Narrative summary

On February 3, YYYY, XXXX was the driver of the truck and parked his vehicle for an overnight stay. While sitting in his 18-wheeler, another truck turned left and hit him. As a result, he sustained injury to his neck.

On February 5, YYYY, Mr. XXXX was examined by XXX, M.D., at A ABC Health System Affiliated Provider for the complaints of having pain and soreness in his neck sustained due to the motor vehicle collision. He reported that his pain was present in his left and the quality of pain was described as aching. His symptoms were aggravated by bending and position and his pain was same all the time. On examination, he had palpable tenderness in the left side of his neck. His Allen's test was positive bilaterally.

On February 12, YYYY, Mr. XXXX had an initial chiropractic evaluation with XXX, D.C., at ABC Spine & Sports for the complaints of neck pain radiating into his shoulders. He also reported sharp pain radiation into his shoulder blades. He also had pain with sitting for long periods in his low back, as well as mid back and low back stiffness. He had severe neck pain and significant decreased range of motion in all ranges. He reported that the mechanism of injury involved flexion of his neck in a jerking motion when he was hit by an 18 wheeler while his truck was not moving. The quality of pain was described as aching, burning, constant, electrical, radiating pain, sharp, stabbing and a severity with a moderate intensity level. His signs and symptoms were exacerbated with movement and increased with inspiration, prolonged sitting, prolonged standing, bending, movement, exercise, twisting, lifting, leaning, lying down, walking, stooping, sit to stand, and sitting reclined. He also had headaches along with tingling and numbness in his extremities. On examination, he had palpable tenderness, taught and tender points, swelling, edema, decreased range of motion, myofascial pain, taught fibers in his neck.The orthopedic tests included shoulder depression test, foraminal compression test, and cervical distraction test were positive. He was diagnosed with sprain of ligaments of cervical spine, sprain of ligaments of thoracic spine, sprain of ligaments of lumbar spine, abnormal posture, muscle weakness (generalized), and myositis. He was recommended not to work due to severe pain in his neck. Due to his loss of cervical spine mobility he was unable to view the entire road as needed while driving. His treatment was comprised of electrical stimulation, manual therapy, and cold and/or hot pack applications.

On the same day, an X-ray of Mr. XXXX' cervical spine was obtained by XXX, M.D., at ABC Center of Louisiana. The study revealed normal alignment with no abnormal movement. Spondylotic changes and early facet arthropathy along the cervical spine was noted.

On March 11, YYYY, an MRI of Mr. XXXX' cervical spine was obtained by XXX, M.D., at ABC Center of Louisiana. The study revealed narrowing of the foramen, greater to the right by uncovertebral joint hypertrophy and more so at C6-C7 level. There was disc or osteophyte bulging and no central canal stenosis and no spondylolisthesis were noted.

On May 24, YYYY, Mr. XXXX was examined by XXX, M.D., and XXX, PA-C at The Spine Center at ABC Clinic of Baton Rouge for the complaints of having pain in his neck. He developed neck pain and he was diagnosed with cervical strain due to the motor vehicle collision. He was complaining of neck pain bilaterally worsened on his left with numbness in his left upper extremity in the C6 distribution

intermittently but it does extend into his hand. His symptoms worsened with sitting. He has had chiropractic care and reported that his right side neck pain was resolved but he continued to have left sided symptoms. He denied having any neck pain prior except some chiropractic care over the years for adjustments. Dr. XXX opined that the MRI scan of the cervical spine performed on March 11, YYYY looked like he had a disc bulge at C3-C4 level. He was diagnosed with cervical spondylosis, degenerative disc disease, and disc bulging. Robaxin was prescribed. He was recommended to receive a cervical epidural steroid injection at C7-T1 level. He was advised to follow up in two weeks post epidural.

On July 29, YYYY, Mr. XXXX' C7-T1 cervical interlaminar epidural steroid injection was denied by Jason Picard, M.D., at Louisiana Workforce Commission. It was stated that the injection level does not agree with the MRI level of abnormality.

On August 16, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-C at The Spine Center at ABC Clinic of Baton Rouge for the complaints of having pain in his neck. He had complaints of neck pain in his left greater than right into his head with numbness in the left C6 distribution. He has had physical therapy with dry needling and Robaxin was taken for symptomatic control. On examination, he had tenderness to palpation over his left paraspinal musculature. There was a bruise on his right arm and questionable bicep tendon rupture. He was diagnosed with cervical spondylosis, degenerative disc disease, and disc bulging. He was recommended to receive C7-T1 cervical interlaminar epidural steroid injection.

On August 26, YYYY, Mr. XXXX received fluoroscopically-guided interlaminar cervical injection C7-T1 and cervical interlaminar epidurogram under fluoroscopic imaging for guidance. His pre and post-operative diagnosis was cervical radiculopathy. The procedure was done by Dr. XXX at Orthopedic Surgery Center, LLC.

On September 9, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-C at The Spine Center at ABC Clinic of Baton Rouge for the complaints of having pain in his neck. He had neck pain to the left along with headaches. He mentioned some left arm numbness with driving occasionally. He reported his pain level as 4-6/10. He was diagnosed with cervical spondylosis and cervical herniated nucleus pulposus. Zofran was refilled. He was recommended to receive cervical interlaminar epidural steroid injection at C7-T1 level. He was advised to follow up in two weeks after receiving the injection.

On September 30, YYYY, Mr. XXXX received fluoroscopically-guided interlaminar cervical injection C7-T1 and cervical interlaminar epidurogram under fluoroscopic imaging for guidance. His pre and post-operative diagnosis was cervical radiculopathy. The procedure was done by Dr. XXX at Orthopedic Surgery Center, LLC.

On October 14, YYYY, Mr. XXXX was examined by Dr. XXX at ABC Office for a follow up evaluation of his neck pain. He reported his pain level as 5/10. He had left sided neck pain along with numbness in his left arm. Examination showed positive Spurling's to his left. He was diagnosed with cervical radiculopathy. He was also recommended for cervical fusion surgery. He was advised to follow up in two weeks after receiving the third epidural steroid injection.

On November 8, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, FNP-C at The Spine Center at ABC Clinic of Baton Rouge for the complaints of having pain in his neck radiating to his left arm along with headaches. He was diagnosed with cervical radiculopathy. He was recommended to receive third cervical epidural steroid injection.

On December 9, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-Cat ABC Office for the complaints of having pain in his neck and occipital region to the back of his head. He reported that he received his third cervical epidural steroid injection on November 18, YYYY. He had occasional numbness in his shoulder while lifting his arms. He admitted that he had left his previous job. He was diagnosed with cervical radiculopathy and cervical spondylosis. He was recommended to undergo physical therapy for his neck. Mobic and Robaxin were prescribed. He was advised to follow up in six weeks.

On January 6, YYYY, Mr. XXXX was examined by Dr. XXX at The Spine Center at ABC Clinic of Baton Rouge for the complaints of having pain in his neck. He was recommended to undergo physical therapy for his neck. He was also recommended to undergo acupuncture therapy if his pain worsened. He was diagnosed with cervical spondylosis. He was advised to follow up in eight weeks.

From February 15, YYYY through February 6, YYYY, Mr. XXXX underwent chiropractic treatment with XXX, D.C., at ABC Spine & Sports for the complaints of neck pain radiating into his shoulders. His treatment was comprised of electrical stimulation, manual therapy, cold and/or hot pack application, spinal adjustments, and therapeutic exercises.

On February 9, YYYY, XXXX had a final chiropractic evaluation with XXX, D.C., at ABC Spine & Sports for the complaints of having constant pain in his neck and mid-back along with headaches and vision changes. He reported that he had not experienced any relief from treatment and the pain continued to be constant at the same frequency. The quality of pain was described as aching, cramping, constant, burning, radiating pain, sharp, and stabbing. He reported that his signs and symptoms occurred during physical exertion, during a sporting activity, at rest, and at work. His pain and symptoms worsened with prolonged sitting, sitting reclined, bending, stooping, movement, rest, exercise, twisting, lifting, and leaning. On examination, he had palpable tenderness, hypertonicity, taught fibers, decreased range of motion, myofascial pain, and swelling in his neck. He was diagnosed with sprain of ligaments of cervical spine, initial encounter sprain of ligaments of thoracic spine, initial encounter, sprain of ligaments of lumbar spine, initial encounter, abnormal posture, muscle weakness (generalized), and unspecified myositis. His treatment was comprised of hot or cold packs therapy, electric stimulation therapy, manual therapy, therapeutic exercises, spinal adjustments, and chiropractic manipulation.

On March 24, YYYY, Mr. XXXX was examined by Dr. XXX at The Spine Center at ABC Clinic of Baton Rouge for the complaints of having pain in his neck despite receiving three injections. His symptoms were worsened and he reported his pain level as 6/10. He was diagnosed with cervical radiculopathy. He was recommended to undergo anterior cervical discectomy and fusion (ACDF) at C5-C7 levels. He was advised to follow up for a pre-operative evaluation.

On May 3, YYYY, Mr. XXXX was examined by XXX Ph.D., M.P., at The Neuro Medical Center Clinic for a pre-operative psychological evaluation. He reported having neck pain as well as tingling and

numbness down his left arm. He had completed the Personality Assessment Inventory. On examination, he had stiffness in his neck. Amlodipine Besylate, Carvedilol, and Lisinopril-hydrochlorothiazide were prescribed. He was considered cleared from a psychological perspective.

On May 16, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-C at The Spine Center at ABC Clinic of Baton Rouge for the complaints of having pain in his neck. His ACDF surgery for C5-C7 was denied. He reported having neck pain down his left shoulder and down the arm all the way down to his fingers located to the thumb, numbness, and pain and tingling as well as weakness. He reported that he had tried chiropractic care, physical therapy, and cervical epidural steroid x3 as well as medications without any relief. He reported his pain level as 6/10. He was diagnosed with cervical radiculopathy and cervical spondylosis. Diclofenac Sodium and Neurontin were prescribed. His Maximum Medical Improvement status was unknown. He was advised to follow up in four weeks for a pre-operative visit.

On June 29, YYYY, an X-ray of Mr. XXXX' chest was obtained by XXX, M.D., at Our Lady of the Lake Livingston. The study revealed no cardiopulmonary process.

On July 5, YYYY, Mr. XXXX was examined by XXX, PA-C at The Spine Center at ABC Clinic of Baton Rouge for the complaints of having pain in his neck along with weakness in his right hand. He was recommended to wear a cervical collar. He was scheduled to undergo ACDF surgery on July 12, YYYY.

On July 12, YYYY, Mr. XXXX underwent anterior cervical discectomy and fusion, C5-6, C6-7, interbody structural cage, C5-6, C6-7, anterior cervical plate, C5-C7, local autograft, fluoroscopic imaging for placement of above, and placement of amnio membrane over the plate to prevent future adhesions and dysphagia. His preoperative and post-operative diagnoses were cervical radiculopathy, cervical herniated nucleus pulposus, cervical stenosis, and cervical spondylosis. The surgery was performed by Dr. XXX at Baton Rouge General – Bluebonnet.

From August 18, YYYY through September 28, YYYY, Mr. XXXX had ophthalmology consultation with Cynthia Baker, O.D., for his vision problems. He had double vision, excessive tears, and blurred vision. He was diagnosed with Primary Open-Angle Glaucoma (POAG) suspect and mild cataract.

On January 26, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-C at The Spine Center at ABC Clinic of Baton Rouge for a post-operative follow up evaluation of his neck pain. He reported having 60-70% improvement after his ACDF surgery. He continued to have tightness in his neck especially when looking up. He also had pain looking down or side to side. He tried physical therapy in the past but reported that it was causing pain and his numbness was returning. He reported performing a home exercise program. He stated that he was fired from his job because he was unable to return to work due to neck pain. He was maintained on Flexeril at nighttime, Lorzone as needed, and Tramadol at bedtime. On examination, he continued to have mild limitations with range of motion especially with extension. Two view cervical spine x-rays AP and lateral was obtained which revealed good position of the hardware without failure or lucency. He was diagnosed with status post ACDF surgery. He was recommended to undergo physical therapy and home exercise program. He was also recommended to continue his medication regimen. He was provided a new prescription of Lorzone as well as refills of Flexeril and

Tramadol. Urine drug screen was performed for monitoring. He was advised to follow up in two to three months.

On April 13, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-C at ABC Office for the complaints of having pain in his neck and shoulders left greater than right. He continued to have tingling down his left arm into his hand especially during raising his arm. He stated if he looked down for any period of time he had difficulty and had to return to the neutral position. He was having more and more trouble with his neck and left arm. He was maintained on Flexeril and Tramadol. On examination, he had increased neck pain with flexion and extension. He was diagnosed with status post ACDF surgery. He was recommended to have an updated MRI of his cervical spine due to his continued postoperative complaints. He was also recommended for adjacent level facet joint injections. He was given a new prescription of Parafon Forte to utilize for spasms during the day. He was advised to have a follow up with Dr. XXX. He was recommended to remain out of work with an estimated length being one year post op. If he continued to have significant pain at one year he would likely be a candidate for CT to assess his fusion.

On April 16, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-C at The Spine Center at ABC Clinic of Baton Rouge for the evaluation of his continued neck pain, between his shoulder blades along with left hand numbness. He reported his pain level as 7-8/10. On examination, he had increased pain with extension of his cervical spine. Two view cervical spine x-rays was obtained which showed hardware in a good position. He was diagnosed with status post ACDF surgery and cervicalgia with left arm paresthesia. Tramadol and Flexeril were prescribed. He was recommended to have an MRI of his cervical spine. He was also recommended for a possible cervical facet injection. He was advised to follow up in four to six weeks.

On May 8, YYYY, an MRI of Mr. XXXX' cervical spine was obtained by XXX, M.D., at ABC Center of Louisiana. The study revealed interval surgery with decompression of the central canal and foramina at C5-6 and C6-7 levels and stable disc bulge at C3-4 level.

On May 17, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, FNP-C at The Spine Center at ABC Clinic of Baton Rouge for the follow up on his neck and bilateral shoulder blade pain and left hand numbness status post ACDF surgery. He reported having some left arm pain and numbness despite taking Lorzone, Tramadol and Flexeril. On examination, he had increased pain with extension of his cervical spine. Two view cervical spine x-rays were obtained and the AP and lateral showed C5 through C7 hardware in good position without lucency or failure. He was diagnosed with status post ACDF surgery and neck pain with left arm paresthesia. He was unable to return to work. He was recommended to receive a cervical epidural steroid injection. He was suggested to have a CT of his cervical spine once he was eighteen months out, to rule out effusion. He was recommended to receive facet injection in the future if he had no improvement. He was advised to follow up two weeks after receiving the injection.

On July 2, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-C at ABC Office for the complaints of having pain in his neck more pronounced on his left. He also had occasional numbness and tingling in his left hand and pain that radiated upwards towards his left ear. Two view cervical spine x-rays AP and lateral showed good position of the hardware without failure or lucency. He was diagnosed with status post ACDF surgery and neck pain with left upper extremity radiculopathy. He was recommended to

receive a cervical epidural steroid injection. He was recommended for CT of the cervical spine to assess fusion if he was symptomatic at eighteen months. He was also recommended for adjacent level facet joint injections if he continued to have symptoms after receiving cervical epidural steroid injection. He was advised to follow-up in two weeks post procedure.

On July 20, YYYY, Mr. XXXX underwent fluoroscopically-guided interlaminar cervical injection at C7-T1, cervical interlaminar epidurogram, and fluoroscopic imaging for guidance of above. His pre and post-operative diagnoses were cervical radiculopathy. The procedure was performed by Dr. XXX at Orthopedic Surgery, LLC.

On August 6, YYYY, Mr. XXXX was examined by XXX, PA-C at The Spine Center at ABC Clinic of Baton Rouge for the evaluation of his continued neck pain despite receiving injection. On examination, he had increased pain with extension of his cervical spine. He was diagnosed with status post ACDF surgery and cervicalgia. He was recommended to have a CT of his cervical spine at eighteen months post-operatively to make sure that he was fully healed. He was also recommended to receive a medial branch block in his bilateral C3-4 and C4-5 levels. He was advised to follow up one week after receiving the medial branch block.

On October 15, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-C at ABC Office for the complaints of having worsened pain in his neck. He reported his pain level as 8/10. He was unable to resume his normal daily activities. He was diagnosed with status post ACDF surgery and neck pain with left upper extremity paresthesia. He was recommended to remain off work. He was advised to proceed with the recommended medial branch block for his bilateral C3-4 and C4-5 levels. He was also recommended to have CT of his cervical spine to assess fusion at his prior surgical level. He was advised to follow up after receiving the medial branch block with Dr. XXX for additional options and recommendations.

On November 2, YYYY, Mr. XXXX received bilateral C3-C4 and C4-C5 fluoroscopically-guided medial branch blocks. His pre and post-operative diagnoses were cervical spondylosis and cervical facet syndrome. The procedure was performed by Dr. XXX at Orthopedic Surgery, LLC.

On November 20, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-C at ABC Office for the complaints of having continued pain in his neck despite receiving injections. His pain went from 7/10 to various levels of 5-8/10 for 6 hours. He reported that his pain was flared up more than usual after an 8 hour trip. He was having occipital headaches and nausea. He had occasional pain to his left ear which felt like nerve pain. He reported that he heard "rice krispies and grinding" in his neck. He was scheduled for a CT of his cervical spine on November 30, YYYY.

On November 30, YYYY, a CT of Mr. XXXX' cervical spine was obtained by XXX, M.D., at ABC Center of Louisiana. The study revealed no significant change in the appearance of his cervical spine since an MRI examination dated May 8, YYYY. There were changes of ACDF involving C5-C6 and C6-C7 levels noted. There was mild posterior osteophytic ridging but no significant spinal canal narrowing noted. There were small disc bulges at C3-C4 and C4-C5 levels causing no significant spinal canal narrowing. Mid facet arthropathy and some uncovertebral spurring causing no significant foraminal narrowing was noted.

On December 20, YYYY, Mr. XXXX was examined by Dr. XXX and XXX, PA-C at The Spine Center at ABC Clinic of Baton Rouge for the complaints of having severe persistent pain in his neck. He was unable to drive due to his pain. He had pain in the right side of his neck below his ear. He had grinding severe pain on his right at the C5-6 level. He reported that the medial branch block had not provided him significant pain relief. He was unable to do the things he used to do before the collision. On examination, he had increased pain with extension and flexion of his cervical spine. An X-ray of his cervical spine was obtained which revealed anterior endplate changes. There was a spondylolisthesis noted at C3-4 level which measured on flexion at 4.1. He was diagnosed with status post ACDF surgery, cervicalgia, and C3-4 spondylolisthesis. He was recommended to have a CT cervicothoracic myelogram. Tramadol and Zofran were prescribed. He was advised to follow up in four to six weeks after the CT cervicothoracic myelogram.

On January 25, YYYY, Mr. XXXX had a CT myelogram of his thoracic spine for his neck and back pain. The study revealed posterior disc herniations at T7-T8, T10-11, and T12-L1 levels. The disc herniation at T7-T8 extended superiorly and caused mild spinal canal narrowing and indenting the ventral surface of the cord. There was no cord deformation at the remaining levels. The procedure was performed by XXX, M.D., at ABC Center of Louisiana.

On the same day, Mr. XXXX had a CT myelogram of his cervical spine for his neck and back pain. The study revealed no significant change in the appearance of his cervical spine since a CT scan dated November 30, YYYY. There were changes of ACDF involving C5-C6 and C6-C7 levels with ventral plating. There was no significant spinal canal narrowing noted at these levels. There were very small disc bulges at the remaining levels of his cervical spine causing no spinal canal narrowing. Early facet arthropathy causing no significant foraminal narrowing was noted. The procedure was performed by XXX, M.D., at ABC Center of Louisiana.

On the same day, Mr. XXXX had a CT myelogram of his entire spine and a comparison was made with CT dated January 25, YYYY. The study revealed changes of ACDF involving C5-C6 and C6-C7. There was no spinal canal narrowing, no cord deformation, and no nerve root compromise along his cervical spine. The hardware appeared intact. The cervical elements were normal in height and alignment. There was no fracture noted. In comparison with a CT myelogram of the thoracic spine performed the same day, the studies demonstrated posterior disc herniations at T7-T8, T10-T11, and T12-L1. The thoracic elements were normal in height and alignment. The disc herniation at T7-T8 caused mild spinal canal narrowing and indented the ventral surface of the cord. The concurrent CT myelogram better demonstrated some impingement upon the ventral surface of the cord by the disc herniation. The remaining levels of the thoracic spine appeared normal on this examination but the concurrent CT myelogram better demonstrated small posterior disc herniations at T10-T11 and T11-T12 levels causing no spinal canal narrowing and no cord deformation. The procedure was performed by XXX, M.D., at ABC Center of Louisiana.

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