of Weeks: 6 Total# of Visits: 12 Exercises: Stretching, ROM. Flexibility, Strengthening as appropriate. HEP Modalities: Yes, as needed. Include dry needling as. Appropriate Manual Therapy: Joint and Soft tissue mobilization techniques. And traction *Related records: Pdf ref:240, 324-326*		
04/10/YYYY - 10/08/YYYY	Hospital/ Provider	**Summary of interim physical therapy visits:** **Date of visits:** *04/10/YYYY, 09/18/YYYY, 09/27/YYYY, 10/08/YYYY* **04/10/YYYY:** Patient arrives for dry needling of cervical spine. Consent form signed. Potent al risks reviewed, and all questions answered. Patient wishes to proceed with intervention. **Assessment** Dry needling performed in standard fashion without complications. Patient educated on potential side effects as well as expectations. Patient to call with any questions or concerns. In general, The patient is progressing as expected with treatment and POC. Patient tolerance/response to treatment: well Due to continued symptoms noted above the patient requires continued skilled rehabilitation. Anticipate the next encounter will fall appropriately in the treatment pathway.	279-282, 271-274, 268-271, 265-268, 639-640	$561.10

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Plan Next visit will focus on repeated movements and exorcises/dry needling as indicated to benefit the patient's functional limitations noted today. **09/18/YYYY:** Patient has returned. She has not recovered from her MVA yet. She gets massages and they help but she continues with bilateral neck pain up to occiputs and upper chest pain. No N+ T, no UE symptoms. Pain is worse at end of work day. **09/27/YYYY:** Patient continues to complain of bilateral cervical spine tightness, trigger points. Patient has elevated anxiety about cervical ROM. **10/08/YYYY:** Patient states neck not a whole lot better. She lost her HEP and has been doing what she remembers **Physical Exam:** Patient is a 63-year·old female**.** **AROM:** Minimum and painful loss of L rot and extension. Her side bends are both a mod loss with obvious tight bands of upper traps popping up and rebound pain on way back up. **Assessment:** Patient's pain appears to be coming from tight upper traps. She has no relief or increase in ROM with mechanical ex. Her upper traps really fatigued with the elevation ex and she could barely do 2 sets with 1# hand weights. Patient performed treatment session today requiring an expected amount of physical and/or verbal Input from the clinician. Patient is progressing with rehab well based on current performance and progress. Patient will benefit from continued skilled therapeutic intervention to maximize functional improvement. Patient continues to demonstrate inability to complete or perform daily activity or ADL's without pan. **Plan:** Goals remain appropriate and patient is on target for achievement by DC. Clinician expects to increase the HEP and progress the treatment at the next visit**.** ** Reviewer's Comments: Only the initial and final visits have been elaborated. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.**		
10/18/YYYY	Hospital/ Provider	**Final physical therapy visit:** **HPI:** Patient states last Friday she did her HEP and was in so much pain she was miserable all the next day at a wedding. The pain was shooting up both sides of her neck. She has not done any	263-265, 641	$111.85

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		of the exercises since as she's not sure which one caused it. **Procedure Documentation** **Mechanical Traction:** The patient received intermittent cervical mechanical traction for10 minutes at 15 pounds for 20 seconds on, 10 seconds off in supine position. **Therapeutic Exercise: 20 minutes** The patient performed therapeutic exercise to develop strength, ROM and flexibility. See exercise log for specific information. **Assessment/ Plan** **Assessment:** Due to patient complaining of severe pain after HEP therapist advised against upper trap stretches for now. She had no pain with treatment session today. Patient performed treatment session today requiring an expected amount of physical and/or verbal input from the clinician. Patient is progressing with rehab well based on current performance and progress. Patient will benefit from continued skilled therapeutic intervention to maximize Functional improvement. Patient continues to demonstrate inability to complete or perform daily activity of ADL's without pain. **Plan:** Goals remain appropriate and patient is on target for achievement by DC. Clinician expects to increase the HEP and progress c- spine ROM exercise al the next visit. **Return to Office:** Lynn Marchisen, PT for Rehab Follow Up at Rehab Roswell on 10/25/YYYY at 11:30 AM		
11/12/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief Complaint:** Neck/C-spine problem 10 Sessions therapy, no relief, pain is constant with dull stabbing, radiates to head with migraine. **HPI:** Patient follows up today for reevaluation of cervical spine pain. Her symptoms are due to a motor vehicle accident which occurred in March 2018. She has had 10 sessions of rehabilitation services since her last office visit. She has experienced no relief. She feels that her pain has gotten worse. It is constant in the neck and upper shoulders and extends into the head and she complains of headaches. She is poorly tolerant of medications and only taken occasional Tylenol. Her occasional paresthesias in her left arm and hand. **Review of systems**: Positive for anxiety and fatigue **Physical Exam** Patient is a 63-year-old female.	260-263, 641	$164.12

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Cervical exam: **Inspection**: Head is held in normal posture. There are no obvious skin changes. Atrophy or asymmetry. **Palpation**: No tenderness to palpation of the paraspinals. **Range of motion**: Decreased toward end ranges of rotation and sidebendinq **Directional preference**: None **Upper extremity exam**: **Inspection**: No evidence of significant skin changes, atrophy or asymmetry. **Palpation**: No tenderness to palpation. **Range of motion**: Normal motion of the shoulders. Elbows, and wrists. **Strength**: Manual muscle testing shows 515 strength throughout the major muscle groups of the upper extremities. **Neurological**: Sensation is intact to light touch throughout the upper extremities. Deep tendon reflexes: 2+ biceps, 2+ brachioradialis and 2+ triceps bilaterally. **Provocative maneuvers**: Spurling's is negative bilaterally. **Cardiovascular**: Distal pulses are Palpable **Assessment/ Plan:** **Imaging:** 4 views of the cervical spine ordered. Performed and interpreted by me today shows normal vertebral body alignment with mildly diminished cervical lordosis, There is narrowing of the disc space at C5-6. **Assessment:** 1. Acute cervical sprain secondary to rear end motor vehicle collision on 3/23/18. Patient was doing well prior to the accident and not experiencing any of her current symptoms. She has participated in rehabilitation services but her symptoms are worse than before starting. 2. Mild degenerative disc disease at C5-6 **Recommendations:** 1. Proceed with MRI of the cervical spine. She will require oral Valium for the study due to anxiety/claustrophobia 2. Tizanidine 2 mg 1 p.o., nightly as needed for muscular spasm. #20 3. Follow-up when MRI results are available for review. **Neck pain: Cervicalgia** Physical therapy neck referral – Schedule Within: provider's discretion Evaluate & Treat: Cervical spine Visits per Week: 1-2		

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Number of Weeks: 6 Total# of Visits: 12 Exercises: Stretching, ROM. Flexibility, Strengthening as appropriate. HEP Modalities: Yes, as needed. Include dry needling as. Appropriate Manual Therapy: Joint and Soft tissue mobilization techniques. And traction *Related records: Pdf ref:239, 321-323*		
12/06/YYYY	Hospital/ Provider	**MRI of cervical spine without contrast:** **Clinical history:** Neck pain, acute cervical sprain secondary to MVC occurred on march 23, 2018 **Comparison:** 05/23/YYYY **Findings**: Visualized portions of the posterior fossa structures appear intact. Preserved cervical vertebral body heights with grade 1 retrolisthesis of C5 on C6 with mild intervening spondylotic changes and minor endplate marrow signal. Normal size contour and signal intensity in the cervical cord. No muscle signal abnormality is identified At C2-3 there is no disc bulge or herniation with patent neural foramina bilaterally At C3-4 there is mild central disc bulge without change. Patient neural foramina bilaterally At C4-5 there is no disc bulge or herniation with patent neural foramina bilaterally Stable grade 1 retrolisthesis of C5-6 with mild spondylotic changes and mild to moderate broad based posterior osteophytic disc complex, offset to the left causing effacement of the anterior thecal sac without cord indentation. There is moderate asymmetric left uncinate hypertrophy and foraminal stenosis without change. Patient right neural foramen. At C6-7, there is no bulge or herniation with patent neural foramina bilaterally At C7-T1, there is no disc bulge or herniation with patent neural foramina bilaterally **Impression**: • Stable grade 1 retrolisthesis of C5-6 with mild spondylotic	310-311, 641	$1225.00

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		changes and mild to moderate broad based posterior osteophytic disc complex, offset to the left without cord indentation. Stable moderate asymmetric left uncinate hypertrophy and foraminal stenosis. • Stable C3-4 mild central; disc bulge with patent neural foramina bilaterally *Related records: Pdf ref:238*		
12/17/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief Complaint:** Neck/C-spine problem Cervical spine, MRI review. **HPI:** Patient is a 63-year·old woman following up today to review the results of an MRI of the cervical spine. She continues to have neck pain and some symptoms extending into the left shoulder. She has participated in rehabilitation services which has included use of traction which she has found helpful. Patient is employed working regular duty. She is a non-smoker. There is no history of previous cervical spine surgery. **Review of systems**: Positive for anxiety and fatigue **Assessment/ Plan:** **Imaging:** MRI of the cervical spine 12/6/YYYY was reviewed and discussed. There is a slight retrolisthesis of C5 on C6 with disc osteophyte complex offset to the left. C3-4 shows mild disc bulge without foraminal stenosis The reading radiologist was able to compare this MRI to an MRI from 5/23/YYYY and there have been no significant interval changes. **Assessment:** 125. Cervical pain with a myofascial component. There's underlying spondylosis at C5-6 and at C3-4 which may contribute to her overall symptoms. Her symptoms came about following an MVA on 3/23/18 **Recommendations:** 1. MRI results were discussed and she does not appear to have experienced significant changes to the MRI scan since the March 23, 2018 MVA. We discussed options such as spinal injection procedures and she does not wish to pursue injections at this time 2. Recommended that she add a soft tissue work/massage to address her myofascial pain. She has a home traction unit which she finds helpful so she will continue to use this. Some of the exercises exacerbated her pain and we discussed which ones to eliminate	258-260, 642	$164.12

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		3. Patient expressed understanding of the above and she left today after all concerns were addressed. **Cervical radiculopathy: radiculopathy, cervical region** Physical therapy neck referral – Schedule Within: provider's discretion Evaluate & Treat: Cervical spine Visits per Week: 1-2 Number of Weeks: 6 Total# of Visits: 12 Exercises: Stretching, ROM. Flexibility, Strengthening as appropriate. HEP Modalities: Yes, as needed. Include dry needling as. Appropriate Manual Therapy: Joint and Soft tissue mobilization techniques. And traction **Displacement of cervical intervertebral disc without myelopathy: Other cervical disc displacement, unspecified cervical region** Cervical disc disease – care instructions *Related records: Pdf ref:237, 318-320*		
04/23/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** **Patient words**: Patient is here for the physical. The patient is a 63 year old female who presents for a physical exam. General health: feels well with minor complaints (patient with sinus symptoms in last week. Facial pressure, postnasal drip. No coughing. No fevers/chills). The patient's appetite is normal. Nutrition: normal/adequate. Exercises 0 days per week **Assessment & Plan:** Routine medical exam **Impression:** EBCT score zero 04/YYYY Seeing Dr. bowen breast specialist utd mammogram/pap/colonoscopy/dexa scheduled **Sinusitis**: Given duration will treat with Augmentin **Reviewers comment: Since this visits is unrelated it's not elaborated in detail**	22-26	N/A
05/13/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief Complaint:** Neck/C-spine problem Constant neck pain radiates to both shoulders and right elbow, she	255-257, 642	$164.12

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		was unable to have therapy due to increase pain, she want to discuss Celebrex and another referral for therapy **HPI:** 63-year·old woman following up today due to chronic cervical pain. She notes constant pain in the neck which radiates into both shoulders, right hand and elbow. She was unable to start rehabilitation services as discussed at her last office visit because she was experiencing increased pain. She like to discuss taking Celebrex and she would like a new order for therapy. She works full-time and she travels significantly with her job, She feels that this does adversely affects her symptoms, Pain level is rated 7-9/10 with a sharp and aching quality. She improves with rest, heat or ice. Sitting makes her pain worse. **Review of systems**: Positive for arm pain and fatigue **Physical Exam** Patient is a 63-year-old female. **Cervical exam:** **Inspection**: Head is held in normal posture. There are no obvious skin changes. Atrophy or asymmetry. **Palpation**: there is tenderness to palpation of the paraspinals and trapezius muscles bilaterally **Range of motion**: Limitation toward end range of rotation and sidebendinq bilaterally **Directional preference**: None **Upper extremity exam**: **Inspection**: No evidence of significant skin changes, atrophy or asymmetry. **Palpation**: No tenderness to palpation. **Range of motion**: Normal motion of the shoulders. Elbows, and wrists. **Strength**: Manual muscle testing shows 515 strength throughout the major muscle groups of the upper extremities. **Neurological**: Sensation is intact to light touch throughout the upper extremities. Deep tendon reflexes: 2+ biceps, 2+ brachioradialis and 2+ triceps bilaterally. **Provocative maneuvers**: Spurling's is negative bilaterally. **Cardiovascular**: Distal pulses are Palpable **Lymphadenopathy:** No palpable lymphadenopathy **Assessment/ Plan:** **Imaging:** MRI of the cervical spine 12/6/YYYY was reviewed and discussed. There is a slight retrolisthesis of C5 on C6 with disc osteophyte complex offset to the left. C3-4 shows mild disc bulge without foraminal stenosis The reading radiologist was able to compare this MRI to an MRI		

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		from 5/23/YYYY and there have been no significant interval changes. **Assessment:** 125. Cervical pain with a myofascial component. There's underlying spondylosis at C5-6 and at C3-4 which may contribute to her overall symptoms. Her symptoms came about following an MVA on 3/23/18 **Recommendations:** • New orders for rehabilitation services are provided • Celebrex 200mg 1 P.O daily #30, GI precautions discussed • Recheck in 6 to 8 weeks , sooner if needed • All patient questions reviewed and answered **Pain in cervical spine: Cervicalgia** Physical therapy neck referral – Schedule Within: provider's discretion Evaluate & Treat: Cervical spine Visits per Week: 1-2 Number of Weeks: 6 Total# of Visits: 12 Exercises: Stretching, ROM. Flexibility, Strengthening as appropriate. HEP Modalities: Yes, as needed. Include dry needling as. Appropriate Manual Therapy: Joint and Soft tissue mobilization techniques. And traction Celecoxib 200mg capsule- Take 1 capsule every day by oral route. Qty: 30, Refills: 1 *Related records: Pdf ref:236, 314-317*		
05/16/YYYY	Hospital/ Provider	**Follow-up visit:** **History of present illness:** **Patient words**: Patient is here for an f/u visit. She has poison ivy on her bilateral hands. She stated that used hydrocortisone on them. The patient is a 63 year old female who presents with a rash. Note for "Rash": patient woke up this morning and noticed red blisters on hands palms and in lines on some of fingers. Patient put hydrocortisone cream on her hands that really helped. +itchy. Patient was gardening yesterday pulling weeds some. Doesn't think she touched poison ivy although she knows it's in her back yard. No fevers/chills. No joint pains.	20-21	N/A

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		Assessment & Plan: Rash Impression: Contact dermatitis on hands-suspect poison ivy from gardening. Treat with Medrol pack. Call if not resolved. **Reviewers comment: Since this visits is unrelated it's not elaborated in detail**		
06/03/YYYY	Hospital/ Provider	**Telephone Conversation:** **Assessment:** Sinus infection **Plans:** Started Augmentin 875-125mg, 1 tablet BID, #20, 10 days starting 06/03/YYYY, no refill	19	N/A
07/19/YYYY	Hospital/ Provider	**Bilateral digital diagnostic mammogram with CAD:** **Clinical History:** Left lumpectomy in 2010. Comparison is made to exams dated: 6/11/YYYY mammogram, 6/21/YYYY mammogram, 6/17/YYYY mammogram, 6/8/YYYY, mammogram, 5/8/YYYY mammogram, and 06/11/YYYY ultrasound – Breast Care Specialists, L.L.C. Both breasts are heterogeneously dense, which may obscure small masses. Current study was evaluated with a Computer Aided Detection (CAD) system. The patient is status post lumpectomy of the left breast in the medial aspect. The left breast has post-operative findings. There are few being appearing calcifications No significant masses, calcifications, or other findings are seen in either breast. **Impression:** There is no mammographic evidence of malignancy or recurrence. A follow-up mammogram in 12 months is recommended.	125-126	N/A
05/18/YYYY	Hospital/ Provider	**Pharmacy bills:** Medications **Reviewers comment: The record of the following date are unavailable for review**	2-3	$1.06
02/12/YYYY	Hospital/ Provider	**Pharmacy bills:** Medications **Reviewers comment: The record of the following date are*	6-7	$21.87

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		*unavailable for review**		
03/13/YYYY - 09/23/YYYY	Hospital/ Provider	**Pharmacy bills:** Medications **Reviewers comment: Upon review, we have found that there are pharmacy bills available for many dates under CVS pharmacy. However, only few of the visits are available for review.*	8-14	$7957.03

Other records:

Others, Law firm, Affidavit, Orders, Consents: Pdf ref: *350-355, 1, 15-18, 108-124, 130-136, 185, 218-227, 247-250, 299, 309, 311-314, 331, 357-359, 454-455, 461, 549-551, 555, 469-470, 473-475, 485-486, 494-497, 513-514, 577, 581-582, 585, 588-591, 595, 601-603, 612, 617-618, 462*

Medical bills: Pdf ref: *2-14, 620-634, 636-642*

Echocardiogram: Pdf ref:*127, 139, 174-175, 177, 215*

Referral report: Pdf ref: *227-235, 390, 400, 548, 448-451*

Patient information: Pdf ref: *242*

Patient education: Pdf ref: *300-302, 488, 518, 523, 528, 530, 540, 558-559*

Blank Pages: Pdf ref: *327, 635*

Labs: Pdf ref: *367-368, 370-371, 373, 128-129, 213, 193-196, 161-165*

Medications: Pdf ref*: 360-366, 564*

Flow sheet: Pdf ref: *593, 587, 584, 580, 576*

Poor quality: Pdf ref: *463-467, 487, 515-516, 524, 563, 579*

Reviewer's Comments: All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence not elaborated.