THE LAW FIRM OF HERB SANTOS, JR.
225 South Arlington Avenue, Suite C, Reno, Nevada, 89501
Tel: (775) 323-5200 Fax: (775) 323-5211

IN THE SUPREME COURT OF THE STATE OF NEVADA

-o0o-

KIMBERLY KLINE,

Appellant,

vs.

CITY OF RENO; CANNON COCHRAN MANAGEMENT SERVICES, "CCMSI"; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION, HEARINGS DIVISION, an Agency of the State of Nevada; the STATE OF NEVADA DEPARTMENT OF ADMINISTRATION APPEALS DIVISION, an Agency of the State of Nevada; MICHELLE MORGANDO,, ESQ., Sr. Appeals Officer; RAJINDER NIELSEN, ESQ., Appeals Officer; ATTORNEY GENERAL AARON FORD, ESQ.,

Respondents.

Supreme Court No. 82608

Injured Worker Appellant's Appeal of the

Second Judicial District Court,

The Honorable Connie Steinheimer's Order

of the Appeals Officer's Decision of the Department of Administration

APPELLANT'S APPENDIX

Volume VI

Pages 1251 - 1500

HERB J. SANTOS, JR., ESQ.
Nv Bar No 4376
The Law Firm of Herb Santos, Jr.
225 S. Arlington Avenue, Suite C
Reno, Nevada 89501
(775) 323-5200
herb@santoslawfirm.com
Attorney for the Appellant

THE LAW FIRM OF HERB SANTOS, JR.
225 South Arlington Avenue, Suite C, Reno, Nevada, 89501
Tel: (775) 323-5200 Fax: (775) 323-5211

ALPHABETICAL INDEX

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THE LAW FIRM OF HERB SANTOS, JR.
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Tel: (775) 323-5200 Fax: (775) 323-5211

AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby certify that the preceding documents, ***APPELLANT'S APPENDIX VOLUMES I - IX***, filed in Supreme Court case number 82608, do not contain the social security number of any person.

DATED this 18 day of January, 2022.

THE LAW FIRM OF HERB SANTOS, JR.
225 South Arlington Avenue, Suite C
Reno, Nevada 89501

By _____

HERB SANTOS, JR., Esq.
Attorney for Petitioner

THE LAW FIRM OF HERB SANTOS, JR.
225 South Arlington Avenue, Suite C, Reno, Nevada, 89501
Tel: (775) 323-5200 Fax: (775) 323-5211

TRANSMISSION VERIFICATION REPORT

TIME 02/22/2016 16:07
NAME
FAX
TEL
SER. # BROK3J465759

DATE, TIME 02/22 16:06
FAX NO. / NAME 9823759
DURATION 00:00:56
PAGE(S) 02
RESULT OK
MODE STANDARD ECM

CCMSI

February 22, 2016

Renown

Attn: Medical Records

Sent via fax to: 775-982-3759 Pages: 2 (including cover)

Re: Claimant: [redacted]
Claim No.: 158536839641
S.S.N.:
D.O.B.: 10/07/1979
Employer: City of Reno

Dear Medical Records Department:

Enclosed is a C-4 form signed by the injured worker allowing this office to obtain prior medical records. Please forward copies of any and all medical reporting between 10/1/2015 and 2/30/2016 to the address noted below. This includes all treatment provided for any condition for the above referenced injured worker.

If there is a charge for the copies, please forward an invoice with the requested copies. If payment is required prior to shipment, please fax the invoice to my attention at the number noted below.

If you have further questions or wish to discuss this case further, please contact me at 775-324-9890.

Sincerely

CCMSI

February 22, 2016

Attn: Medical Records

Sent via fax to: 775-982-3758 Pages: 2 (including cover)

Re: Claimant: Kimberly
Claim #:
SS #:
DOB: 10/07/1979
Date of Injury: On claim

RECEIVED
FEB 29 2016
CCMSI - RENO

Dear Medical Records Department:

Enclosed is a DOI form signed by the injured worker allowing this office to obtain prior medical records. Please forward copies of any and all medical reports dating back to 10/3/2015 and 1/20/2016 to the address noted below. This includes all treatment provided for any condition for the above referenced injured worker.

If there is a charge for the copies, please advise us of same with the requested copies. If payment is required prior to shipment, please fax the invoice to my attention at the number noted below.

If you have further questions or wish to discuss this case further, please contact me at 775-324-9650.

Sincerely,

Yesenia Martinez, Medical Only Claims Representative
CCMSI – Reno, Nevada

cc: File

CCMSI

February 22, 2016

Renown

Attn: Medical Records

Sent via fax to: 775-982-3759 Pages: 2 (including cover)

Claimant:	Kimberly Kline
Claim No.:	15853E839641
S.S.N	
D.O.B.:	10/07/1979
Employer	City of Reno

Dear Medical Records Department:

Enclosed is a C-4 form signed by the injured worker allowing this office to obtain prior medical records. Please forward copies of any and all medical reporting between 10/1/2015 and 1/30/2016 to the address noted below. This includes all treatment provided for any condition for the above referenced injured worker.

If there is a charge for the copies, please forward an invoice with the requested copies. If payment is required prior to shipment, please fax the invoice to my attention at the number noted below.

If you have further questions or wish to discuss this case further, please contact me at 775-324-9890.

Sincerely,

Yesenia Martinez, Medical Only Claims Representative
CCMSI – Reno, Nevada

cc: File

Cannon Cochran Management Services, Inc.
PO Box 20068 • Reno, NV 89515
866-601-8165 • 775-324-3301 • Fax: 775-324-9893 • www.ccmsi.com

TRANSMISSION VERIFICATION REPORT

TIME 02/22/2016 16:16
NAME
FAX
TEL
SER. # . BROK3J469769

DATE,TIME 02/22 16:15
FAX NO./NAME 3568367
DURATION 00:00:56
PAGE(S) 02
RESULT OK
MODE STANDARD ECM

CCMSI

February 22, 2016

Northern Nevada Medical

Attn: Medical Records

Sent via fax to: 775-356-0357 Pages: 2 (including cover)

Re: Claimant:
Claim No.:
S.S.N..
D.O.B.: 10/07/1979
Employer: City of Reno

Dear Medical Records Department:

Enclosed is a C-4 form signed by the injured worker allowing this office to obtain prior medical records. Please forward copies of any and all medical reporting between 10/1/2015 and 2/22/2016 to the address noted below. This includes all treatment provided for any condition for the above referenced claim to date.

If there is a charge for the copies, please forward an invoice with the requested copies. If payment is required prior to shipment, please fax the invoice to my attention at the number noted below.

If you have further questions or wish to discuss this case further, please contact me at 775-324-9890

Sincerely,

February 22, 2016

Northern Nevada Medical

Attn: Medical Records

Sent via fax to: 775-356-0357 Pages: 2 (including cover)

Re		
	Claimant:	Kimberly Kline
	Claim No.:	15855E839641
	S.S.N.:	
	D.O.B.:	10/07/1979
	Employer:	City of Reno

Dear Medical Records Department:

Enclosed is a C-4 form signed by the injured worker allowing this office to obtain prior medical records. Please forward copies of any and all medical reporting between 10/1/2015 and 1/30/2016 to the address noted below. This includes all treatment provided for any condition for the above referenced injured worker.

If there is a charge for the copies, please forward an invoice with the requested copies. If payment is required prior to shipment, please fax the invoice to my attention at the number noted below.

If you have further questions or wish to discuss this case further, please contact me at 775-324-9890.

Sincerely,

Yesenia Martinez, Medical Only Claims Representative
CCMSI – Reno, Nevada

cc: File

Cannon Cochran Management Services, Inc.
PO Box 20068 • Reno, NV 89515
866-601-6165 • 775-324-3301 • Fax: 775-324-9893 • www.ccmsi.com

TRANSMISSION VERIFICATION REPORT

TIME 02/22/2016 16:03
NAME
FAX
TEL
SER.# BROK3J465765

DATE,TIME	02/22 16:02
FAX NO./NAME	2644902
DURATION	00:01:07
PAGE(S)	02
RESULT	OK
MODE	STANDARD

CCMSI

February 22, 2016

Leading Edge Chiropractic

Attn: Medical Records

Sent via fax to: 775-284-4902 Pages: 2 (including cover)

Re: Claimant: [redacted]
Claim No.: [redacted]
S.S.N.:
D.O.B.: 10/07/1979
Employer: City of Reno

Dear Medical Records Department:

Enclosed is a C-4 form signed by the injured worker allowing this office to obtain prior medical records. Please forward copies of any and all medical reporting prior to 6/25/2015 and any medical reporting after 6/25/2015 to the address noted below. This includes all treatment provided for any condition for the above referenced injured worker.

If there is a charge for the copies, please forward an invoice with the requested copies. If payment is required prior to shipment, please fax the invoice to my attention at the number noted below.

If you have further questions or wish to discuss this case further, please contact me at 775-324-9890.

CCMSI

February 22, 2016

Leading Edge Chiropractic

Attn: Medical Records

Sent via fax to: 775-284-4902 Pages: 2 (including cover)

Re: Claimant: Kimberly Kline
Claim No. 158536839641
S.S.N.:
D.O.B.: 10/07/1979
Employer: City of Reno

Dear Medical Records Department:

Enclosed is a C-4 form signed by the injured worker allowing this office to obtain prior medical records. Please forward copies of any and all medical reporting prior to 6/25/2015 and any medical reporting after 6/25/2015 to the address noted below. This includes all treatment provided for any condition for the above referenced injured worker.

If there is a charge for the copies, please forward an invoice with the requested copies. If payment is required prior to shipment, please fax the invoice to my attention at the number noted below.

If you have further questions or wish to discuss this case further, please contact me at 775-324-9890.

Sincerely,

Yasonia Martinez, Medical Only Claims Representative
CCMSI – Reno, Nevada

cc: File

Cannon Cochran Management Services, Inc.
PO Box 20068 • Reno, NV 89515
866-601-6165 • 775-324-3301 • Fax 775-324-9893 • www.ccmsi.com

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:	Hearing Number: 1548[illegible] Claim Number: 15853[illegible]
KIMBERLY KLINE 305 PUMA DR WASHOE VALLEY, NV 89704	CITY OF RENO ATTN ANDRENA ARREYGUE PO BOX 1900 RENO, NV 89505

BEFORE THE HEARING OFFICER

The Claimant's request for Hearing was filed on January 19, 2016 and a discovery was scheduled for February 17, 2016. The Hearing was held on February 17, 2016 in accordance with Chapters 616 and 617 of the Nevada Revised Statutes.

The Claimant was present. The Employer was not present. The Insurer was represented by Yesenia Martinez of CCMSI by telephone conference call.

ISSUE

The Claimant appealed the Insurer's determination dated November 16, 2015. The issue before the Hearing Officer is claim closure without a permanent partial disability (PPD) evaluation.

RECEIVED
FEB 29 2016
CCMSI - RENO

DECISION AND ORDER

The determination of the Insurer is hereby **REMANDED**.

On June 25, 2015, the Claimant sustained a compensable industrial injury. The Claimant was treated conservatively under the claim and on October 28, 2015, Dr. Hall reported the industrial injury had reached maximum medical improvement (MMI) without a ratable impairment. On November 6, 2015, the Insurer noticed the Claimant of its intention to close her claim without a PPD evaluation, the instant appeal. At today's hearing, the Claimant testified that her condition has significantly worsened and that she has been going to a chiropractor for relief under her private insurance. Her chiropractor ordered an MRI which revealed disc degeneration with large disc protrusion at the C5-C6 and C6-C7 levels. Having reviewed the submitted evidence and in consideration of the representations made at today's hearing, the Hearing Officer finds a medical question regarding the Claimant's MMI status as well as the disc degeneration with large disc protrusion as it relates to the industrial injury. As such, the Hearing Officer instructs the Insurer to provide Dr. Hall with the MRI results and question him accordingly. Upon receipt of Dr. Hall's medical reporting, the Insurer shall render a new determination with appeal rights regarding the further disposition of the claim, i.e., medical treatment, claim closure, PPD, etc.

APPEAL RIGHTS

Pursuant to NRS 616C.345(1), should any party desire to appeal this final Decision and Order of the Hearing Officer, a request for appeal must be filed with the Appeals Officer within thirty (30) days of the date of the decision by the Hearing Officer.

IT IS SO ORDERED this 25th day of February, 2016.

[redacted], Hearing Officer

RECEIVED
FEB 29 2016
CCMSI - RENO

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing DECISION AND ORDER was deposited into the State of Nevada interdepartmental mail system, OR with the State of Nevada mail system for mailing via United States Postal Service, OR placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 1050 E. Williams Street, Suite 400, Carson City, Nevada, to the following:

KIMBERLY KLINE
305 PUMA DR
WASHOE VALLEY NV 89704

CITY OF RENO
ATTN ANDRENA ARREYGUE
PO BOX 1900
RENO, NV 89505

CCMSI
PO BOX 20068
RENO, NV 89515-0068

Dated this 25th day of February, 2016.

Employee of the State of Nevada

RECEIVED
FEB 29 2016
CCMSI - RENO

15853839641

FAX

Medical Records Attached

TO:	Records Dept.
ORGANIZATION:	CCMSI
FAX NUMBER:	17753240453
DATE / TIME:	02/29/2016 01:14 PM
SUBJECT:	KIMBERLY KLINE(#12546853)
FROM:	The Valley Health System/NV
RETURN FAX:	(610) 982-8421
COMPANY:	MRO Corporation
CONTACT EMAIL:	roihelp@mrocorp.com

RECEIVED
FEB 29 2016
CCMSI - RENO

NO RECORDS FOR DATE REQUESTED STATEMENT

I, the undersigned, being the duly authorized medical records custodian or other qualified witness declare the following: **A thorough search of our files, carried out under my direction revealed no documents, records or other materials called for in the request for medical records identified below**

Request for medical records for [redacted]

Records requested by [redacted]

Date of request [redacted]

[redacted]

Signature [redacted]

Name [redacted]

Signed On [redacted]

NORTHERN NEVADA MEDICAL CENTER
2375 E PRATER WAY
SPARKS, NV 89434

RECEIVED
FEB 29 2016
CCMSI - RENO

CCMSI

February 22, 2016

Northern Nevada Medical

Attn: Medical Records

Sent via fax to: 775-356-0857 Pages: 2 (including cover)

Re		
	Claimant	Kimberly Kline
	Claim No	158538639641
	S.S.N.	
	D.O.B	10/07/1979
	Employer	City of Reno

Dear Medical Records Department:

Enclosed is a C-8 form signed by the injured worker allowing this office to obtain prior medical records. Please forward copies of any and all medical reporting between 10/1/2015 and 1/30/2016 to the address noted below. This includes all treatment provided for any condition for the above referenced injured worker.

If there is a charge for the copies, please forward an invoice with the requested copies. If payment is required prior to shipment, please fax the invoice to my attention at the number noted below.

If you have further questions or wish to discuss this case further, please contact me at 775-824-8890.

Sincerely,

Yesenia Martinez, Medical Only Claims Representative
CCMSI – Reno, Nevada

cc: File

RECEIVED
FEB 29 2016
CCMSI - RENO

Gallagher Bassett Management Services, Inc.
PO Box 20088 • Reno, NV 89515
866 801-8165 • 775-324-3301 • Fax: 775-324-0393 • www.ccmsi.com

MRO
P.O. Box 61507
King of Prussia, PA 19406

MRO

Fax: (610) 962-8421
Phone: (855) 253-4146

Request Number: 12546853
Tracking #: TVHSYMN4LE54S

Track your request at www.ROILOG.com.
Enter your Tracking # and Request Number.

Records Dept.
CCMSI
P.O. Box 20066
Reno, NV 89515

Date: 2/26/2018
Phone: 775-324-3301
Fax: 776-324-0453

Confirmation of Receipt of Medical Records Information Request

The Medical Facility below is in the process of searching for and retrieving a copy of the requested records. You will be notified of any issues with your request. If there are no issues, you will receive a pre-payment invoice. The records will be mailed to you upon receipt of your payment.

Should you have any questions, send an e-mail to Requestinformation@MROcorp.com. Please be sure to enter your Request number in the subject field of the email. PLEASE DO NOT CONTACT THE MEDICAL FACILITY ABOUT THIS REQUEST.

Thank you,
MRO

Patient Name: KIMBERLY KLINE
Date of Birth:

Your Request Date: [illegible]
Your Reference Number: 15853E829641
Date Received at MRO: 2/26/2018

Your request is being processed by MRO on behalf of the following facility:
Northern Nevada Medical Center
2375 E Prater Way
Sparks, NV 89434

RECEIVED
FEB 26 2018
CCMSI - RENO

CCMSI

March 16, 2016

Specialty Health Clinic
Attn: Scott Hall, M.D.
330 East Liberty Street, Suite 200
Reno, NV 89501

Claim No:	15853E839641
Claimant:	Kimberly Kline
DOI:	6/25/2015
Employer:	City of Reno
Body Part:	Cervical Strain

Dear Dr. Hall:

Ms. Kline treated with you for a cervical strain and reached MMI on 8/20/2015. Due to continued symptoms, she followed up at Leading Edge Chiropractic, at which time an MRI was ordered and performed on 1/13/2016. Enclosed please find copies of chiropractic notes, as well as a copy of the MRI report.

At this time we need further clarification. Can you please answer the following:

1. Is the diagnosed disc degeneration with large disc protrusion related to the industrial injury of 6/25/2015, or is it non-industrial/pre-existing? Please explain.

2. Is Ms. Kline at MMI for the industrial injury of 6/25/2015?

Dr. Hall, I would like to thank you in advance for your professional cooperation and courtesy regarding this matter. I will be looking forwarding to your prompt reply.

Sincerely,

Industrial Only Claims Representative

Cc: File, City of Reno, Kimberly Kline
Enc: Reporting from Leading Edge Chiropractic and 1/13/2016 MRI

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DOB:** 10/07/1978	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 03/16/2016 2:15PM	**Chart:** K_KI000001

letter:

KIMBERLY KLINE was seen at SpecialtyHealth for a medical evaluation on 03/16/2016 02:15PM

I received written communication from the administrator including medical records from a local chiropractor and an MRI of her cervical spine with questions.

Ms. Kline was injured in June of 2015 during a motor vehicle accident with subsequent treatment for a cervical strain. Her treatment included conservative care with medications and physical therapy. The patient reported pain centralized in her neck without significant radiation into her arms. No neurologic symptoms were identified in her arms. The last visit with me was October 28, 2015 when she reported essentially no symptoms and minimal pain.

The medical records I received demonstrate a visit to a local chiropractor on January 13, 2016 with the acute onset of cervical pain, 7 days duration, pain rated 10/10 with radiation into the left arm and associated neurologic signs. An MRI done also on January 13, 2016 demonstrates findings of disc degeneration and protrusions at the C5-6 and C6-7 levels. A recommendation was made by the chiropractor to see for physiatry evaluation for further treatment.

Questions from the administrator included my opinion about the disc degeneration and protrusions and their relationship to the industrial injury. It is likely the patient had disc degeneration prior to the industrial injury which may have been exacerbated by the industrial injury, however there was no evidence of neurologic symptoms during treatment for the industrial injury noted by myself or her physical therapist. The patient responded to conservative care with resolution. The collective records from the industrial injury support appropriate treatment and resolution of the cervical strain. I find no objective evidence connecting the significant MRI findings from 1/13/16 and the industrial injury.

The medical records from the recent visit to the chiropractor demonstrate the acute onset of symptoms in her neck and left arm. Based on the most recent visit from the chiropractor it would seem these symptoms started spontaneously without provocation. It is uncertain if there is a relation to the industrial injury. Prior to the industrial injury the patient did seek treatment by an orthopedist and he noted degenerative changes in her lumbar spine. This suggests that the patient was having disc degeneration prior to the industrial injury in part of her spine.

The 2nd question is in regards to a maximum improvement after treatment for the industrial injury. As I outlined

RECEIVED
MAR 18 2016
CCMSI - RENO

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DOB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 03/16/2016 2:15PM	**Chart:** KLK1000001

above, all indications were the patient had recovered completely from the industrial injury on June 25 2015 by the end of october 2015.

Signed: Scott Hall, MD

RECEIVED
MAR 18 2016
CCMSI - RENO

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE | **DOB:** 10/07/1979 | **Sex:** F
Provider: Dr. Scott Hall, MD | **Visit:** 03/16/2016 2:15PM | **Chart:** KLKI000020

Chief Complaint: cervical issue

Medications & Allergies:

Allergy	Reaction
No Known Drug Allergies (NKDA)	NKA

Assessment:

Type	Code	Description
ICD-10-CM Condition	S13.4XXA	Sprain of ligaments of cervical spine, initial encounter

letter:

KIMBERLY KLINE was seen at Specialty Health for a medical evaluation on 03/16/2016 02:15PM.

I received written communication from the administrator including medical records from a local chiropractor and an MRI of her cervical spine with questions.

Mrs. Kline was injured in June of 2015 during a motor vehicle accident with subsequent treatment for a cervical strain. Her treatment included conservative care with medications and physical therapy. The patient reported pain centralized in her neck without significant radiation into her arms. No neurologic symptoms were identified in her arms. The last visit with me was October 26, 2015 when she reported essentially no symptoms and minimal pain.

The medical records I received demonstrate a visit to a local chiropractor on January 13, 2016 with the acute onset of cervical pain, 7 days duration, pain rated 10/10 with radiation into the left arm and associated neurologic signs. An MRI was also on January 13, 2016 demonstrating findings of disc degeneration and protrusions at the C5-6 and C6-7 levels. A recommendation was made by the chiropractor to see for physical evaluation for further treatment.

Questions from the administrator included my opinion about the disc degeneration and protrusions and their relationship to the industrial injury. It is likely the patient had disc degeneration prior to the industrial injury which may have been exacerbated by the industrial injury; however, there was no evidence of neurologic symptoms during treatment for the industrial injury noted by myself or her physical therapist. The patient responded to conservative care with resolution. The collective records from the industrial injury support

E-signed by Dr. Scott Hall, MD on 03/16/2016 2:25PM

appropriate treatment and resolution of the cervical strain. I find no objective evidence connecting the significant MRI findings from 1/13/16 and the industrial injury.

The medical records from the recent visit to the chiropractor demonstrate the acute onset of symptoms in her neck and left arm. Based on the most recent visit from the chiropractor, it would seem these symptoms started spontaneously without provocation. It is uncertain if there is a relation to the industrial injury. Prior to the industrial injury, the patient did seek treatment by an orthopedist and he noted degenerative changes in her lumbar spine. This suggests that the patient was having disc degeneration prior to the industrial injury in part of her spine.

The 2nd question is in regards to a maximum improvement after treatment for the industrial injury. As I outlined above, all indications were the patient had recovered completely from the industrial injury on June 25, 2015 by the end of october 2015

Signed: Scott Hall, MD

E-signed by Dr. Scott Hall, MD on 03/16/2016 2:25PM

C C M S I

March 14, 2016

Kimberly Kline
305 Punta Dr.
Washoe Valley NV 89704

RE: Claimant: Kimberly Kline
Claim No: 15853E839641
Injury Date: 6/25/2015
Employer: City of Reno

Dear Ms. Kline

In compliance with the Hearing Officer's decision [illegible] Dr. [illegible] results and questioned [illegible] regarding your claim. After [illegible] of your workers' compensation claim, it has been determined that all benefits have been paid [illegible]

You are not being scheduled for a disability evaluation because Dr. Hall indicated that you do not have a ratable impairment as a result of your above-referenced claim.

If you do not agree with this determination, you have the right to request a hearing [illegible] please complete the enclosed "Request for Hearing" form [illegible] copy of this letter, to the Department of Administration, Hearings Division [illegible] within seventy (70) days from the date of this letter.

If you have any questions regarding the above matter, please contact our office at [illegible]

[illegible]

cc: File, City of Reno

REQUEST FOR HEARING - CONTESTED CLAIM

Pursuant to NAC 616C.274

REPLY TO: Department of Administration
Hearings Division
1050 E. William Street, Ste. 400
Carson City, NV 89701
(775) 687-8440

OR: Department of Administration
Hearings Division
2200 S. Rancho Drive, Suite [illegible]
Las Vegas, NV 89102
(702) 486-2525

Employee Information

Employer Information

Insurer Information

Third-Party Administrator Information

Do Not Complete & Mail This Form Unless You Disagree With the Insurer's Determination.

YOU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARING WILL NOT BE SCHEDULED PURSUANT TO NRS 616C.315

Briefly explain the basis for this appeal:

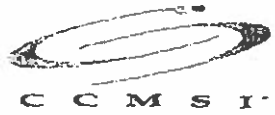
The Injured Employee

This request for hearing is filed by or on behalf of **The Employer**

and is dated this _____ day of _____ 20_____

Signature of Injured Employee/Employer

Injured Employee's/Employer's Rep. (Advisor)
Details



PO Box 20068, Reno, NV 89515

Total Pages Faxed (including cover sheet)

Date: 4/27/2016

To: Kimberly Kline

Fax Number: 775-323-5211

From: Lisa Jones, Claims Representative

Telephone Number: (775) 324-9891

Fax Number: (775) 324-9893

RE: Acecptance letter

Comments: Per your request, attached is a copy of the acceptance letter. Please let me know if you need anything else.

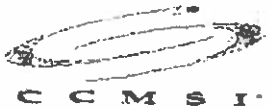
Thank you,
Lisa Jones

TRANSMISSION VERIFICATION REPORT

TIME 04/27/2016 10:57
NAME
FAX
TEL
SER.

04/27 10:55
3235211
00:01'27
07

STANDARD
ECM



CCMSI

PO Box 20068, Reno, NV 89515

Total Pages Faxed (including cover sheet)

Date: 4/27/2016

To: Kimberly Kline

Fax Number: 775-323-5211

From: Lisa Jones, Claims Representative

Telephone Number: (775) 324-9891

Fax Number: (775) 324-9893

RE: Acecptance letter

Comments: Per your request, attached is a copy of the acceptance letter. Please let me know if you need anything else.

May 2, 2016

SENT VIA FACSIMILE; HARD COPY WILL NOT FOLLOW

Yesenia Martinez
CCMSI
P.O. Box 209687
Reno, NV 89515

RE: Claimant: Kimberly Kline
Claim No.. 15853E839641
DOI: 6-25-15

Dear Ms. Martinez,

Please be advised that I have retained the Law Firm of Herb Santos, Jr. to represent me in connection with my industrial injury which occurred on June 25, 2015. Please forward any and all documents to Mr. Santos' office including, but not limited to my medical records, investigative reports correspondence, etc.

[illegible] matter is greatly appreciated.

Very truly yours,

Kimberly Kline

Received
MAY 03 2016
CCMSI-Reno

15853E83964

THE LAW FIRM OF
HERB SANTOS, JR.

225 S. Arlington Ave, Suite C
Reno, Nevada 89501
(775) 323-5200
Fax: (775) 323-5211

FAX COVER SHEET

FAX NUMBER TRANSMITTED TO: 1-775-687-8461

To: Hearings Office
From: Herb Santos, Jr.
Client/Matter: Kimberly Kline/56373-JL
Date: May 2, 2016

DOCUMENTS	NUMBER OF PAGES
Dr. Hansen report dated 1/13/16	3

COMMENTS:

Please be advised that Herb will be representing the Claimant for the above referenced hearing. Herb will participate by telephone at (775) 323-5200. Also enclosed is medical reporting that Herb may rely upon for the hearing.

Should you have any questions or concerns, please do not hesitate to contact this office at (775)323-5200. Thank you.

cc: Lisa Jones @ 324-0453

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MAY 02 2016
CCMSI - RENO

THE LAW FIRM OF
HERB SANTOS, JR.

May 2, 2016

SENT VIA FACSIMILE; HARD COPY WILL NOT FOLLOW

Yesenia Martinez
CCMSI
P.O. Box 202687
Reno, NV 89515

RE: Claimant: Kimberly Kline
Claim No.: 15853E839641
DOI: 6-25-15

Dear Ms. Martinez:

Please be advised that the above-referenced Claimant has retained this office in connection with the industrial injury also referenced above.

Please assure me that all correspondence to the Claimant, employer, healthcare provider, or any other person or entity associated with this claim is copied to this office unless it is privileged by law.

Thank you for your anticipated cooperation. Should you have any questions, please feel free to contact me at (775) 323-5200.

Very truly yours,

Herb Santos, Jr.

HJS:ks

Received
MAY 03 2016
CCMSI-Reno

335 South Arlington Avenue, Suite C, Reno, Nevada, 89501 Tel: (775) 323-5200 Fax: (775) 323-5211
www.SANTOSLAWFIRM.com

THE LAW FIRM OF HERB SANTOS, JR.
225 S. Arlington Avenue, Suite C
Reno, Nevada 89501
(775) 323-5200
Fax: (775) 323-5211

AUTHORIZATION TO RELEASE INFORMATION

To:

I hereby authorize you to permit Herb Santos, Jr., of the Law Firm of Herb Santos Jr. 225 South Arlington Avenue, Suite C, Reno, Nevada, 89501, or his duly authorized agents to inspect and obtain copies of all of my medical, hospital and therapy records, reports, documents, prescriptions, papers and x-rays and/or any and all records pertaining to vocational, psychological and rehabilitative testing and training, together with copies of all billings for any of said services, accident reports taken by a police department or Highway Patrol, employment records which you have in your possession, control or custody. I also authorize the release of my police report and any employment records I may have.

You are hereby requested to disclose no information, orally or otherwise, to any insurance representative or other person, including other physicians, without specific written authority from me to do so (pursuant to privileged and confidential communications statutes). All prior authorizations are hereby canceled. I hereby waive any privilege I have to said information to my attorney.

This authorization is extended to and includes photostatic copies of this executed medical authorization.

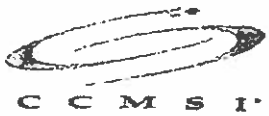
Dated this 2 day of May, 2015.

Klino

Date of Birth: 10-07-79

Date of Accident: 6-25-15

Received
MAY 09 2016
CCMSI-Reno



PO Box 20068, Reno, NV 89515

Total Pages Faxed 29 (including cover sheet)

Date: 5/3/2016

To: Herb Santos, Esq.

Fax Number: 775-323-5211

From: Lisa Jones, Claims Representative

Telephone Number: (775) 324-9891

Fax Number: (775) 324-9893

RE: Kimberly Kline 15853E839641

Comments: Per your request attached is a copy of the hearing packet for HO#56373-JL.

Thank you,
Lisa Jones

15853E839641

TRANSMISSION VERIFICATION REPORT

TIME 05/03/2016 08:44
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FAX
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PO Box 20068, Reno, NV 89515

Total Pages Faxed 29 (including cover sheet)

Date: 5/3/2016

To: Herb Santos, Esq.

Fax Number: 775-323-5211

From: Lisa Jones, Claims Representative

Telephone Number: (775) 324-9891

Fax Number: (775) 324-9893

RE: Kimberly Kline 15853E839641

Comments: Per your request attached is a copy of the hearing packet for HO#56373-JL.

Thank you.

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:

Hearing Number: 55873-JL
Claim Number: [illegible]

KIMBERLY KLINE
305 PUMA DR
WASHOE VALLEY, NV 89704

CITY OF RENO
ATTN ANDRENA ARREYGUE
PO BOX 1900
RENO, NV 89505

BEFORE THE HEARING OFFICER

The Claimant's request for Hearing was filed on April 6, 2016 and a Hearing was scheduled for May 3, 2016. The Hearing was held on May 3, 2016, in accordance with Chapters 616 and 617 of the Nevada Revised Statutes.

The Claimant and her attorney, Herbert Santos, Jr., were present by telephone conference call. The Employer was not present. The Insurer was represented by Lisa Jones of CCMSI by telephone conference call.

ISSUE

The Claimant appeals the Insurer's determination dated March 24, 2016. The issue before the Hearing Officer is claim closure without a permanent partial disability (PPD) award.

DECISION AND ORDER

The determination of the Insurer is hereby **AFFIRMED**.

On March 24, 2016, the Insurer noticed the Claimant that her claim would remain closed and she would not be scheduled for a PPD evaluation. The instant appeal Pursuant to Decision and Order Number 55487-JL, the Insurer was instructed to provide Dr. Hall with the MRI results and question him regarding the need for further medical treatment, claim closure, PPD, etc. On March 16, 2016, Dr. Hall responded and stated he found no objective evidence connecting the significant MRI findings and the industrial injury. As such, the Hearing Officer finds the Insurer's determination is proper.

APPEAL RIGHTS

Pursuant to NRS 616C 345(3), should any party desire to appeal this final Decision and Order of the Hearing Officer, a request for appeal must be filed with the Appeals Office within thirty (30) days of the date of the decision by the Hearing Officer.

IT IS SO ORDERED this 6th day of May, 2016.

Jason Luis, Hearing Officer

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MAY 09 2016
CCMSI - RENO

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing DECISION AND ORDER was deposited into the State of Nevada interdepartmental mail system, OR with the State of Nevada mail system for mailing via United States Postal Service, OR placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 1050 E. Williams Street, Suite 400, Carson City, Nevada, to the following:

KIMBERLY KLINE
305 PUMA DR
WASHOE VALLEY, NV 89704

HERBERT SANTOS JR, ESQ
225 S ARLINGTON AVE STE C
RENO NV 89501

CITY OF RENO
ATTN ANDRENA ARREYGUE
PO BOX 1900
RENO, NV 89505

CCMSI
PO BOX 20068
RENO, NV 89515-0068

Dated this 6th day of May, 2016.

Susan Simons
Employee of the State of Nevada

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MAY 09 2016
CCMSI - RENO

Russell N. Anderson, DC
290 SE Court Street
Prineville, OR 97754
(541) 903-1444 (541) 362-4090-FAX

PERMANENT PARTIAL DISABILITY EVALUATION

Claim #: [illegible]
Lisa Jones-Claims Representative
Date of Injury: 08\25\2015
Date of Evaluation: November 10th, 2017

Kimberly Kline presented to my Reno Office for a formal PPD evaluation on Friday, November 10th, 2017 at 8:30 AM. The insurance company approved the evaluation of her cervical spine

Treatment History

5\11\2015: Brett Men-Muir, MD: She is here for bilateral lower back pain. This is not work related. She has been complaining of LBP for several months. It was exacerbated last month. It is 8\10 in severity. She takes diclofenac, Zoloft, and ibuprofen. A history of depression. X-rays show L4-5 disc D.D. DX: discogenic back pain. Plan: PT and voltaren.

6\25\2015: Richard Law, MD: Moderate pain in the upper lumbar spine, mid lumbar, and lower lumbar spine; radiates to the right thigh and left thigh. She had similar symptoms recently, had an MRI 1 month ago; hx of herniated disc at L3-4 and L4-5. She has had previous chronic LBP; intervertebral disc disease. Her meds include Zoloft. Exam show tenderness in the lumbar spine. Impression: acute lumbar radiculopathy, lumbar spasm, and acute lumbar pain. Plan: ice, limited activity, flexeril, norco, prednisone, follow up.
08\25\2015: This is a C-4 form that states "I was rear ended". The claimant was seen at St Mary's regional Medical Center ER. Her initial DX was acute lumbar sprain; MVA.
6\30\2015: Scott Hall, MD: She presents for her back after a [illegible] MVA on 8\25\15. She now reports: neck pain, lumbar and thoracic pain. Assessment: neck and back sprain. Plan: chiropractic care, full duty work, return in 2 weeks.
7\13\2015: Scott Hall, MD: She continues with neck and back issues. Plan: PT, full duty, conservative treatment
8\20\2015: Scott Hall, MD: Her neck has improved and she describes only muscular tightness that is mild. She has no arm symptoms, PT has been helpful. Plan: complete her PT and monitor
8\26\2015: Custom PT: She had a PT re-eval today; 12 more visits are recommended over the next 4 weeks.
9\23\2015: Scott Hall, MD: She reports improving NP; a 3\10. She is getting PT
10\28\2015: Scott Hall, MD: Her neck has improved; no current significant symptoms. Reduced arm symptoms.

SCANNED

PAGE 2: Kim Kline continued

1\3\2016: *MRI of the C-Spine:* Impression. Disc degeneration with large protrusions at C5-6 and at C6-7; this results in complete effacement of the CSF from the dorsal and the ventral aspects of the cord with severe canal stenosis without cord compression or abnormal signal intensity to suggest cord edema or myelomalacia.

1\13\2016: Bryan Hansen, MS DC (Leading Edge Chiropractic): She presents with NP with associated weakness and numbness. Her symptoms started 7 days ago, but there is "high likelihood that her symptoms are related to the MVA she recently sustained". She was released from care for that several weeks ago. Her DX is disc displacement. Plan: cold pack to the neck, spinal decompression; E-stim; laser therapy.

1\14\2016: She reports symptoms of numbness and weakness. She was treated again with cold, decompression table, E-stim, and laser.

1\25\2015: She states NP, numbness, and weakness; same treatment.

01\18\2016: The notes are about the same today.

01\19\2016: Decompression treatment and therapies.

1\20\2016: She continues with chiropractic treatment.

1\21\3016: Nothing new.

1\25\2016: Same notes and treatment.

01\27\1016: A re-exam was done today. Continue treatment plan. There were further chiropractic, traction, and therapy modalities on: 1\28\16, 2\1\16, 2\2\16, 2\5\16, 2\8\16, 2\10\16, 2\12\16, 2\16\16, 2\19\16, 2\24\16, 3\16\2016: She has completed the 20 visits of prescribed treatment; non-surgical spinal decompression to address the C6-7 and C5-6 radiculitis to the left. She has improved greatly and has only mild pain in the left UE. She is to do HEP.

3\16\3016: Scott Hall, MD: There was no evidence of neurologic involvement after the MVA. She responded to conservative care with resolution of her symptoms. The new onset of quite severe symptoms started spontaneously and it is uncertain if there is any relation to the industrial injury. She had sought treatment from an orthopedist prior to the WC injury. All indications are that the claimant had completely recovered from the industrial injury by the end of October, 2015.

4\28\2016: Bryan Hansen, DC: She presents with NP, weakness, and numbness. She is to do HEP.

7\5\2016: Lali Sekhon, MD: Her CC is NP, stiffness, and left arm numbness and pain. She previously had neck and back issues that were manageable in the past until she was in the car accident in June, 2015. There were actually 2 accidents. She had physical therapy and chiropractic treatments. She had an epidural that really did not help. She rates her NP, HA and pressure feeling in the neck as 5\10 in severity. The left arm symptoms are in a C6 distribution. Her right arm is OK. She feels that she has plateaued. Assessment: cervicalgia, cervical spine stenosis, C4-5 spondylolisthesis, failed conservative therapy, minimal spondylosis at L3-4 to L5-S1. She has cord compression and weakness; Dr. Sekhon thinks that it is reasonable to offer her surgery; the accident probably exacerbated her underlying stenosis. She was offered C4-5 to C6-7 decompression and fusion.

Page 3 Kim Kline continued

4\3\2017: Kurt Erickson, PA-C: Dr Sekhon and were able to review Kim Kline again today She has continued with posterior neck pain and pressure. The pain continues to extend down the left arm following a C6 distribution The left arm symptoms are rated as 9\10 She has trouble sleeping. The intensity is about the same as last July She has cervical spondylosis with cord pressure at C5-6 and C6-7. She has failed conservative treatment. It is reasonable to offer her surgery. The plan is to repeat C-spine MRI and X-rays.

4\21\2017: *C-Spine MRI:* Impression: Moderate disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis.

C Spine X-rays Impression: mild disc narrowing and facet degenerative changes of the lower C-spine; development of retrolisthesis of 2mm, C4 on C5 and 1mm retro of C6 on C7 on extension of the C-spine

4\25\2017: Lali Sekhon, MD: Her arm is worse Her options were discussed, she wants surgery

6\8\2017: Lali Sekhon, MD: She returns for review and all of her questions were answered She again requests surgery.

6\12\2017: Lali Sekhon, MD: Operative Report: Procedures: C4-5, C5-6, and C6-7 anterior cervical decompression, interbody fusion using interbody cages and bone graft substitute C4-C7 anterior fixation using a cervical locking plate The X-ray shows "anterior cervical fusion and placement of disc devices"

6\26\2017: Curt Erickson, PA-C: She still has achiness in her neck; the left arm symptoms have improved. Follow in 4 weeks.

7\26\2017: Curt Erickson, PA-C (For Dr Sekhon): The X-rays show no instability She has ongoing numbness in the left hand and forearm; not as bad as before

8\10\2017 Amanda Cowles, PT (Custom PT) She is having some trouble with ADLs She can flex to 25 degrees, extend to 20, left bending to 20, right bending to 25, rotation to 60. She had about 7 PT follow ups. On the 9\14\17 visit, Kim could flex to 40, extend to 30, left rotation 55, right rotation 70, left bending 15, right bending to 20

9\5\2017: Curt Erickson, PA-C: Her symptoms are much improved, there is slight numbness in her left hand very manageable. She has occasional neck pain. She believes the PT is helping Cervical spine X-rays today show fusion from C4 to C7 with no evidence of hardware complications

9\21\2017: Dr. Sekhon fills out a questionnaire from Specialty Health He says the claimant is stable and reached maximum medical improvement She is released to full duty. Her restrictions are "common sense" She is ratable.

The above represents all of the medical records that were presented for my review.

PAST MEDICAL HISTORY

Prior to this work related injury\accident, Kimberly has previously received some chiropractic care She tells me that this was mostly for lower back pain. She would get her neck (C-spine)

adjusted sometimes, but denies any significant prior neck pain, disability, or radiation upper

extremity symptoms. She was treating in the months before this accident (2015) for LBP that was not work related. Ms. Kline previously used Zoloft for depression. She denies any current prescription medications. She currently takes OTC Advil.

Ms. Kline previously suffered a work-related right wrist injury and right shoulder injury. She did not receive impairment ratings for this. Her surgical history includes an ankle surgery to re attach tendons.

CURRENT SYMPTOMS

Currently, Ms. Kline has a chief complaint of frequent, daily headaches and limited mobility in her neck. She complains particularly of limitations with looking up to either side. She is also complaining of numbness in the left wrist and hand effecting the ring and little fingers in a C6 and\or ulnar nerve pattern.

Kim is having some difficulty with looking up to rinse in the shower. When driving, it is difficult for her to look into the back seat or behind her. Her neck seems to get tired quickly when driving and when working on the computer. Her neck gets tired when reading.

Physical Examination

Cervical Spine

Inspection reveals no cervical antalgia. She is in no distress. I observe a surgical scar on the anterior\left cervical region. It measures 7.2 CM.

Palpating the cervical spine soft tissue structures, I find the right splenius to by hypertonic. The right SCM muscle is tight and tender.

Passive motion of the cervical spine is noticeably limited on right rotation. There is a tight end-feel.

Measuring the muscle girth of the forearms, I find the right forearm to be 26.6 CM at the area of greatest circumference. The left forearm measures 25.2 CM.

The claimant performed a brief warm-up of cervical spine motions, after which we measured active ranges of motion using dual inclinometers. The claimant did appear to give her best effort on all ROM measurements.

Cervical Spine Active Ranges of Motion

Flexion: Calvarium 1: 48 2: 48 3: 46

PAGE 5 (KIMBERLY KLINE)

T1: 1. 8 2. 4 3. 6
Max ROM = 48-4= 44 degrees (1% WPI)
Extension: Calvarium: 1. 38 2. 38 3. 38
T1: 1. 8 2. 10 3. 8
Max ROM = 38-8= 30 degrees (3% WPI)
Right Bending: Head: 1. 38 2. 40 3. 44 4. 40
T1: 1. 4 2. 6 3. 6
Max ROM = 44-6= 38 degrees (no impairment
Left Bending: Calvarium: 1. 38 2. 36 3. 36
T1: 1. 4 2. 3. 4
Max ROM = 38-4= 34 degrees (1% WPI)
Right Rotation 1. 64 2. 64 3. 62
Max ROM = 64 degrees (1% WPI)
Left Rotation: 1. 56 2. 58 3. 58
Max ROM = 56 degrees (1% PW.)

Whole person impairments from motion loss at various cervical spine motions are added 1+3+2+1+0 = 7% WPI from motion loss in the cervical spine.

I can elicit equal, +2 deep tendon reflexes at Right and Left biceps, brachioradialis, and triceps

The claimant can demonstrate 5\5 strength, equal bilaterally at shoulder, elbow, wrist, and fingers.

She has some decreased sensibility to light touch over the C6 dermatome on the left. This includes partial loss of 2 point discrimination over the palmar left right and little fingers (3 point sense at 9mm). This is grade 3 sensory loss, 25% sensory deficit of the C6 nerve root (Table 15-15); we multiply this to the maximum upper extremity impairment for sensory loss at C6 (8% Table 15-17) and we get *2% left upper extremity impairment, 1% WPI*

Impairment Calculation

If we are to use the diagnosis related estimate in this case (due to multi-level involvement and multilevel fusion), then; using Table 15-7, part IV, Ms. Kline has 10% WPI from spinal fusion with residual signs and symptoms. We add 1% for each additional level (2 additional) to get *12% whole person impairment from Specific Spine Disorder*

As described above, this claimant has a cumulative total of *7% whole person impairment from motion loss* in the cervical spine

She has *1% WPI for sensory loss coming from the C6 nerve root*

Combining 12% with 7%, we get 18%; this is then combined with 1% to get a total of *19% whole person impairment from the cervical spine*

Recommend

Page 6 (Kimberly Grime)

Using the DRE method, this claimant would be easily placed in Cervical Spine DRE category IV due to loss of motion segment integrity. This is ***25% impairment of the whole person*** and this method should be used since it results in a higher rating (AMA Guides, 5th Edition, page 380).

MMI AND MEDICAL STABILITY

The claimant has reached a stable plateau of medical improvement. Her condition has not changed over the last 45 days. Her condition is not likely to change significantly over the next 12 months with or without treatment.
She has reached maximum medical improvement.

APPORTIONMENT

The claimant had underlying cervical spine issues that pre-date this work related car accident and injury. Namely, the MRI and radiographic reports show cervical spine degenerative discs with large protrusions at C5-6, C6-7, effacement of the CSF and severe canal stenosis (MRI of 1\3\2016). It is not logical to believe that these findings are related to the car accident that she was involved in 6 months earlier.

This claimant's 25% whole person impairment is based upon the surgery that was performed. The surgery was performed due to cervical spine spondylosis, stenosis, and cord pressure at C4-5 to C6-7.

75% of this claimant's whole person impairment (cervical spine) is apportioned as non-industrial.
25% of her impairment is industrial and related to the work injury that occurred on 6\25\2015 because:

- The claimant had no documented cervical spine injury or pain immediately after the accident (symptoms began 6\30\2015). After that, the cervical strain could be described as slight.
- The findings of cervical spine spondylosis, stenosis, and disc bulges cannot be logically attributable to this car accident\work injury. These findings provided the indication for fusion surgery in the cervical spine.
- The claimant had responded well to physical therapy and medical treatment and had nearly completely resolved her cervical spine complaints prior to December, 2015. She had no upper extremity symptoms at the time of release from care.

On the other hand, the claimant denies any prior upper extremity symptoms (radiculopathy) before this injury. This work injury likely played some role in the onset of symptoms that led to surgery, but was not the primary cause.

Page 7 (Campbell Kline)

So, apportioning 75% of this claimant's impairment as non-industrial, we take 25% of this claimant's whole person impairment (which was 25% WPI), and we get *6% WPI related to this work injury (that occurred on 6\25\2015).*

PERMANENT IMPAIRMENT SUMMARY

The claimant has 25% whole person impairment coming from the cervical spine. Of this, *6% WPI is related to the work related injury that occurred on 6\25\2015.*

This is reasonable, should be awarded, and case closure should occur.

Russell N. Anderson, DC

Nov 21 17 04:22p

Russell N. Anderson, DC
290 SE Court Street
Prineville, OR 97754
(541) 903-1446 (541) 352-4080-fax

BILLING STATEMENT

November 21st, 2017

Claimant: Kimberly Kline
Claim #: 15853E839641
CCMSI-Lisa Jones-Claims Representative
Date of Evaluation: November 10th, 2017

Service Performed: NVD1000: Records review, PPD Exam and Report $804

Service Performed at: 1699 S Virginia Street
Suite 100
Reno, NV 89502

Please send all payment and other correspondence to:

Russell N. Anderson, DC
290 SE Court Street
Prineville, OR 97754

A W-9 form is attached

Russell N. Anderson, DC
Chiropractor-Independent Rating Physician

C C M S I

December 5, 2017

KIMBERLY KLINE
305 Puma Dr
Washoe Valley, NV 89704-9739

Re	Claimant:	Kimberly Kline
	Claim No.:	15853E839641
	D.O.I.:	6/25/2015
	Employer:	City of Reno

Dear Ms. Kline:

We are in receipt of Dr. Russell Anderson's Permanent Partial Disability (PPD) report dated November 10, 2017. As a result of your Permanent Partial Disability (PPD) evaluation, you have been granted a permanent partial disability award of six (6%) percent on a whole body basis for impairment of your cervical.

Please be advised the PPD award will be paid in monthly installments pursuant to NRS 616C.380.

If you disagree with the above determination, you have the right to appeal by requesting a hearing before a Hearing Officer by completing the Request for Hearing form of this notice and sending it to the State of Nevada, Department of Administration, Hearings Division. Your appeal must be filed within seventy (70) days after the date on which the notice of this determination was **mailed**

If you have further questions or wish to discuss this case further, please contact me at (775) 324-3301 x 1029.

Sincerely,

[illegible]
Claims Representative
CCMSI – Reno, Nevada

cc File, City of Reno, Tim Rowe Esq, Herb Santos Esq

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:	Hearing Number: 1801761-JL Claim Number: 15853E839641
KIMBERLY KLINE 305 PUMA DR WASHOE VALLEY, NV 89704-9739	CITY OF RENO ATTN ANDRENA ARREYGUE PO BOX 1900 RENO, NV 89505

BEFORE THE HEARING OFFICER

The Claimant's request for Hearing was filed on December 13, 2017, and a Hearing was scheduled for January 10, 2018. The Hearing was held on January 10, 2018, in accordance with Chapters 616 and 617 of the Nevada Revised Statutes.

The Claimant was represented by her attorney, Herbert Santos, Jr., by telephone conference call. The Employer was not present. The Insurer was represented by Lisa Wiltshire Alstead, Esquire, by telephone conference call.

ISSUE

The Claimant appealed the Insurer's determination dated December 5, 2017. The issue before the Hearing Officer is the 6% permanent partial disability (PPD) evaluation.

DECISION AND ORDER

The determination of the Insurer is hereby **REMANDED**.

On November 10, 2017, this Claimant was evaluated for a PPD by Dr. Anderson wherein Dr. Anderson awarded a 6% PPD. Dr. Anderson concluded that the Claimant has a 25% whole person impairment. Dr. Anderson further determined that 75% of the impairment should be apportioned as non-industrial. Having reviewed the submitted evidence and in consideration of the representations made at today's hearing, the Hearing Officer finds a medical question regarding Dr. Anderson's 75% apportionment. As such, the Hearing Officer instructs the Insurer to schedule the Claimant for a second PPD evaluation pursuant to NRS 616C.330. Upon on completion of the second PPD evaluation, the Insurer shall render a new determination with appeal rights accordingly.

NRS 616C.330(3) grants authority to the hearing officer to refer an employee to a physician or chiropractor chosen by the hearing officer to resolve a medical question. If the medical question concerns the Permanent Partial Disability rating, the rating physician or chiropractor must be selected pursuant to NRS 616C.490(2)(a), unless the insurer and injured employee otherwise agree to a rating physician or chiropractor. The insurer shall pay the costs of any medical examinations requested by the hearing officer.

APPEAL RIGHTS

Pursuant to NRS 616C.345(1), should any party desire to appeal this final Decision and Order of the Hearing Officer, a request for appeal must be filed with the Appeals Officer within thirty (30) days of the date of the decision by the Hearing Officer.

IT IS SO ORDERED this 16th day of January, 2018.

Jason Luis, Hearing Officer

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing **DECISION AND ORDER** was deposited into the State of Nevada Interdepartmental mail system, **OR** with the State of Nevada mail system for mailing via United States Postal Service, **OR** placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 1050 E. Williams Street, Suite 400, Carson City, Nevada, to the following:

KIMBERLY KLINE
305 PUMA DR
WASHOE VALLEY, NV 89704-9739

HERBERT SANTOS JR, ESQ
225 S ARLINGTON AVE STE C
RENO NV 89501

CITY OF RENO
ATTN ANDRENA ARREYGUE
PO BOX 1900
RENO, NV 89505

CCMSI
PO BOX 20068
RENO, NV 89515-0068

LISA M WILTSHIRE ALSTEAD ESQ
MCDONALD CARANO WILSON
100 W LIBERTY ST 10TH FLOOR
RENO NV 89501

Dated this 10th day of January, 2013

Susan [illegible]
Employee of the State of Nevada

CCMSI

April 4, 2018

KIMBERLY KLINE
305 Puma Dr.
Washoe Valley, NV 89704-9739

Re: Claim No.: 15853E839641
D.O.I.: 6/25/2015
Employer: City of Reno
Body part: Cervical

Dear Ms. Kline:

In compliance with the denial of Stay Order filed on 3/27/2018, you have been scheduled for a Permanent Partial Disability evaluation with Dr. James Jempsa on 5/8/2018 at 2:00 p.m. Please check in at least 30 minutes early to your appointment. The physician's office is located at 6580 South Virginia Street Reno, NV 89511. Please call the physician's office at (775) 786-9072 to confirm this appointment.

If your injury involves your back or a lower extremity (i.e. knee, ankle, leg), please wear comfortable clothing and bring gym shorts or cut offs for your evaluation.

One of the necessary factors in computing a monetary award is the injured worker's age. Please bring a copy of your driver's license, birth certificate, or other official record that documents your exact age with you to the evaluation, or send a copy to CCMSI at the address below.

You are asked to hand carry any diagnostic films to this appointment, including but not limited to ALL MRI films taken for your injury. If you do not bring films to the evaluation the rating physician may not perform the evaluation.

As of the date of your scheduled evaluation, whether or not you are present, your claim will close for all benefits, except the right to request reopening and any ongoing rehabilitation programs.

Also, as of the date of this letter, CCMSI will not authorize payment of any further medical treatment. However, payments will be honored for any treatments and/or prescriptions authorized prior to the date of this letter up through the date of this evaluation.

CCMSI

It is very important that you keep this appointment and cooperate fully with the physician. NRS 616C.140 (5) states: "If the employee refuses to submit to an examination ordered or requested pursuant to subsection 1 or 2 or obstructs the examination, his right to compensation is suspended until the examination has taken place, and no compensation is payable during or for the period of suspension."

If you are a no call / no show for this appointment, or if you fail to cancel at least 24 hours prior to the examination, you will be responsible for any associated charges (NRS 616C.230).

If you disagree with this determination, you have the right to request a hearing by completing the bottom portion of the enclosed Request for Hearing form, and sending it to the State of Nevada, Department of Administration, Hearings Division, Carson City address, within seventy (70) days from the date of this letter.

If you have questions regarding this letter, you may contact me at (775) 324-9891.

Sincerely,

[redacted]
Claims Representative
CCMSI – Reno, Nevada

cc file
City of Reno
Lisa Wiltshire-Alstead, Esq.
Herb Santos, Esq.
Dr. Jempsa

REQUEST FOR HEARING - CONTESTED CLAIM

(Pursuant to NAC 616C.274)

REPLY TO

Department of Administration
Hearings Division
1050 E. William Street, Ste. 400
Carson City, NV 89701
(775) 687-8440

OR

Department of Administration
Hearings Division
2200 S. Rancho Drive, Suite 2.0
Las Vegas, NV 89102
(702) 486-2525

Employee Information

Employee's Name and Address
KIMBERLY KLINE
305 Puma Dr
WASHOE VALLEY, NV 89704

Employee's Telephone Number
775-326-6637

Claim No. 15853E639841

Date of Injury 06/25/2015

Employer Information

Employer's Name and Address
CITY OF RENO
1 EAST FIRST STREET
RENO, NV 89505

Employer's Telephone Number
775-326-6637

Insurer Information

Insurer Name and Address

Insurer's Telephone Number

Third-Party Administrator Information

Third-Party Administrator's Name and Address

Third-Party Administrator's Telephone Number

Do Not Complete or Mail This Form Unless You Disagree With the Insurer's Determination

YOU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARING WILL NOT BE SCHEDULED PURSUANT TO NRS 616C.315.

Briefly explain the basis for this appeal:

This request for hearing is filed by, or on behalf of: **The Injured Employee** / **The Employer**

and is dated this _____ day of _____, 20__

Signature of Injured Employee/Employer

Injured Employee's/Employer's Rep. (Address)

JAMES C. JEMPSA, DO

Reno, Nevada
Telephone: 775-786-9072
Fax: 775-787-6430

Lisa Jones
CCMSI
PO Box 20068
Reno, NV 89515
Telephone: 775-324-3301
Fax: 775-324-9893

PERMANENT PARTIAL DISABILITY EVALUATION

RE		
	CLAIMANT:	Kimberly Kline
	SSN:	
	CLAIM NO.:	15853E839641
	DOI:	06/25/2015
	EMPLOYER:	City of Reno
	DATE OF EXAM:	05/08/2018
	DATE OF REPORT	05/14/2018
	BODY PARTS:	1. Cervical.

DIAGNOSIS:

1. Multilevel cervical fusion.

PLACE OF EXAMINATION: Reno, Nevada.

INTRODUCTION: The claimant presents to our office today for a Permanent Partial Disability rating performed in accordance with the Fifth Edition, Sixth Printing AMA Guides to the evaluation of Permanent Impairment. The claimant was informed with regards to the purpose of this examination. It is understood that there is no patient/treating physician relationship established on the basis of today's examination. It was explained that the evaluation was requested by the referral source and the report will be sent to the referral source upon completion.

Dear Lisa Jones:

Kimberly Kline sustained industrial injury to her neck on June 25, 2015. She subsequently went on to have a multilevel fusion of her cervical spine. She presents today for a PPD evaluation of the cervical spine.

PERSONAL DATA

The claimant was identified by her picture on a Nevada Driver's License #0701144556. She gives a birth date of 10/07/1979 making the claimant 38 years of age at the time of this evaluation.

The claimant has lived in Reno for approximately the last 38 years.

She has completed school greater than 16 years.

The claimant has not served in the military.

REVIEW OF MEDICAL RECORDS:

All significant medical records provided were reviewed.

On June 25, 2015 initial evaluation at St. Mary's Regional Medical Center. History of Present Illness: Chief Complaint: Back injury and back pain. It is described as being moderate degree of pain in the upper lumbar mid lumbar and lower lumbar spine radiating into the right thigh and the left thigh. No bladder dysfunction, bowel dysfunction, sensory loss or motor loss. Past History: The patient had prior back pain. Physical Exam. Neck: Normal inspection. Neck nontender. Painless range of motion. Back: Mild vertebral point tenderness over the upper, mid and lower lumbar spine. Neuro: No motor deficit. No sensory deficit. Reflexes normal. Impression: Acute lumbar radiculopathy. Sprain of lumbar spine. Acute pain in the lower back. Prescription Medications: Flexeril, Norco and prednisone.

On June 30, 2015 evaluation at Specialty Health Clinic. Chief Complaint. Back-2nd MVA 6-25-15. History of Present Illness: Patient was involved in a second motor vehicle accident on June 25, 2015 when she was rear-ended at high-speed. Currently the patient reports: 1. Neck discomfort-moderate, diffuse, radiation into the right shoulder, associated stiffness. 2. Lumbar and thoracic pain-diffuse, nonradiating, no red flags, no numbness or weakness reported and legs. Physical Exam. Cervical exam-mild diffuse muscular tenderness to palpation, normal inspection, normal strength and sensation in both arms, normal reflexes throughout both arms, range of motion, flexion 40°, extension 50°, lateral rotation 70° bilaterally with pain at extremes. Assessment. Sprain of neck. Plan: Chiropractic, full duty, return in two weeks.

On May 11, 2015 initial evaluation by Dr. Men-Muir. He evaluated her low back.

On July 14, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports ongoing lumbar and neck pain, moderate to severe, associated sleep disruption and stiffness, minimal improvement with chiropractic care, no numbness or weakness. Physical Exam: Musculoskeletal: Neck-normal inspection, mild diffuse muscular tenderness to palpation, grossly normal strength and sensation. Assessment: Sprain of neck. Plan: Physical therapy, Full duty, return in two weeks.

On August 20, 2015 follow-up visit at Specialty Health Clinic. Chief Complaint: Cervical strain. History of Present Illness: Patient notes improvement in her neck symptoms and describes only mild muscular tightness currently. She reports no arm symptoms. Physical therapy has been helpful and continues. Physical Exam: Musculoskeletal: Exam-normal inspection, mild muscular tenderness palpation over the trapezius, full motion with grossly normal strength and sensation in arms. Assessment: Sprain of neck. Plan: Full duty, MMI.

On September 23, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports improving neck discomfort, rated 3/10, Central without radiation, improving with conservative care including physical therapy and occasional muscle relaxants, no associated symptoms. Physical Exam: Musculoskeletal: Neck exam-normal inspection, minimal muscle tenderness to palpation, full motion, normal strength and sensation in both arms. Assessment: Sprain of neck. Plan: Physical therapy, Full duty, return in two weeks.

On October 28, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports improvement in her neck without significant symptoms currently, no arm symptoms reported. Patient has completed treatment. Physical Exam: Musculoskeletal: Neck exam-normal inspection, nontender to palpation, full motion with grossly normal strength. Assessment: Sprain of ligament of the cervical spine Plan: Full duty, MMI

On January 13, 2016 MRI of the cervical spine without contrast impression: Disc degeneration with large disc protrusion at the C5-C6 and C6-C7 levels resulting in complete effacement of CSF from the ventral and dorsal aspect of the cord with severe canal stenosis without cord compression or abnormal signal intensity in the cord to suggest cord edema or myelomalacia

On January 13, 2016 chiropractic treatment by Dr. Hansen.

On January 14, 2016 chiropractic treatment by Dr. Hansen.

On January 15, 2016 chiropractic treatment by Dr. Hansen.

On January 18, 2016 chiropractic treatment by Dr. Hansen.

On January 19, 2016 chiropractic treatment by Dr. Hansen.

On January 20, 2016 chiropractic treatment by Dr. Hansen.

On January 21, 2016 chiropractic treatment by Dr. Hansen.

On January 25, 2016 chiropractic treatment by Dr. Hansen.

On January 26, 2016 chiropractic treatment by Dr. Hansen.

On January 27, 2016 chiropractic treatment by Dr. Hansen.

On January 28, 2016 chiropractic treatment by Dr. Hansen.

On February 1, 2016 chiropractic treatment by Dr. Hansen.

On February 2, 2016 chiropractic treatment by Dr. Hansen

On February 5, 2016 chiropractic treatment by Dr. Hansen

On February 8, 2016 chiropractic treatment by Dr. Hansen

On February 10, 2016 chiropractic treatment by Dr. Hansen

On February 12, 2016 chiropractic treatment by Dr. Hansen

On February 16, 2016 chiropractic treatment by Dr. Hansen

On February 19, 2016 chiropractic treatment by Dr. Hansen

On February 24, 2016 chiropractic treatment by Dr. Hansen

On March 16, 2016 follow-up visit at Specialty Health Clinic.

On April 28, 2016 chiropractic treatment by Dr. Hansen

On July 5, 2016 neurosurgical evaluation. Chief Complaint: 1. Neck pain and stiffness 2. Left arm numbness and pain. History of Present Illness: When I saw her today, she has neck pain and stiffness. She has a pressure feeling in the neck. She rates this as a 5/10. She has aching in the left arm again it is 5/10. She maps out numbness and aching in the forearm down to the thumb in the C6 distribution. Her right arm is okay. She feels she has plateaued. She is done extensive physical therapy. Physical Examination: Cervical: Neck, shoulders and low back have normal range of motion with no scars. Palpation for tenderness. Arms have normal range of motion with no scars. She has a reduce range of motion of the cervical spine. She has numbness of the left forearm in the C6 distribution. On physical examination, she has 4/5 weakness in external rotators in the left, biceps and triceps on the left. She has diminished reflexes in the upper extremities. Impression/Plan: 1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord

compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy 4. Minimal spondylosis, L3-4, L4-5 and L5-S1. Kimberly has a cord compression and weakness. I think it is reasonable to offer her surgery. She states she never had these arm symptoms before the accident and although she may have had pre-existing spondylosis, the accident had probably exacerbated her underlined stenosis. I offered her C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On April 3, 2017 follow-up neurosurgical visit. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: She has continued with posterior neck pain and pressure. The pain continues to extend down the left arm following the left C-6 distribution. Most of his symptoms are in the left arm and rated at times at a 9/10. Continues to limit her ability to sleep at night the symptoms may be slightly improved but overall are very similar to the intensity she had the last allied. Physical Exam: She had a reduce range of motion of the cervical spine. She has numbness of the left form in the C6 distribution. On physical examination, she has 4/5 weakness in external rotators on the left biceps and triceps on the left. She has depressed reflexes in the upper extremity. Assessment and Plan: 1. Neck pain. 2. Cervical spondylosis. 3. Spinal stenosis and cervical region. Plan: 1. Repeat MRI and C-spine x-rays. 2. Follow-up in 2-4 weeks.

On April 21, 2017 x-rays of the cervical spine. Impression: 1. Mild disc space narrowing and facet degenerative change of the lower cervical spine. 2. Development of retrolisthesis of 2 mm of retrolisthesis C4 on 5 and 1 mm retrolisthesis of C6 on 7 upon extension.

On April 21, 2017 MRI of the cervical spine without contrast. Impression: Moderate posterior disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis.

On April 25, 2017 follow-up neurosurgical visit. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: Returns. Arm worse. Options discussed. Wants surgery. Physical Exam: She has a reduce range of motion of the cervical spine. She has numbness of the left forearm and the C6 distribution. Physical examination, she has 4/5 weakness in external rotators on the left, biceps and triceps on the left. She has depressed reflexes in the left upper extremity. Impression: 1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. 4. Minimal spondylosis, L3-4, L4-5 and L5-worsening symptoms and stenosis on MR. 5. Cord compression and failed conservative therapy. I offered her C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On June 8, 2017 follow-up neurosurgical visit chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: She has stopped all blood thinning medications. She does again request surgery. She would like to remain off work first six weeks as was discussed. Physical Exam: She has a reduce range of motion of the cervical spine. She has numbness of the left form in the C6 distribution. On physical examination, she has 4/5 weakness

in external rotators on the left, brought biceps and triceps on the left. She has depressed reflexes in the upper extremity. Impression: 1. Cervical spine bond low doses. C4-5, C5-6 and C6-7 with cord compression. C5-6 and C6-7. 2. Motile spondylolisthesis at C4-5. 3. Failed conservative therapy. She was offered C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On June 12, 2017 operative report by Dr. Sekhon. Preoperative Diagnosis: Cervical stenosis. Postoperative Diagnosis: Cervical stenosis. Title of the Procedure: 1. C4/5, C5/6, and C6/7 Anterior cervical decompression using a left-sided approach and the microscope. 2. C4-5, C5/6 and C6/7 interbody fusion using peak interbody cages and bone graft substitute. 3. C4-7 anterior segment fusion using a cervical locking plate. 4. Microscopic microdissection. 5. Fluoroscopic guidance for placement of the screws.

On June 26, 2017 postop neurosurgical visit. Chief Complaint: 1. Two weeks status post C4-C7 ACDF. 2. Left upper extremity radiculopathy. History of Present Illness: She has noticed some improvement to the left upper extremity symptoms. The numbness in her arm and hand specifically have improved. She still has some achiness posteriorly of her neck. She has some mild dysphasia that slowly seems to be improving. She has been wearing her soft collar when she is up and about, but she states that she is actually feeling quite well for two weeks after surgery. The strength in her arms is good. Overall, she takes about one pain tablet towards the end of the day, but otherwise the pain is very manageable. Physical Exam: On physical exam, the wound is clean, dry, and intact. There is no evidence of infection. There is minor superficial edema and swelling that is non-concerning. Upper extremity motor strength is 5/5 throughout bilaterally. Sensation is grossly intact. The equivalent and normal bilaterally. Impression: 1. Two weeks status post C4-C7 ACDF. 2. Improvement to preoperative symptomatology in the left upper extremity. 3. Stable postoperative course. Plan: 1. Follow-up in four weeks with static and dynamic cervical x-rays. 2. Call with any questions or concerns or changes in her condition.

On July 24, 2017 x-rays of the cervical spine with flexion and extension. Impression: Anterior interbody fusion C4 through C7 with no instability with flexion/extension views.

On July 26, 2017 follow-up postoperative neurosurgical visit. Chief Complaint: 1. Two week status post C4-C7 ACDF. 2. Left upper extremity radiculopathy. History of Present Illness: Today, she presents to six weeks postoperative review. She continues to notice improvement to the left upper extremity symptoms. Left arm is overall much improved, but she has noticed some ongoing numoness in the left hand and forearm. Her posterior neck pain has mostly settled and her swallowing is not problematic. She occasionally takes about one pain tablet towards the end of the day, but otherwise the pain is very manageable. Physical Exam: On physical exam, the wound is clean, dry, and intact. There is no evidence of infection. Upper extremity motor strengths are 5/5 throughout bilaterally. Sensation is grossly intact. DTRs are equivalent and normal bilaterally. Impression: 1. 6 weeks status post C4-C7 ACDF. 2. Improvement in postoperative symptomatology in the left upper extremity. 3. Stable postoperative course. Plan:

1. Follow-up in 6 weeks with static and dynamic cervical x-rays. Physical therapy. Release to work without restrictions on 7/31/17.

On September 5, 2017 x-rays of the cervical spine with flexion-extension views. Impression: ACDF C 4-C7 without evidence of hardware complication.

On September 6, 2017 follow-up postop neurosurgical visit. Chief Complaint: 1. 12 weeks status post C4-C7 ACDF. History of Present Illness: Today, she presents 12-weeks postoperative. Her symptoms continue to much improved. There is slight numbness in her left hand but it is very manageable. She also has some occasional posterior neck pain. She is not having the shooting pains that she once did. She has done physical therapy which she believes is helping. She also believes that the pressure in her neck has settled as well. She is very pleased with her recovery at this stage. Physical exam: On physical exam, the wound is clean, dry and intact. There is no evidence of infection. Upper extremity motor strengths are 5/5 throughout bilaterally. Sensation is grossly intact. DTRs are equivalent and normal bilaterally. Impression: 1. 12 weeks status post C4-C7 ACDF. 2. Improvement to preoperative symptomatology in the left upper extremity. 3 Stable postoperative course.

On September 11, 2017. She was placed at maximum medical improvement. She was returned to full duty. She had a ratable impairment.

PRESENT SYMPTOMS AND COMPLAINTS:

The claimant states that she has a tight/sore neck, tight/sore shoulders, daily headaches, weak neck, and numbness down her left arm to her left thumb. She states that her current neck pain is a 4/10 and at its worse 8/10 and at its best 2/10.

As far as activities of daily living are concerned:

As far as self-care/personal hygiene is concerned: She states no difficulty with brushing teeth, eating, urinating and bowel movements. She states mild difficulty with dressing and combing hair. She states moderate difficulty with bathing.

As far as communication is concerned: She states no difficulty with speaking, hearing and writing.

As far as physical activity is concerned: She states no difficulty walking and climbing stairs. She states mild difficulty with standing, sitting, changing positions.

As far sensory function is concerned: She states no diff code was seeing, smelling, tasting, feeling sharp versus dull and feeling hot versus cold except for her left thumb.

As far as hand activities are concerned: She states no difficulty with coordination. She states mild difficulty with grasping and lifting.

As far as advanced activities are concerned: She states no difficulty with preparing meals, managing money/checkbook, taking medications, and using public transportation. She states mild difficulty with working around the house/housework, using the phone or writing letters, shopping/carrying groceries, social activities, sexual activities and vigorous physical activity. She states moderate difficulty with driving a car. She states severe difficulty with restful sleep secondary to pain.

PAST MEDICAL HISTORY:

Past Medical History: She has no history of chronic illnesses. She states that she had no problems with her neck prior to her industrial injury of June 25, 2015.

Past Surgical History: Right ankle surgery 2013.

Medications: Advil.

Allergies to Medications: No known drug allergies.

PHYSICAL EXAMINATION:

On May 8, 2018 the claimant stood 67" tall and weighed 178 pounds. The claimant is right hand dominant.

This person's general appearance is that of a well-hydrated, well-nourished adult female in no acute distress. Her mood and manner were appropriate. She was well oriented and cooperative throughout the examination. She was not wearing an orthotic device.

On visual inspection of the cervical spine there was normal development. There was a 7 cm surgical scar located over the left anterior inferior aspect of the neck. The scar was generally straight in appearance and normal in color. On palpation of the neck there was muscle tightness along the paravertebral musculature. On strength testing, motor strength was 5/5 in all muscle groups of the right and left upper extremities. On sensory testing there was intact sensation to light and sharp touch except for the left thumb which was 4.56 on monofilament testing. Deep tendon reflexes at the biceps and triceps were +2/+4 bilaterally. The right and left upper extremities have normal temperature color and pulses. There was no evidence of atrophy, upper arm and forearm circumferences were equal bilaterally.

Range of motion of the cervical spine:

The claimant was informed not to perform any motions that were painful or that she was uncomfortable performing or that might cause her harm. The claimant was also informed that she can take a rest break during any part of the examination.

Warm-up exercise were performed as described on page 399.

Range of motion of the cervical spine was performed according to Section 15.11 Range of Motion: Cervical Spine. Starting on page 417.

Movement	Description	Range		
Cervical Flexion	Calvarium angle	40	40	40
	T1 ROM	20	20	20
	Maximum cervical flexion angle	20	20	20
	≥10% or 5°	*Yes	No	
	Maximum cervical flexion angle	20		
	% Impairment			

Movement	Description	Range		
Cervical Extension	Calvarium angle	20	20	20
	T1 ROM	5	5	5
	Cervical extension angle	15	15	15
	≥10% or 5°	*Yes	No	
	Maximum cervical extension angle	15		
	% Impairment	5		

Movement	Description	Range		
Cervical Left Lateral Bending	Calvarium angle	30	30	30
	T1 ROM	10	10	10
	Cervical left lateral flexion angle	20	20	20
	≥10% or 5°	*Yes	No	
	Maximum cervical left lateral flexion angle	20		
	% Impairment	2		

Movement	Description	Range		
Cervical Right Lateral Bending	Calvarium angle	30	30	30
	T1 ROM	10	10	10
	Cervical right lateral flexion angle	20	20	20
	≥10% or 5°	*Yes	No	
	Maximum cervical right lateral flexion angle	20		
	% Impairment	2		

Movement	Description	Range				
Cervical Left Rotation	Cervical left rotation angle	40	40	40		
	+10% or 5°	*Yes				
	Maximum cervical left rotation angle	40				
	% Impairment	2				

Movement	Description	Range				
Cervical Right Rotation	Cervical right rotation angle	40	40	40		
	+10% or 5°	*Yes				
	Maximum cervical right rotation angle	40				
	% Impairment	2				

SUMMARY AND DISCUSSION

STABILITY OF MEDICAL CONDITION: The claimant was placed at maximum medical improvement on September 11, 2017 permanent and stationary, stable and ratable by Dr. Sexton.

APPORTIONMENT: There is no prior history of disease, injury, or impairment to the affected body part necessitating apportionment consideration.

IMPAIRMENT EVALUATION ACCORDING TO THE GUIDES:

Impairment rating was done according to the Fifth Edition, Sixth Printing AMA Guides to the Evaluation of Permanent Impairment. The examination, measurements and impairment percentages were compiled by me. The history and medical records provided were reviewed by me and any discrepancies were discussed with the claimant.

Body Part: The claimant is rated according to the cervical spine.

On page 380 right hand column. Range of motion method if: b. there is radiculopathy bilaterally or at multiple levels in the same spinal region.

In this case, there was multiple levels in the same spinal region. Therefore, the claimant will be rated by range of motion.

On page 398 Section 15.8 Range-of-Motion Method. Although called the range of motion method, this evaluation method action consists of three elements that need to be assessed: (1) the range of motion of the impaired spinal region; (2) accompanying diagnosis (Table 15-7); and (3)

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MAY 14 2018

any spinal nerve deficit, which is described in this chapter and in chapter 13. The whole person impairment rating is obtained by combining ratings from all three components, using the combined values chart (p. 604).

On page 404, Table 15-7, Criteria for Rating Whole Person Impairment Percentage Due to Specific Spine Disorders to Be Used As Part of the Range of Motion Method. The claimant fits into the Category IV D. Single-level spinal fusion with or without decompression with residual signs and symptoms. Also Category IV E. multiple levels, operated on, with residual, medically documented pain and rigidity. Add 1% per level. Therefore, an additional 2% will be added for the additional levels. Therefore, the total equals 12% whole person impairment from Table 15-7.

On page 418, Table 15-12, Cervical Region Impairment from Abnormal Flexion or Extension or Ankylosis. Therefore, flexion of 20° equals 3% whole person impairment. Extension of 15° equals 5% whole person impairment. Total impairment due to abnormal flexion and extension equals 8% whole person impairment.

On page 420 Table 15-13, Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Lateral Bending. Right lateral bending of 20° equals 2% whole person impairment. Left lateral bending of 20° equals 2% whole person impairment. Therefore, total impairment due to lateral bending equals 4% whole person impairment.

On page 421 Table 15-14 Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Rotation. Right rotation of 40° equals 2% whole person impairment. Left rotation of 40° equals 2% whole person impairment. Therefore, total impairment due to abnormal rotation equals 4% whole person impairment.

Therefore 16% whole person impairment for abnormal motion.

On page 423 Section 15.12 Nerve Root and/or Spinal Cord. The claimant has decreased sensation along the C6 nerve root on the left. She best fits into grade 3 30% Sensory Deficit. On page 424, Table 15-17 Maximum % Loss of Function Due to Sensory Deficit or Pain is 8% for the C6 nerve root. Therefore, multiplying 30% times 8% equals 2.4% upper extremity impairment rounded to 2% upper extremity impairment. On page 459 Table 16-3 Conversion of Impairment of the Upper Extremity to Impairment of the Whole person. Therefore, 2% upper extremity impairment equals 1% whole person impairment.

The total whole person impairment for accompanying diagnoses from Table 15-7 equals 12%.

The total whole person impairment for loss of motion equals 16%.

The total whole person impairment for sensory loss equals 1%.

Received

Therefore, combining the whole person impairment for accompanying diagnoses from Table 15-7 12% with impairment for loss of motion 16% with impairment for sensory loss of 1% equals 27% whole person impairment from the combined values chart on page 604.

ESTIMATED WHOLE PERSON IMPAIRMENT: Upon review of the available medical records and after examining the claimant, apportionment does not appear to be an issue with regards to this claim. **It is my recommendation that the claim be closed with 27% whole person impairment.**

If there are any further questions regarding the impairment rating provided, please do not hesitate to contact me.

Sincerely,

James C. Jempsa, DO
Board Certified American Board of Osteopathic Family Physicians; Member, American College of Osteopathic Family Physicians, DIR Designated Rating Physician, State of Nevada.

May 15, 2018

Dr. James Jempsa
Fax # 775-787-6430

RE:	Claimant:	Kimberly Kline
Re:	Claim No.:	15853E839641
	D.O.I.:	6/25/2015
	Body Part:	Cervical
	Employer:	City of Reno

Dear Dr. Jempsa:

Thank you for your permanent partial disability report (PPD) dated May 8, 2018. Enclosed please find a copy of Dr. Anderson's PPD report dated November 10, 2017. Please review Dr. Anderson's PPD evaluation and advise if you agree with apportionment and provide an addendum report.

Thank you for your time and consideration regarding this matter. Please fax your report to (775) 324-9893.

Respectfully,

Lisa Jones
Claims Representative

CC: City of Reno, Herb Santos, Esq. Lisa Wiltshire Alstead, Esq.

Enc. Dr. Anderson PPD report

LS

Russell N. Anderson, DC
290 SE Court Street
Prineville, OR 97754
(541) 903-1444 (541) 362-4090-FAX

PERMANENT PARTIAL DISABILITY EVALUATION

Claimant: Kimberly Kline
Claim #: 585388-9041
CCMSI
Lisa Jones-Claims Representative
Date of Injury: 06\25\2015
Date of Evaluation: November 10th, 2017

Kimberly Kline presented to my Reno Office for a formal PPD evaluation on Friday, November 10th, 2017 at 8:30 AM. The insurance company approved the evaluation of her cervical spine.

Treatment History

5\11\2015: Brett Men-Muir, MD: She is here for BL lower back pain. This is not work related. She has been complaining of LBP for several months. It was exacerbated last month. It is 8\10 in severity. She takes diclofenac, Zoloft, and ibuprofen. A history of depression. X-rays show L4-S disc DJD. DX: discogenic back pain. Plan: PT and voltaren.

6\25\2015: Richard Law, MD: Moderate pain in the upper lumbar spine, mid lumbar, and lower lumbar spine; radiates to the right thigh and left thigh. She had similar symptoms recently; had an MRI 1 month ago; hx of herniated disc at L3-4 and L4-S. She has had previous chronic LBP; intervertebral disc disease. Her meds include Zoloft. Exam show tenderness in the lumbar spine. Impression: acute lumbar radiculopathy, lumbar sprain, and acute lumbar pain. Plan: ice, limited activity, flexeril, norco, prednisone, follow up.
06\25\2015: This is a C-4 form that states "I was rear-ended". The claimant was seen at St. Mary's regional Medical Center ER. Her initial DX was acute lumbar sprain; MVA".
6\30\2015: Scott Hall, MD: She presents for her back after a (2nd) MVA on 6\25\15. She now reports: neck pain, lumbar and thoracic pain. Assessment: neck and back sprain. Plan: chiropractic care, full duty work, return in 2 weeks.
7\14\2015: Scott Hall, MD: She continues with neck and back issues. Plan: PT, full duty, conservative treatment.
8\20\2015: Scott Hall, MD: Her neck has improved and she describes only muscular tightness that is mild. She has no arm symptoms; PT has been helpful. Plan: complete her PT and monitor.
8\26\2015: Custom PT: She had a PT re-eval today; 12 more visits are recommended over the next 4 weeks.
9\23\2015: Scott Hall, MD: She reports improving NP; a 3\10. She is getting PT.
10\28\2015: Scott Hall, MD: Her neck has improved; no current significant symptoms. Her arm symptoms.

PAGE 2: Kim Kline continued

1\3\2016: *MRI of the C-Spine:* Impression: Disc degeneration with large protrusions at C5-6 and at C6-7; this results in complete effacement of the CSF from the dorsal and the ventral aspects of the cord with severe canal stenosis without cord compression or abnormal signal intensity to suggest cord edema or myelomalacia.

1\13\2016: Bryan Hanson, MS DC (Leading Edge Chiropractic): She presents with NP with associated weakness and numbness. Her symptoms started 7 days ago, but there is "high likelihood that her symptoms are related to the MVA she recently sustained". She was released from care for that several weeks ago. Her DX is disc displacement. Plan: cold pack to the neck; spinal decompression; E-stim; laser therapy.

1\14\2016: She reports symptoms of numbness and weakness. She was treated again with cold, decompression table, E-stim, and laser.

1\15\2015: She states NP, numbness, and weakness; same treatment.

01\18\2016: The notes are about the same today.

01\19\2016: Decompression treatment and therapies.

1\20\2016: She continues with chiropractic treatment.

1\21\2016: Nothing new.

1\25\2016: Same notes and treatment.

01\27\1016: A re-exam was done today. Continue treatment plan. There were further chiropractic, traction, and therapy modalities on: 1\28\16, 2\1\16, 2\2\16, 2\5\16, 2\8\16, 2\10\16, 2\12\16, 2\16\16, 2\19\16, 2\24\16, 3\16\2016: She has completed the 20 visits of prescribed treatment, non-surgical spinal decompression to address the C6-7 and C5-6 radiculitis to the left. She has improved greatly and has only mild pain in the left UE. She is to do HEP.

3\16\3016: Scott Hall, MD: There was no evidence of neurologic involvement after the MVA. She responded to conservative care with resolution of her symptoms. The new onset of quite severe symptoms started spontaneously and it is uncertain if there is any relation to the industrial injury. She had sought treatment from an orthopedist prior to the WC injury. All indication are that the claimant had completely recovered from the industrial injury by the end of October, 2015.

4\28\2016: Bryan Hansen, DC: She presents with NP, weakness, and numbness. She is to do HEP.

7\5\1016: Lali Sekhon, MD: Her CC is NP, stiffness, and left arm numbness and pain. She previously had neck and back issues that were manageable in the past until she was in the car accident in June, 2015. There were actually 2 accidents. She had physical therapy and chiropractic treatments. She had an epidural that really did not help. She rates her NP, nA and pressure feeling in the neck as 5\10 in severity. The left arm symptoms are in a C6 distribution. Her right arm is OK. She feels that she has plateaued. Assessment: cervicalgia, cervical spine stenosis, C4-5 spondylolisthesis, failed conservative therapy, minimal spondylosis at L3-4 to L5-S1. She has cord compression and weakness; Dr. Sekhon thinks that it is reasonable to offer her surgery; the accident probably exacerbated her underlying stenosis. She was offered C4-5 to C6-7 decompression and fusion.

Page 3: Kim Kline continued

4\3\2017: Kurt Erickson, PA-C: Dr. Sekhon and I were able to review Kim Kline again today. She has continued with posterior neck pain and pressure. The pain continues to extend down the left arm following a C6 distribution. The left arm symptoms are rated as 9\10. She has trouble sleeping. The intensity is about the same as last July. She has cervical spondylosis with cord pressure at C5-6 and C6-7. She has failed conservative treatment. It is reasonable to offer her surgery. The plan is to repeat C-spine MRI and X-rays.

4\21\2017: *C-Spine MRI:* Impression: Moderate disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis.

C-Spine X-rays: Impression: mild disc narrowing and facet degenerative changes of the lower C-spine; development of retrolisthesis of 2mm, C4 on C5 and 1mm retro of C6 on C7 on extension of the C-spine.

4\25\2017: Lali Sekhon, MD: Her arm is worse. Her options were discussed, she wants surgery.

6\8\2017: Lali Sekhon, MD: She returns for review and all of her questions were answered. She again requests surgery.

6\12\2017: Lali Sekhon, MD: Operative Report: Procedures: C4-5, C5-6, and C6-7 anterior cervical decompression, interbody fusion using interbody cages and bone graft substitute; C4-C7 anterior fixation using a cervical locking plate. The X-ray shows "anterior cervical fusion and placement of disc devices"

6\26\2017: Curt Erickson, PA-C: She still has achiness in her neck; the left arm symptoms have improved. Follow in 4 weeks.

7\26\2017: Curt Erickson, PA-C (For Dr. Sekhon): The X-rays show no instability. She has ongoing numbness in the left hand and forearm, not as bad as before.

8\10\2017: Amanda Cowles, PT (Custom PT): She is having some trouble with ADLs. She can flex to 25 degrees, extend to 20, left bending to 20, right bending to 25, rotation to 60. She had about 7 PT follow ups. On the 9\14\17 visit, Kim could flex to 40, extend to 30, left rotation 55, right rotation 70, left bending 15, right bending to 20.

9\5\2017: Curt Erickson, PA-C: Her symptoms are much improved; there is slight numbness in her left hand; very manageable. She has occasional neck pain. She believes the PT is helping. Cervical spine X-rays today show fusion from C4 to C7 with no evidence of hardware complications.

9\11\2017: Dr. Sekhon fills out a questionnaire from Specialty Health. He says the claimant is stable and reached maximum medical improvement. She is released to full duty. Her restrictions are "common sense". She is ratable.

The above represents all of the medical records that were presented for my review.

PAST MEDICAL HISTORY

Prior to this work related injury\accident, Kimberly has previously received some chiropractic care. She tells me that this was mostly for lower back pain. She would get her neck (C-spine)

adjusted sometimes, but denies any significant prior neck pain, disability, or radiation upper

extremity symptoms. She was treating in the months before this accident (2015) for LBP that was not work related. Ms. Kline previously used Zoloft for depression. She denies any current prescription medications. She currently takes OTC Advil.

Ms. Kline previously suffered a work-related right wrist injury and right shoulder injury. She did not receive impairment ratings for this. Her surgical history includes an ankle surgery to re-attach tendons.

CURRENT SYMPTOMS

Currently, Ms. Kline has a chief complaint of frequent, daily headaches and limited mobility in her neck. She complains particularly of limitations with looking up to either side. She is also complaining of numbness in the left wrist and hand effecting the ring and little fingers in a C6 and\or ulnar nerve pattern.

Kim is having some difficulty with looking up to rinse in the shower. When driving, it is difficult for her to look into the back seat or behind her. Her neck seems to get tired quickly when driving and when working on the computer. Her neck gets tired when reading.

Physical Examination

Cervical Spine

Inspection reveals no cervical antalgia. She is in no distress. I observe a surgical scar on the anterior\left cervical region. It measures 7.2 CM.

Palpating the cervical spine soft tissue structures, I find the right splenius to by hypertonic. The right SCM muscle is tight and tender.

Passive motion of the cervical spine is noticeably limited on right rotation. There is a tight end-feel.

Measuring the muscle girth of the forearms, I find the right forearm to be 26.6 CM at the area of greatest circumference. The left forearm measures 25.2 CM.

The claimant performed a brief warm-up of cervical spine motions, after which we measured active ranges of motion using dual inclinometers. The claimant did appear to give her best effort on all ROM measurements.

Cervical Spine Active Ranges of Motion

Flexion: Calvarium: 1. 48 2. 48 3. 46

PAGE 5 (KIMBERLY KLINE)

T1: 1. 8 2. 4 3. 8
Max ROM = 48-4= 44 degrees (1% WPI)
Extension: Calvarium: 1. 38 2. 38 3. 38
T1: 1. 8 2. 10 3. 8
Max ROM = 38-8= 30 degrees (3% WPI)
Right Bending: Head: 1. 38 2. 40 3. 44 4. 40
T1: 1. 4 2. 6 3. 6
Max ROM = 44-6= 38 degrees (no impairment)
Left Bending: Calvarium: 1. 38 2. 36 3. 36
T1: 1. 4 2 3. 4
Max ROM = 38-4= 34 degrees (1% WPI)
Right Rotation: 1. 64 2 64 3 62
Max ROM = 64 degrees (1% WPI)
Left Rotation: 1. 56 2. 58 3. 58
Max ROM = 56 degrees (1% PWI)

Whole person impairments from motion loss at various cervical spine motions are added 1+3+1+1+1= 7% WPI from motion loss in the cervical spine.

I can elicit equal, +2 deep tendon reflexes at Right and Left biceps, brachioradialis, and triceps.

The claimant can demonstrate 5\5 strength, equal bilaterally at shoulder, elbow, wrist, and fingers.

She has some decreased sensibility to light touch over the C6 dermatome on the left. This includes partial loss of 2 point discrimination over the palmar left right and little fingers (2 point sense at 9mm). This is grade 3 sensory loss, 25% sensory deficit of the C6 nerve root (Table 15-15); we multiply this to the maximum upper extremity impairment for sensory loss at C6 (8%, Table 15-17) and we get *2% left upper extremity impairment, 1% WPI.*

Impairment Calculation

If we are to use the diagnosis related estimate in this case (due to multi-level involvement and multilevel fusion), then; using Table 15-7, part IV, Ms. Kline has 10% WPI from spinal fusion with residual signs and symptoms. We add 1% for each additional level (2 additional) to get *12% whole person impairment from Specific Spine Disorder*

As described above, this claimant has a cumulative total of *7% whole person impairment from motion loss* in the cervical spine.

She has *1% WPI for sensory loss* coming from the C6 nerve root.

Combining 12% with 7%, we get 18%; this is then combined with 1% to get a total of *19% whole person impairment from the cervical spine.*

PAGE 6 (KIMBERLY KLINE)

Using the DRE method, this claimant would be easily placed in Cervical Spine DRE category IV due to loss of motion segment integrity. This is ***25% impairment of the whole person*** and this method should be used since it results in a higher rating (AMA Guides, 5th Edition, page 380).

MMI AND MEDICAL STABILITY

The claimant has reached a stable plateau of medical improvement. Her condition has not changed over the last 45 days. Her condition is not likely to change significantly over the next 12 months with or without treatment
She has reached maximum medical improvement

APPORTIONMENT

The claimant had underlying cervical spine issues that pre-date this work related car accident and injury. Namely, the MRI and radiographic reports show cervical spine degenerative discs with large protrusions at C5-6, C6-7; effacement of the CSF, and severe canal stenosis (MRI of 1\3\2016). It is not logical to believe that these findings are related to the car accident that she was involved in 6 months earlier.

This claimant's 25% whole person impairment is based upon the surgery that was performed. The surgery was performed due to cervical spine spondylosis, stenosis, and cord pressure at C4-5 to C6-7.

75% of this claimant's whole person impairment (cervical spine) is apportioned as non-industrial
25% of her impairment is industrial and related to the work injury that occurred on 6\25\2015 because:

- The claimant had no documented cervical spine injury or pain immediately after the accident (symptoms began 6\30\2015). After that, the cervical strain could be described as slight.
- The findings of cervical spine spondylosis, stenosis, and disc bulges cannot be logically attributable to this car accident\work injury. These findings provided the indication for fusion surgery in the cervical spine.
- The claimant had responded well to physical therapy and medical treatment and had nearly completely resolved her cervical spine complaints prior to December, 2015. She had no upper extremity symptoms at the time of release from care.

On the other hand, the claimant denies any prior upper extremity symptoms (radiculopathy) before this injury. This work injury likely played some role in the onset of symptoms that led to surgery, but was not the primary cause.

PAGE 7 (CUMBERLAND KLINIC)

So, apportioning 75% of this claimant's impairment as non-industrial, we take 25% of this claimant's whole person impairment (which was 25% WPI), and we get ***6% WPI related to this work injury (that occurred on 6\25\2015).***

PERMANENT IMPAIRMENT SUMMARY

The claimant has 25% whole person impairment coming from the cervical spine. Of this, ***6% WPI is related to the work related injury that occurred on 6\25\2015.***

This is reasonable, should be awarded, and case closure should occur.

Respectfully,

Russell N. Anderson, DC

JAMES C. JEMPSA, DO

Reno, Nevada
Telephone: 775-786-9072
Fax: 775-787-6430

Lisa Jones
CCMSI
PO Box 20068
Reno, NV 89515
Telephone: 775-324-3301
Fax: 775-324-9893

PERMANENT PARTIAL DISABILITY EVALUATION ADDENDUM

RE:	CLAIMANT:	Kimberly Kline
	SSN:	
	CLAIM NO.:	15853E839641
	DOI:	06/25/2015
	EMPLOYER:	City of Reno
	DATE OF EXAM:	05/08/2018
	DATE OF REPORT:	05/18/2018
	BODY PARTS:	1. Cervical.

In regards to your letter dated May 15, 2018. You will need to contact Dr. Anderson concerning his rationale for apportionment of Ms. Kline. I will provide you my opinion as far as apportionment is concerned with Ms. Kline. The claimant stated that she had no problems with her neck prior to her industrial injury of June 25, 2015. I have not received any medical records prior to the industrial injury of June 25, 2015. In accordance with NAC 616C.490 it is my opinion that apportionment is not necessary in this case. Therefore, 0% whole person impairment for apportionment. I recommend that the case should be closed with 27% whole person impairment for her cervical spine.

If there are any further questions regarding the impairment rating provided, please do not hesitate to contact me.

Sincerely,

James C. Jempsa, DO
Board Certified American Board of Osteopathic Family Physicians; Member, American College of Osteopathic Family Physicians, DIR Designated Rating Physician, State of Nevada.

C C M S I

May 24, 2018

KIMBERLY KLINE
305 Puma Dr
Washoe Valley, NV 89704-9739

Re: Claim No.: 15853E839641
D.O.I.: 6/25/2015
Employer: City of Reno
Body Parts: cervical

Dear Ms. Kline;

We are in receipt of Dr. Jempsa's PPD rating dated 5/14/2018. We have asked Dr. Betz to review Dr. Anderson's and Dr. Jempsa's PPD report and provide an opinion regarding apportionment.

Please be advised that we are holding the Permanent Partial Disability award in abeyance pursuant to NAC 616C.103. Upon receipt of Dr. Betz response, a new determination will be rendered regarding the permanent partial disability award.

If you disagree with this determination, you may request a hearing before a Hearing officer by completing the enclosed "Request For Hearing:" form within seventy (70) days after the date on which this notice was mailed and sending it to the State of Nevada, Department of Hearings, Carson City.

Sincerely,
CCMSI
Lisa Nobles
Claims Representative

cc: City of Reno, Herb Santos, Esq Lisa Wiltshire Alstead, Esq

Enc: D-12a (Appeal Rights) PPD report, addendum report

REQUEST FOR HEARING - CONTESTED CLAIM

(Pursuant to NAC 616C.274)

REPLY TO:

Department of Administration
Hearings Division
1050 E. William Street, Ste 400
Carson City, NV 89701
(775) 687-8440

OR

Department of Administration
Hearings Division
2200 S Rancho Drive, Suite 210
Las Vegas, NV 89102
(702) 486-2525

Employee Information

Employee's Name and Address
KIMBERLY KLINE
305 Puma Dr
WASHOE VALLEY, NV 89704

Employee's Telephone Number
775-326-6637

Claim No. 15853E839641

Date of Injury 06/25/2015

Employer Information

Employer's Name and Address
CITY OF RENO
1 EAST FIRST STREET
RENO, NV 89505

Employer's Telephone Number
775-326-6637

Insurer Information

Insurer's Name and Address

Third-Party Administrator Information

Third-Party Administrator's Name and Address

Do Not Complete or Mail This Form Unless You Disagree With the Insurer's Determination.

YOU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARING WILL NOT BE SCHEDULED PURSUANT TO NRS 616C.315.

Briefly explain the basis for this appeal

This request for hearing is filed by, or on behalf of **The Injured Employee** / **The Employer**

and is dated this ____ day of _____ 20__

Signature of Injured Employee/Employer

Injured Employee's/Employer's Rep. (Advisor)

D-12a (Rev. 7/07)

JAMES C. JEMPSA, DO

Reno, Nevada
Telephone: 775-786-9072
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Lisa Jones
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PERMANENT PARTIAL DISABILITY EVALUATION ADDENDUM

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	SSN:	
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If there are any further questions regarding the impairment rating provided, please do not hesitate to contact me.

Sincerely,

James C. Jempsa, DO
Board Certified American Board of Osteopathic Family Physicians; Member, American College of Osteopathic Family Physicians, DIR Designated Rating Physician, State of Nevada.

JAMES C. JEMPSA, DO

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Lisa Jones
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PERMANENT PARTIAL DISABILITY EVALUATION

RE:	CLAIMANT:	Kimberly Kline
	SSN:	
	CLAIM NO.:	15853E839641
	DOI:	06/25/2015
	EMPLOYER:	City of Reno
	DATE OF EXAM:	05/08/2018
	DATE OF REPORT:	05/14/2018
	BODY PARTS:	1. Cervical.

DIAGNOSIS:

1. Multilevel cervical fusion.

PLACE OF EXAMINATION: Reno, Nevada.

INTRODUCTION: The claimant presents to our office today for a Permanent Partial Disability rating performed in accordance with the Fifth Edition, Sixth Printing, AMA Guides to the evaluation of Permanent Impairment. The claimant was informed with regards to the purpose of this examination. It is understood that there is no patient/treating physician relationship established on the basis of today's examination. It was explained that the evaluation was requested by the referral source and the report will be sent to the referral source upon completion.

Dear Lisa Jones:

Kimberly Kline sustained industrial injury to her neck on June 25, 2015. She subsequently went on to have a multilevel fusion of her cervical spine. She presents today for a PPD evaluation of the cervical spine.

PERSONAL DATA:

The claimant was identified by her picture on a Nevada Driver's License #0701144556. She gives a birth date of 10/07/1979 making the claimant 38 years of age at the time of this evaluation.

The claimant has lived in Reno for approximately the last 38 years.

She has completed school greater than 16 years.

The claimant has not served in the military.

REVIEW OF MEDICAL RECORDS:

All significant medical records provided were reviewed.

On June 25, 2015 initial evaluation at St. Mary's Regional Medical Center. History of Present Illness: Chief Complaint: Back injury and back pain. It is described as being moderate degree of pain in the upper lumbar mid lumbar and lower lumbar spine radiating into the right thigh and the left thigh. No bladder dysfunction, bowel dysfunction, sensory loss or motor loss. Past History: The patient had prior back pain. Physical Exam: Neck: Normal inspection. Neck nontender. Painless range of motion. Back: Mild vertebral point tenderness over the upper, mid and lower lumbar spine. Neuro: No motor deficit. No sensory deficit. Reflexes normal. Impression: Acute lumbar radiculopathy. Sprain of lumbar spine. Acute pain in the lower back. Prescription Medications: Flexeril, Norco and prednisone.

On June 30, 2015 evaluation at Specialty Health Clinic. Chief Complaint: Back-2nd MVA 6-25-15. History of Present Illness: Patient was involved in a second motor vehicle accident on June 25, 2015 when she was rear-ended at high-speed. Currently the patient reports: 1. Neck discomfort-moderate, diffuse, radiation into the right shoulder, associated stiffness. 2. Lumbar and thoracic pain-diffuse, nonradiating, no red flags, no numbness or weakness reported and legs. Physical Exam: Cervical exam-mild diffuse muscular tenderness to palpation, normal inspection, normal strength and sensation in both arms, normal reflexes throughout both arms, range of motion, flexion 40°, extension 50°, lateral rotation 70° bilaterally with pain at extremes. Assessment: Sprain of neck. Plan: Chiropractic, full duty, return in two weeks.

On May 11, 2015 initial evaluation by Dr. Men-Muir. He evaluated her low back.

On July 14, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports ongoing lumbar and neck pain, moderate to severe, associated sleep disruption and stiffness, minimal improvement with chiropractic care, no numbness or weakness. Physical Exam: Musculoskeletal: Neck-normal inspection, mild diffuse muscular tenderness to palpation, grossly normal strength and sensation. Assessment: Sprain of neck. Plan: Physical therapy, Full duty, return in two weeks.

On August 20, 2015 follow-up visit at Specialty Health Clinic. Chief Complaint: Cervical strain. History of Present Illness: Patient notes improvement in her neck symptoms and describes only mild muscular tightness currently. She reports no arm symptoms. Physical therapy has been helpful and continues. Physical Exam: Musculoskeletal: Exam-normal inspection, mild muscular tenderness palpation over the trapezius, full motion with grossly normal strength and sensation in arms. Assessment: Sprain of neck. Plan: Full duty, MMI.

On September 23, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports improving neck discomfort, rated 3/10, Central without radiation, improving with conservative care including physical therapy and occasional muscle relaxants, no associated symptoms. Physical Exam: Musculoskeletal: Neck exam-normal inspection, minimal muscle tenderness to palpation, full motion, normal strength and sensation in both arms. Assessment: Sprain of neck. Plan: Physical therapy, Full duty, return in two weeks.

On October 28, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports improvement in her neck without significant symptoms currently, no arm symptoms reported. Patient has completed treatment. Physical Exam: Musculoskeletal: Neck exam-normal inspection, nontender to palpation, full motion with grossly normal strength. Assessment: Sprain of ligament of the cervical spine Plan: Full duty, MMI.

On January 13, 2016 MRI of the cervical spine without contrast impression: Disc degeneration with large disc protrusion at the C5-C6 and C6-C7 levels resulting in complete effacement of CSF from the ventral and dorsal aspect of the cord with severe canal stenosis without cord compression or abnormal signal intensity in the cord to suggest cord edema or myelomalacia.

On January 13, 2016 chiropractic treatment by Dr. Hansen.

On January 14, 2016 chiropractic treatment by Dr. Hansen.

On January 15, 2016 chiropractic treatment by Dr. Hansen.

On January 18, 2016 chiropractic treatment by Dr. Hansen.

On January 19, 2016 chiropractic treatment by Dr. Hansen.

On January 20, 2016 chiropractic treatment by Dr. Hansen.

On January 21, 2016 chiropractic treatment by Dr. Hansen.

On January 25, 2016 chiropractic treatment by Dr. Hansen.

On January 26, 2016 chiropractic treatment by Dr. Hansen.

On January 27, 2016 chiropractic treatment by Dr. Hansen.

On January 28, 2016 chiropractic treatment by Dr. Hansen.

On February 1, 2016 chiropractic treatment by Dr. Hansen.

On February 2, 2016 chiropractic treatment by Dr. Hansen

On February 5, 2016 chiropractic treatment by Dr. Hansen

On February 8, 2016 chiropractic treatment by Dr. Hansen

On February 10, 2016 chiropractic treatment by Dr. Hansen

On February 12, 2016 chiropractic treatment by Dr. Hansen

On February 16, 2016 chiropractic treatment by Dr. Hansen

On February 19, 2016 chiropractic treatment by Dr. Hansen

On February 24, 2016 chiropractic treatment by Dr. Hansen

On March 16, 2016 follow-up visit at Specialty Health Clinic.

On April 28, 2016 chiropractic treatment by Dr. Hansen

On July 5, 2016 neurosurgical evaluation. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: When I saw her today, she has neck pain and stiffness. She has a pressure feeling in the neck. She rates this as a 5/10. She has aching in the left arm again it is 5/10. She maps out numbness and aching in the forearm down to the thumb in the C6 distribution. Her right arm is okay. She feels she has plateaued. She is done extensive physical therapy. Physical Examination: Cervical: Neck, shoulders and low back have normal range of motion with no scars. Palpation for tenderness. Arms have normal range of motion with no scars. She has a reduce range of motion of the cervical spine. She has numbness of the left forearm in the C6 distribution. On physical examination, she has 4/5 weakness in external rotators in the left, biceps and triceps on the left. She has diminished reflexes in the upper extremities. Impression/Plan: 1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord

compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. 4. Minimal spondylosis, L3-4, L4-5 and L5-S1. Kimberly has a cord compression and weakness. I think it is reasonable to offer her surgery. She states she never had these arm symptoms before the accident and although she may have had pre-existing spondylosis, the accident had probably exacerbated her underlined stenosis. I offered her C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On April 3, 2017 follow-up neurosurgical visit. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: She has continued with posterior neck pain and pressure. The pain continues to extend down the left arm following the left C-6 distribution. Most of his symptoms are in the left arm and rated at times at a 9/10. Continues to limit her ability to sleep at night the symptoms may be slightly improved but overall are very similar to the intensity she had the last allied. Physical Exam: She had a reduce range of motion of the cervical spine. She has numbness of the left form in the C6 distribution. On physical examination, she has 4/5 weakness in external rotators on the left, biceps and triceps on the left. She has depressed reflexes in the upper extremity. Assessment and Plan: 1. Neck pain. 2. Cervical spondylosis. 3. Spinal stenosis and cervical region. Plan: 1. Repeat MRI and C-spine x-rays. 2. Follow-up in 2-4 weeks.

On April 21, 2017 x-rays of the cervical spine. Impression: 1. Mild disc space narrowing and facet degenerative change of the lower cervical spine. 2. Development of retrolisthesis of 2 mm of retrolisthesis C4 on 5 and 1 mm retrolisthesis of C6 on 7 upon extension.

On April 21, 2017 MRI of the cervical spine without contrast. Impression: Moderate posterior disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis.

On April 25, 2017 follow-up neurosurgical visit. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: Returns. Arm worse. Options discussed. Wants surgery. Physical Exam: She has a reduce range of motion of the cervical spine. She has numbness of the left forearm and the C6 distribution. Physical examination, she has 4/5 weakness in external rotators on the left, biceps and triceps on the left. She has depressed reflexes in the left upper extremity. Impression: 1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. 4. Minimal spondylosis, L3-4, L4-5 and L5-worsening symptoms and stenosis on MR. 6. Cord compression and failed conservative therapy. I offered her C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On June 8, 2017 follow-up neurosurgical visit chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: She has stopped all blood thinning medications. She does again request surgery. She would like to remain off work first six weeks as was discussed. Physical Exam: She has a reduce range of motion of the cervical spine. She has numbness of the left form in the C6 distribution. On physical examination, she has 4/5 weakness

in external rotators on the left, brought biceps and triceps on the left. She has depressed reflexes in the upper extremity. Impression: 1. Cervical spine bond low doses, C4-5, C5-6 and C6-7 with cord compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. She was offered C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On June 12, 2017 operative report by Dr. Sekhon. Preoperative Diagnosis: Cervical stenosis. Postoperative Diagnosis: Cervical stenosis. Title of the Procedure: 1. C4/5, C5/6, and C6/7 Anterior cervical decompression using a left-sided approach and the microscope. 2. C4/5, C5/6 and C6/7 interbody fusion using peak interbody cages and bone graft substitute. 3. C4-7 anterior segment fusion using a cervical locking plate. 4. Microscopic microdissection. 5. Fluoroscopic guidance for placement of the screws.

On June 26, 2017 postop neurosurgical visit. Chief Complaint: 1. Two weeks status post C4-C 7 ACDF 2. Left upper extremity radiculopathy. History of Present Illness: She has noticed some improvement to the left upper extremity symptoms. The numbness in her arm and hand specifically have improved. She still has some achiness posteriorly of her neck. She has some mild dysphasia that slowly seems to be improving. She has been wearing her soft collar when she is up and about, but she states that she is actually feeling quite well for two weeks after surgery. The strength in her arms is good. Overall, she takes about one pain tablet towards the end of the day, but otherwise the pain is very manageable. Physical Exam: On physical exam, the wound is clean, dry and intact. There is no evidence of infection. There is minor superficial edema and swelling that is non-concerning. Upper extremity motor strength is 5/5 throughout bilaterally. Sensation is grossly intact. The equivalent and normal bilaterally. Impression: 1. Two weeks status post C4-C7 ACDF. 2. Improvement to preoperative symptomatology in the left upper extremity. 3. Stable postoperative course. Plan: 1. Follow-up in four weeks with static and dynamic cervical x-rays. 2. Call with any questions or concerns or changes in her condition.

On July 24, 2017 x-rays of the cervical spine with flexion and extension. Impression: Anterior interbody fusion C4 through C7 with no instability with flexion/extension views.

On July 26, 2017 follow-up postoperative neurosurgical visit. Chief Complaint: 1. Two week status post C4-C7 ACDF. 2. Left upper extremity radiculopathy. History of Present Illness: Today, she presents to six weeks postoperative review. She continues to notice improvement to the left upper extremity symptoms. Left arm is overall much improved, but she has noticed some ongoing numbness in the left hand and forearm. Her posterior neck pain has mostly settled and her swallowing is not problematic. She occasionally takes about one pain tablet towards the end of the day, but otherwise the pain is very manageable. Physical Exam: On physical exam, the wound is clean, dry, and intact. There is no evidence of infection. Upper extremity motor strengths are 5/5 throughout bilaterally. Sensation is grossly intact. DTRs are equivalent and normal bilaterally. Impression: 1. 6 weeks status post C4-C7 ACDF. 2. Improvement in postoperative symptomatology in the left upper extremity. 3. Stable postoperative course. Plan:

1. Follow-up in 6 weeks with static and dynamic cervical x-rays. Physical therapy. Release to work without restrictions on 7/31/17.

On September 5, 2017 x-rays of the cervical spine with flexion-extension views. Impression: ACDF C 4-C7 without evidence of hardware complication.

On September 6, 2017 follow-up postop neurosurgical visit. Chief Complaint: 1. 12 weeks status post C4-C7 ACDF. History of Present Illness: Today, she presents 12-weeks postoperative. Her symptoms continue to much improved. There is slight numbness in her left hand but it is very manageable. She also has some occasional posterior neck pain. She is not having the shooting pains that she once did. She has done physical therapy which she believes is helping. She also believes that the pressure in her neck has settled as well. She is very pleased with her recovery at this stage. Physical exam: On physical exam, the wound is clean, dry and intact. There is no evidence of infection. Upper extremity motor strengths are 5/5 throughout bilaterally. Sensation is grossly intact. DTRs are equivalent and normal bilaterally. Impression: 1. 12 weeks status post C4-C7 ACDF. 2. Improvement to preoperative symptomatology in the left upper extremity. 3. Stable postoperative course.

On September 11, 2017. She was placed at maximum medical improvement. She was returned to full duty. She had a ratable impairment.

PRESENT SYMPTOMS AND COMPLAINTS:

The claimant states that she has a tight/sore neck, tight/sore shoulders, daily headaches, weak neck, and numbness down her left arm to her left thumb. She states that her current neck pain is a 4/10 and at its worse 8/10 and at its best 2/10.

As far as activities of daily living are concerned:

As far as self-care/personal hygiene is concerned: She states no difficulty with brushing teeth, eating, urinating and bowel movements. She states mild difficulty with dressing and combing hair. She states moderate difficulty with bathing.

As far as communication is concerned: She states no difficulty with speaking, hearing and writing.

As far as physical activity is concerned: She states no difficulty walking and climbing stairs. She states mild difficulty with standing, sitting, changing positions.

As far sensory function is concerned: She states no diff code was seeing, smelling, tasting, feeling sharp versus dull and feeling hot versus cold except for her left thumb.

As far as hand activities are concerned: She states no difficulty with coordination. She states mild difficulty with grasping and lifting.

As far as advanced activities are concerned: She states no difficulty with preparing meals, managing money/checkbook, taking medications, and using public transportation. She states mild difficulty with working around the house/housework, using the phone or writing letters, shopping/carrying groceries, social activities, sexual activities and vigorous physical activity. She states moderate difficulty with driving a car. She states severe difficulty with restful sleep secondary to pain.

PAST MEDICAL HISTORY:

Past Medical History: She has no history of chronic illnesses. She states that she had no problems with her neck prior to her industrial injury of June 25, 2015.

Past Surgical History: Right ankle surgery 2013.

Medications: Advil.

Allergies to Medications: No known drug allergies.

PHYSICAL EXAMINATION:

On May 8, 2018 the claimant stood 67" tall and weighed 178 pounds. The claimant is right hand dominant.

This person's general appearance is that of a well-hydrated, well-nourished adult female in no acute distress. Her mood and manner were appropriate. She was well oriented and cooperative throughout the examination. She was not wearing an orthotic device.

On visual inspection of the cervical spine there was normal development. There was a 7 cm surgical scar located over the left anterior inferior aspect of the neck. The scar was generally straight in appearance and normal in color. On palpation of the neck there was muscle tightness along the paravertebral musculature. On strength testing, motor strength was 5/5 in all muscle groups of the right and left upper extremities. On sensory testing there was intact sensation to light and sharp touch except for the left thumb which was 4.56 on monofilament testing. Deep tendon reflexes at the biceps and triceps were +2/+4 bilaterally. The right and left upper extremities have normal temperature color and pulses. There was no evidence of atrophy, upper arm and forearm circumferences were equal bilaterally.

Range of motion of the cervical spine:

The claimant was informed not to perform any motions that were painful or that she was uncomfortable performing or that might cause her harm. The claimant was also informed that she can take a rest break during any part of the examination.

Warm-up exercise were performed as described on page 399.

Range of motion of the cervical spine was performed according to Section 15.11 Range of Motion: Cervical Spine. Starting on page 417.

Movement	Description	Range		
Cervical Flexion	Calvarium angle	40	40	40
	T1 ROM	20	20	20
	Maximum cervical flexion angle	20	20	20
	+10% or 5°	*Yes	No	
	Maximum cervical flexion angle	20		
	% Impairment	3		

Movement	Description	Range		
Cervical Extension	Calvarium angle	20	20	20
	T1 ROM	5	5	5
	Cervical extension angle	15	15	15
	+10% or 5°	*Yes	No	
	Maximum cervical extension angle	15		
	% Impairment	5		

Movement	Description	Range		
Cervical Left Lateral Bending	Calvarium angle	30	30	30
	T1 ROM	10	10	10
	Cervical left lateral flexion angle	20	20	20
	+10% or 5°	*Yes	No	
	Maximum cervical left lateral flexion angle	20		
	% Impairment	2		

Movement	Description	Range		
Cervical Right Lateral Bending	Calvarium angle	30	30	30
	T1 ROM	10	10	10
	Cervical right lateral flexion angle	20	20	20
	+10% or 5°	*Yes	No	
	Maximum cervical right lateral flexion angle	20		
	% Impairment	2		

Movement	Description	Range		
Cervical Left Rotation	Cervical left rotation angle	40	40	40
	+10% or 5°	*Yes	No	
	Maximum cervical left rotation angle	40		
	% Impairment	2		

Movement	Description	Range		
Cervical Right Rotation	Cervical right rotation angle	40	40	40
	+10% or 5°	*Yes	No	
	Maximum cervical right rotation angle	40		
	% Impairment	2		

SUMMARY AND DISCUSSION:

STABILITY OF MEDICAL CONDITION: The claimant was placed at maximum medical improvement on September 11, 2017 permanent and stationary, stable and ratable by Dr. Sekhon.

APPORTIONMENT: There is no prior history of disease, injury, or impairment to the affected body part necessitating apportionment consideration.

IMPAIRMENT EVALUATION ACCORDING TO THE GUIDES:

Impairment rating was done according to the Fifth Edition, Sixth Printing AMA Guides to the Evaluation of Permanent Impairment. The examination, measurements, and impairment percentages were compiled by me. The history and medical records provided were reviewed by me and any discrepancies were discussed with the claimant.

Body Part: The claimant is rated according to the cervical spine.

On page 380 right hand column Range of motion method if: b. there is radiculopathy bilaterally or at multiple levels in the same spinal region.

In this case, there was multiple levels in the same spinal region. Therefore, the claimant will be rated by range of motion.

On page 398 Section 13.8 Range-of-Motion Method. Although called the range of motion method, this evaluation method action consists of three elements that need to be assessed: (1) the range of motion of the impaired spinal region; (2) accompanying diagnosis (Table 15-7), and (3)

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any spinal nerve deficit, which is described in this chapter and in chapter 13. The whole person impairment rating is obtained by combining ratings from all three components, using the combined values chart (p. 604)

On page 404, Table 15-7, Criteria for Rating Whole Person Impairment Percentage Due to Specific Spine Disorders to Be Used As Part of the Range of Motion Method. The claimant fits into the Category IV D. Single-level spinal fusion with or without decompression with residual signs and symptoms. Also Category IV E. multiple levels, operated on, with residual, medically documented pain and rigidity. Add 1% per level. Therefore, an additional 2% will be added for the additional levels. Therefore, the total equals 12% whole person impairment from Table 15-7.

On page 418, Table 15-12, Cervical Region Impairment from Abnormal Flexion or Extension or Ankylosis. Therefore, flexion of 20° equals 3% whole person impairment. Extension of 15° equals 5% whole person impairment. Total impairment due to abnormal flexion and extension equals 8% whole person impairment.

On page 420 Table 15-13, Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Lateral Bending. Right lateral bending of 20° equals 2% whole person impairment. Left lateral bending of 20° equals 2% whole person impairment. Therefore, total impairment due to lateral bending equals 4% whole person impairment.

On page 421 Table 15-14 Impairment Due to Abnormal Motion and Ankylosis of the Cervica Region: Rotation. Right rotation of 40° equals 2% whole person impairment. Left rotation of 40° equals 2% whole person impairment. Therefore, total impairment due to abnormal rotation equals 4% whole person impairment.

Therefore 16% whole person impairment for abnormal motion.

On page 423 Section 15.12 Nerve Root and/or Spinal Cord. The claimant has decreased sensation along the C6 nerve root on the left. She best fits into grade 3 30% Sensory Deficit. On page 424, Table 15-17 Maximum % Loss of Function Due to Sensory Deficit or Pain is 8% for the C6 nerve root. Therefore, multiplying 30% times 8% equals 2.4% upper extremity impairment rounded to 2% upper extremity impairment. On page 439 Table 16-3 Conversion of Impairment of the Upper Extremity to Impairment of the Whole person. Therefore, 2% upper extremity impairment equals 1% whole person impairment.

The total whole person impairment for accompanying diagnoses from Table 15-7 equals 12%.

The total whole person impairment for loss of motion equals 16%.

The total whole person impairment for sensory loss equals 1%.

Therefore, combining the whole person impairment for accompanying diagnoses from Table 15-7 12% with impairment for loss of motion 16% with impairment for sensory loss of 1% equals 27% whole person impairment from the combined values chart on page 604.

ESTIMATED WHOLE PERSON IMPAIRMENT: Upon review of the available medical records and after examining the claimant, apportionment does not appear to be an issue with regards to this claim. It is my recommendation that the claim be closed with 27% whole person impairment.

If there are any further questions regarding the impairment rating provided, please do not hesitate to contact me.

Sincerely,

James C. Jempsa, DO
Board Certified American Board of Osteopathic Family Physicians, Member, American College of Osteopathic Family Physicians, DIR Designated Rating Physician, State of Nevada

evada Occupatio al

Jay E. Betz, MD
Medical Director

Occupational Medicine
Injury Care
Employer Services

June 4, 2018

Lisa Jones
CCMSI
PO Box 20068
Reno, NV 89515

Re: Kimberly Kline
DOI: 6/25/2015
Claim # 15853E839641

PPD/CHART REVIEW

Dear Ms. Jones,

At your request, I reviewed the medical record of Kimberly Kline including 2 PPDs, one performed by Dr. Russell Anderson, DC on 11/10/2017 and the second by Dr. James Jempsa, DO on 5/8/2018.

This review was performed in conjunction with the *AMA Guides to the Evaluation of Permanent Impairment, 5th edition* and NAC 616C.490.

The opinions expressed in this review are stated to a reasonable degree of medical probability based on the medical records provided and may be altered by additional information or examination of the patient.

HISTORY:

Approximately 6 weeks prior to her subsequent occupational injury, Ms. Kimberly Kline was evaluated by Dr. Men-Muir on May 11, 2015 complaining of bilateral low back pain as result of a non-work-related auto accident several months previous. X-ray showed degenerative changes at L4-5. She was diagnosed with discogenic back pain. Voltaren and physical therapy were recommended.

Ms. Kline was then involved in a work related vehicular accident on June 25, 2015 when she was rear-ended at 20 mph. She was initially seen at Saint Mary's Regional Medical Center complaining of pain in the low back with radiation to both thighs. Her history of prior vehicular accident with back pain was noted. It was also noted that a lumbar MRI scan 1 month previous had shown a

herniated disc at L3-4 and L4-5 but that her symptoms nearly resolved in the intervening period. On examination Ms. Kline's neck was normal with painless range of motion and no tenderness. There was mild tenderness over the lumbar spine. No neurologic deficits were found. She was diagnosed with an acute lumbar radiculopathy and sprain of the lumbar spine. She was given medication for pain and spasm as well as prednisone.

In follow up at Specialty Health Clinic on June 30, 2015, it was noted that Ms. Kline had been evaluated by Dr. Meri Muir for low back pain related to a previous auto accident about 6 weeks prior to the 2nd motor vehicle accident on June 25, 2015. Ms. Kline was now complaining of neck, upper back and low back pain. After examination she was diagnosed with neck sprain. Chiropractic care was recommended.

Ms. Kline underwent several chiropractic treatments with Maria Brady, DC, RN.

In follow up with Dr. Hall on July 14, 2015 the patient reported minimal improvement with chiropractic adjustments and complained of persistent lumbar and neck pain. Conservative measures including physical therapy were continued.

On August 20, 2015 Ms. Kline reported she was improving with therapy. She had full range of motion and was intact neurologically. Completion of physical therapy followed by monitoring was recommended.

In follow up with Dr. Hall at Specialty Health Clinic on September 23, 2015, Ms. Kline again reported improving but persistent mild neck pain. Additional physical therapy was recommended.

She improved and was discharged from care on October 28, 2015.

A little over 2 months later on January 13, 2016 MRI scan the patient's cervical spine was obtained to further evaluate significant recurrent neck pain with radiation to the left arm. MRI was remarkable for disc degeneration with large disc protrusions at C5-6 and C6-7 resulting in complete effacement of the cerebral spinal fluid from the ventral and dorsal aspects of the cord with severe canal stenosis.

In follow up with Dr. Hall on March 16, 2016, he noted that Ms. Kline had essentially no symptoms on October 28, 2015 when she was discharged but was complaining of acute onset of neck pain of 7 days duration when she was seen by Dr. Hansen on January 13, 2016 with radiation to the left arm and associated neurologic signs. He noted the MRI results and that the chiropractor had recommended physiatry evaluation for further treatment. Dr. Hall concluded that the patient likely had degenerative disc changes prior to the industrial injury which may have been exacerbated by the industrial injury but that there was no evidence of neurologic symptoms during treatment for the industrial injury and again noted that the patient had improved with conservative measures. He concluded there is no objective evidence to connect the significant MRI findings of January 13,

2016 with the industrial injury. He again indicated that Ms. Kline had recovered completely from the industrial injury of June 25, 2015 by the end of October 2015.

Ms. Kline received multiple chiropractic treatments from Dr. Hanson between January 14th and April 28, 2016 without lasting benefit.

Neurosurgical consultation was obtained from Dr. Sekhon on July 5, 2016. He indicated the patient had pre-existing spondylosis C4 through C7 with cord compression C5-6 and C6-7, mobile spondylolisthesis at C4-5 and failed conservative therapy. He felt the accident exacerbated her underlying stenosis. He offered anterior cervical decompression and fusion C4 through C7.

In neurosurgical follow-up on April 3, 2017 repeat MRI and cervical x-rays were recommended.

Repeat x-rays on April 21, 2017 showed mild disc space narrowing and facet degenerative changes of the lower cervical spine with development of retrolisthesis of 2 millimeters C4 on 5 and 1 millimeters C6 on 7. MRI on the same day showed moderate posterior disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis.

In follow up with the neurosurgeon on April 25, 2017 surgery was again recommended. He noted Ms. Kline had some weakness and depressed reflexes in the left arm.

On June 12, 2017 Dr. Sekhon performed an anterior cervical decompression C4 through C7 followed by interbody fusion.

In follow-up Dr. Sekhon felt the patient was improving and physical therapy was recommended.

X-rays on September 5, 2017 showed no hardware complications.

On September 6, 2017, 12 weeks post op, the patient reported improvement. Exam showed intact motor function throughout the upper extremities and grossly intact sensation. DTRs were equal and normal bilaterally.

On September 11, 2017 Dr. Sekhon felt Ms. Kline was MMI and she was released to full duty.

A rating evaluation was then performed by Dr. Russell Anderson, chiropractor, on June 28, 2018. He noted the patient still had headaches and limited mobility of her neck with numbness in the left wrist and hand affecting the C6 distribution. On exam he found limited range of motion of the cervical spine and concluded she was best assessed on the range of motion method. He allowed 12% whole person impairment for specific spine disorders which included 10% for spinal fusion at one level and 1% each for additional 2 levels. He found 7% impairment related to losses of range of

motion and 1% for sensory changes in the C6 nerve root. The combined total was 19% whole person impairment.

However, Dr. Anderson noted that under the DRE method the patient would be allowed a minimum a 25% whole person impairment and suggested that 25% be the appropriate allowance.

Regarding apportionment, he noted Ms. Kline had significant pre-existing degenerative cervical spine spondylosis and suggested 75% of the whole person impairment be apportioned to non-industrial factors leaving 6% whole person impairment related to the occupational injury.

A 2nd impairment evaluation was performed on May 8, 2018 by Dr. James Jempsa, D.O. He noted Ms. Kline still had a tight sore neck, shoulders and daily headaches with numbness in the left arm to the thumb. On examination he found normal strength in the upper extremities and symmetrical reflexes but decreased sensation over the left thumb. Range of motion measurements found significant losses in flexion and extension and moderate losses in lateral flexion and rotation bilaterally.

Utilizing the range of motion method he allowed 12% whole person impairment for specific spine disorders including 10% for single level fusion and 1% each for 2nd and 3rd levels. Range of motion impairments total 16% and sensory deficits total 1% whole person impairment. The combined total was 27% whole person impairment. Apportionment was not allowed.

DISCUSSION/CONCLUSIONS:

Both Dr. Anderson and Dr. Jempsa initially utilized the range of motion method in this case which is proper considering that a multilevel fusion was performed. They also agreed there is 12% whole person impairment utilizing Table 15 - 5 and both concluded there was 1% whole person impairment for sensory deficit in the left C6 distribution. These conclusions are appropriate and supported by the medical record and known pathologies in this case.

However, there was a large discrepancy between the active range of motion findings of Dr. Anderson versus Dr. Jempsa allowing 7% and 16% respectively.

As noted on page 399 of the Guides, "the physician should seek consistency when testing active motion. Tests with inconsistent results should be repeated. Results that remain inconsistent should be disregarded." On page 375 the Guides it notes, "The physician should record and discuss any physical findings that are inconsistent with the history. Many physical findings are subjective, i.e, potentially under the influence of the individual. It is important to appreciate this and not confuse such observations with truly objective findings."

Clearly, Dr. Jempsa's findings were inconsistent with those of Dr. Anderson which are now part of the medical record. He provides no discussion or explanation for the substantial variation. It is well recognized that patients learn from prior rating experience. This can have a great effect when

findings are "under the influence of the individual" such as active range of motion which requires the full effort and cooperation of the patient to be valid. Consequently, absent an objective basis for the variation, Dr. Anderson's range of motion findings should have priority.

Making an adjustment for the range of motion inconsistency, however, has minimal effect on the final whole person impairment considering that Dr. Anderson recommended the minimum allowance of 25% for fusion under the DRE section. This recommendation is supported on page 380 of the Guides which states: "In the small number of instances in which the range of motion and DRE methods can both be utilized to evaluate the individual with both methods and award the higher rating."

The 2nd issue of concern is apportionment which has a greater impact in this case. Dr. Anderson correctly points out that the patient's cervical pathologies were primarily degenerative in nature and preexisting. This conclusion is further supported by Dr. Hall's opinion on March 24, 2016, in which he noted Ms. Kline's cervical symptoms were initially consistent with a sprain strain and that she recovered completely from the industrial injury with conservative treatments by the end of October 2015. He went on to conclude there is no objective evidence to connect the patient's significant MRI findings of January 13, 2016 with the industrial injury. It is also informative that Ms. Kline had no symptoms or examination findings of neck injury at time of her initial presentation to the ER and was not found to have acute injury related pathologies on MRI.

If the occupational incident had significantly aggravated the patient's preexisting pathologies, the development of radiculopathy symptoms and findings would be expected in the first few days or weeks, not 3 months later. Consequently, it is likely that the patient's radicular symptoms were the result of a natural progression of her significant multilevel degenerative changes rather than the injury.

At any rate, the ultimate need for surgery was primarily the result of pre-existing pathologies. Absent those pre-existing pathologies the patient would not have been a candidate for multilevel cervical discectomy and fusion. It is the fusion that now forms the basis for the patient's substantial permanent partial impairment. NAC 616C.490, paragraph 6 states that "an apportionment may be allowed if at least 50% of the total present impairment is due to a pre-existing or intervening injury, disease or condition."

Consequently, Dr. Anderson's conclusion that 70% of the patient's impairment allowance should be apportioned to pre-existing pathologies is reasonable and supported by the Guides and NAC 616C.490.

In summary, the impairment conclusions reached by Dr. Anderson are well supported by the medical record, known pathologies, AMA guides and Nevada Administrative Code.

I hope this review has been of assistance. If you have further questions or concerns, please do not hesitate to contact me.

Sincerely

Jay E. Betz, MD, CIME, CHCQM, FABQAURP
Certified Independent Medical Examiner
Certified Medical Examiner, Federal Motor Carrier Safety Administration
Certified Healthcare Quality Manager
Fellow American Board of Quality Assurance & Utilization Review Physicians

C C M S I

June 13, 2018

KIMBERLY KLINE
305 Puma Dr
Washoe Valley, NV 89704-9739

Re: Claimant: Kimberly Kline
Claim No.: 15853E839641
D.O.I.: 6/25/2015
Employer: City of Reno

Dear Ms. Kline:

We are in receipt of Dr. Betz Permanent Partial Disability (PPD) review report dated June 4, 2018. Per Dr. Betz, he agrees with Dr. Anderson's PPD evaluation dated November 10, 2017. As a result of your Permanent Partial Disability (PPD) evaluation, you have been granted a permanent partial disability award of six (5%) percent on a whole body basis for impairment of your cervical.

Please be advised the PPD award will be paid in monthly installments pursuant to NRS 616C.380.

If you disagree with the above determination you do have the right to appeal by requesting a hearing before a hearing officer by completing the bottom portion of this notice and sending it to the state of Nevada, Department of Administration, Hearings Division. **Your appeal must be filed within seventy (70) days after the date on which the notice of this determination was mailed**

If you have further questions or wish to discuss this case further, please contact me at (775) 324-3301 x 1029.

Sincerely,

Lisa Jones
Claims Representative
CCMSI – Reno, Nevada

cc: File, City of Reno, Lisa Alstead, Esq., Herb Santos, Esq.

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:	Hearing Number: 1803717/1803718-JL Claim Number: 15853E839641
KIMBERLY KLINE 305 PUMA DR WASHOE VALLEY, NV 89704-9739	CITY OF RENO ATTN ANDRENA ARREYGUE PO BOX 1900 RENO, NV 89505

_____/

BEFORE THE HEARING OFFICER

The Claimant's requests for Hearings were filed on June 19, 2018, and a Hearings were scheduled for July 12, 2018. The Hearings were held on July 12, 2018, in accordance with Chapters 616 and 617 of the Nevada Revised Statutes.

The Claimant and her attorney, Herbert Santos, Jr., were present by telephone conference call. The Employer/Insurer were represented by Lisa Wiltshire Alstead, Esquire, by telephone conference call.

ISSUE

The Claimant appealed the Insurer's determinations dated June 13, 2018 and May 24, 2018. The issues before the Hearing Officer are the 6% permanent partial disability (PPD) award and the 27% PPD held in abeyance.

DECISION AND ORDER

The determination of the Insurer is hereby **REVERSED**.

Under Decision and Order Number 1801761-JL, the Hearing Officer found a medical question regarding Dr. Anderson's 75% apportionment and instructed the Insurer to schedule the Claimant for a second PPD evaluation pursuant to NRS 616C.330. On May 8, 2018, the Claimant was evaluated for a second PPD by Dr. Jempsa wherein Dr. Jempsa awarded a 27% PPD. On May 24, 2018, the Claimant was noticed that the 27% PPD would be held in abeyance pending the results of a PPD review by Dr. Betz. On June 13, 2018, the Insurer noticed the Claimant that Dr. Betz agreed with Dr. Anderson's PPD evaluation and offered him the original 6% PPD, the instant appeals. A review of Dr. Jempsa's PPD evaluation establishes that said evaluation was conducted in accordance with the AMA Guides. As such, the Hearing Officer finds that no medical evidence has been presented to justify the 75% apportionment and the Claimant is entitled to the 27% PPD award determined by Dr. Jempsa.

APPEAL RIGHTS

Pursuant to NRS 616C.345(1), should any party desire to appeal this final Decision and Order of the Hearing Officer, a request for appeal must be filed with the Appeals Officer within thirty (30) days of the date of the decision by the Hearing Officer.

IT IS SO ORDERED this 19th day of July, 2018.

Jason Luis, Hearing Officer

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing **DECISION AND ORDER** was deposited into the State of Nevada Interdepartmental mail system, **OR** with the State of Nevada mail system for mailing via United States Postal Service, **OR** placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 1050 E. Williams Street, Suite 400, Carson City, Nevada, to the following:

KIMBERLY KLINE
305 PUMA DR
WASHOE VALLEY, NV 89704-9739

HERBERT SANTOS JR, ESQ
225 S ARLINGTON AVE STE C
RENO NV 89501

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CCMSI
PO BOX 20068
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DIR
WORKERS COMP SECTION
INTERDEPARTMENTAL MAIL
400 W KING ST
CARSON CITY NV

Dated this 19th day of July, 2018.

Susan Smock
Employee of the State of Nevada

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that I am an employee of McDONALD CARANO LLP, and that on the 14th of August, 2018, I served the within **INSURER'S DOCUMENTARY EVIDENCE** upon the following parties at the addresses and service as identified:

☐ U.S. Mail ☐ Email ☐ FedEx ☒ Hand Delivered/Filing	Appeals Officer Department of Administration 1050 East William St., Suite 450 Carson City, NV 89701
☒ U.S. Mail ☐ Email ☐ FedEx ☐ Hand Delivered ☐ Facsimile	Herb Santos, Jr. 225 S. Arlington Ave., Ste. C Reno, NV 89501

Angela Shoultz

Employee of McDonald Carano LLP

NEVADA DEPARTMENT OF ADMINISTRATION

BEFORE THE APPEALS OFFICER

In the Matter of the contested Industrial Insurance Claim

of

KIMBERLY KLINE

Claimant.

_____/

Claim No.: 15853E839641

Hearing Nos.: 1803717-JL
1803718-JL
1901522-JL

Appeal Nos.: 1900471-RKN
1902049-RKN

INSURER'S FIRST SUPPLEMENTAL DOCUMENTARY EVIDENCE

AFFIRMATION
Pursuant to NRS 239B.030

The undersigned does hereby affirm that the preceding **INSURER'S FIRST SUPPLEMENTAL DOCUMENTARY EVIDENCE**, filed in Nevada Department of Administration Appeal Nos. 1900471-RKN & 1902049-RKN does not contain the social security number of any person.

Lisa Wiltshire Alstead
Attorneys for Employer
CITY OF RENO
Administered by: CCMSI

4/15/19
Date

McDONALD CARANO
100 WEST LIBERTY STREET, TENTH FLOOR • RENO, NEVADA 89501
PHONE 775.788.2000 • FAX 775.788.2020

C C M S I

September 20, 2018

KIMBERLY KLINE
305 Puma Dr
Washoe Valley, NV 89704-9739

Re: Claimant: Kimberly Kline
Claim No.: 15853E839641
D.O.I.: 6/25/2015
Employer: City of Reno

Dear Ms. Kline:

In compliance with the denial of stay order of 9/11/2018, you have been granted a permanent partial disability award of twenty seven (27%) percent on a whole body basis for impairment of your cervical. As indicated in the enclosed documents, you may elect to receive the undisputed six (6) percent either on an installment or lump sum basis.

Please be advised the disputed twenty one (21) percent PPD award will be paid in monthly installments pursuant to NRS 616C.380.

If you disagree with the above determination you do have the right to appeal by requesting a hearing before a hearing officer by completing the bottom portion of this notice and sending it to the state of Nevada, Department of Administration, Hearings Division. **Your appeal must be filed within seventy (70) days after the date on which the notice of this determination was mailed**

If you have further questions or wish to discuss this case further, please contact me at (775) 324-3301 x 1029.

Sincerely,

Lisa Jones
Claims Representative
CCMSI – Reno, Nevada

cc: File, City of Reno, Lisa Alstead- Wiltshire, Esq., Herb Santos, Esq.

RECEIVED
DEC 03 2018
CCMSI - Reno

SCANNED

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:

KIMBERLY KLINE
305 PUMA DR
CARSON CITY, NV 89704-9739

Hearing Number: 1901522-JL
Claim Number: 15853e839641

CITY OF RENO POLICE DEPARTMENT
PO BOX 1900
RENO, NV 89502

/

BEFORE THE HEARING OFFICER

The Claimant's request for Hearing was filed on November 27, 2018, and a Hearing was scheduled for December 19, 2018. The Hearing was held on December 19, 2018, in accordance with Chapters 616 and 617 of the Nevada Revised Statutes.

The Claimant and her attorney, Herbert Santos, Jr., were present by telephone conference call. The Employer and Insurer were represented by Lisa Wiltshire Alstead, Esquire, by telephone conference call.

ISSUE

The Claimant appealed the Insurer's determination dated September 20, 2018. The issue before the Hearing Officer is 27% permanent partial disability (PPD) award with 6% to be paid in lump sum and 21% in installments.

DECISION AND ORDER

The determination of the Insurer is hereby **AFFIRMED and REMANDED**.

On September 20, 2018, the Insurer noticed the Claimant that in compliance with a denied Motion for Temporary Stay Pending Appeal, it was granting a PPD award of 27%. The Insurer offered the undisputed 6% in either installment or lump sum and the undisputed 21% in monthly instalments, the instant appeal. **NRS 616C.380(1)(a)** provides that if a hearing officer, appeals officer or district court renders a decision on a claim for compensation and the insurer or employer appeals that decision, but is unable to obtain a stay of the decision, payment of that portion of an award for a permanent partial disability which is contested **must** be made in installment payments until the claim reaches final resolution. Having reviewed the submitted evidence and in consideration of the representations made at today's hearing, the Hearing Officer finds the Insurer's determination is proper pursuant to NRS 616C.380; however, on the Election of Method of Payment of Compensation (D-10a form), only the 6% is offered, not the disputed 21%. As such, the Hearing Officer instructs the Insurer to recalculate the PPD award and reissue a new Election of Method of Payment of Compensation in compliance with NRS 616C.380.

RECEIVED
DEC 28 REC'D

APPEAL RIGHTS

Pursuant to NRS 616C.345(1), should any party desire to appeal this final Decision and Order of the Hearing Officer, a request for appeal must be filed with the Appeals Officer within thirty (30) days of the date of the decision by the Hearing Officer.

IT IS SO ORDERED this 27th day of December, 2018.

Jason Luis, Hearing Officer

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that I am an employee of McDONALD CARANO LLP, and that on the 15th of April, 2019, I served the within **INSURER'S FIRST SUPPLEMENTAL DOCUMENTARY EVIDENCE** upon the following parties at the addresses and service as identified:

☐ U.S. Mail ☐ Email ☐ FedEx ☒ Hand Delivered/Filing	Appeals Officer Department of Administration 1050 East William St., Suite 450 Carson City, NV 89701
☒ U.S. Mail ☒ Email ☐ FedEx ☐ Hand Delivered ☐ Facsimile	Herb Santos, Jr. 225 S. Arlington Ave., Ste. C Reno, NV 89501

Angela Shoults

Employee of McDonald Carano LLP

McDONALD CARANO
100 WEST LIBERTY STREET, TENTH FLOOR • RENO, NEVADA 89501
PHONE 775.788.2000 • FAX 775.788.2020

NEVADA DEPARTMENT OF ADMINISTRATION

BEFORE THE APPEALS OFFICER

In the Matter of the contested Industrial Insurance Claim

of

KIMBERLY KLINE

Claimant.

Claim No.: 15853E839641

Hearing Nos.: 1803717-JL
1803718-JL
1901522-JL

Appeal Nos.: 1900471-RKN
1902049-RKN

INSURER'S SECOND SUPPLEMENTAL DOCUMENTARY EVIDENCE

AFFIRMATION
Pursuant to NRS 239B.030

The undersigned does hereby affirm that the preceding **INSURER'S SECOND SUPPLEMENTAL DOCUMENTARY EVIDENCE**, filed in Nevada Department of Administration Appeal Nos. 1900471-RKN & 1902049-RKN does not contain the social security number of any person.

Lisa Wiltshire Alstead
Attorneys for Employer
CITY OF RENO
Administered by: CCMSI

4/30/19
Date

ENTERED INTO
EXHIBIT F

McDONALD CARANO
100 WEST LIBERTY STREET, TENTH FLOOR • RENO, NEVADA 89501
PHONE 775.788.2000 • FAX 775.788.2020

CCMSI

January 24, 2019

KIMBERLY KLINE
305 Puma Dr.
Washoe Valley, NV 89704-9739

Re: Claim No.: 15853E839641
D.O.I.: 6/25/2015
Employer: City of Reno
Body part: Cervical

Dear Ms. Kline:

In compliance with the Hearing Officer's decision #1901522-JL and based on the January 24, 2019 correspondence from Mr. Santos, we understand that you are not electing to take the undisputed 6% of the PPD award in lump sum form. Accordingly, we will initiate payment of the full 27% PPD award in installments pursuant to NRS 616C.380. Please find enclosed the revised calculation.

If you disagree with this determination, you have the right to request a hearing by completing the bottom portion of the enclosed Request for Hearing form, and sending it to the State of Nevada, Department of Administration, Hearings Division, Carson City address, within seventy (70) days from the date of this letter.

If you have questions regarding this letter, you may contact me at (775) 324-9891.

Sincerely,

Lisa Jones
Claims Representative
CCMSI – Reno, Nevada

cc: file
City of Reno
Lisa Wiltshire-Alstead, Esq.
Herb Santos, Esq.

REQUEST FOR HEARING - CONTESTED CLAIM

(Pursuant to NAC 616C.274)

REPLY TO:

Department of Administration
Hearings Division
1050 E. William Street, Ste. 400
Carson City, NV 89701
(775) 687-8440

OR

Department of Administration
Hearings Division
2200 S. Rancho Drive, Suite 210
Las Vegas, NV 89102
(702) 486-2525

Employee Information	
Employee's Name and Address KIMBERLY KLINE 306 Puma Dr Washoe Valley, NV 89704	
Employee's Telephone Number 775-326-6637	Claim No. 15853E839641 Date of Injury 06/25/2015

Employer Information
Employer's Name and Address CITY OF RENO 1 EAST FIRST STREET RENO, NV 89505
Employer's Telephone Number 775-326-6637

Insurer Information	Third-Party Administrator Information
Insurer's Name and Address	Third-Party Administrator's Name and Address
Insurer's Telephone Number	Third-Party Administrator's Telephone Number

Do Not Complete or Mail This Form Unless You Disagree With the Insurer's Determination.

☐ **PLEASE CHECK HERE IF YOUR REQUEST IS REGARDING A CLAIM FILED PURSUANT TO NRS 617.455 OR 617.457**

YOU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARING WILL NOT BE SCHEDULED PURSUANT TO NRS 616C.315.

Briefly explain the basis for this appeal:

_____

_____

_____

This request for hearing is filed by, or on behalf of: ☐ **Injured Employee** ☐ **Employer**

and is dated this _____ day of _____, 20_____.

_____ _____

Signature of Injured Employee/Employer

Injured Employee's/Employer's Rep. (Advisor)

D-12a (Rev. 10/2018)

PERMANENT PARTIAL DISABILITY AWARD CALCULATION WORK SHEET

Injured Employee:	Kimberly Kline	DOB:	10/7/1979	Sex:	Female
SS#		D. O. I.:	6/25/2015	Claim #	15853E839641
*Average Monthly Wage:	✓ $4,846.48	* State Average Wage:	$5,356.23	Date of Rating:	12/23/2018
Date Award Offered:	1/21/2019	Date Evaluation Report Received:		12/28/2019	

Body Basis-Verification

Description:	cervical	27.00	%	
			%	Total: 27.00 % BB

Installment Calculation

		**							
*A.	$4,846.48	0.0060	27.00 %BB	= $	785.13	Year of Birth		Last TTD	
	Monthly Wage				Monthly Rate	***		TPD, or DOI	
B.	$785.13 x 12			= $	9,421.56	1979		2017	
	Monthly Rate				Annual Rate	+ 70	+	5	
C.	$9,421.56 / 365.25			= $	25.79	2049		2022	
	Annual Rate				Daily Rate				

Installment Calculation

(1)	Last Date TTD or TPD paid:			7/30/2017		First Payment Date:		1/1/2019	
(2)	Time Covered by First Payment: (a)			7/31/2017		through (b)****		12/31/2018	
	******DOI/date of claim reopening or day after last TTD/TPD								
(3)	First Payment:	$25.79	+	$3,925.65	+	$9,421.56	=	$13,373.00	
		1 Day(s)		5 Month(s)		1 Year(s)			
(4)	Time Covered by Annual Payments:	1/1/2019	through	12/31/2048	=			$282,646.80	
(5)	Time Covered by Final Payment:	1/1/2049	through	10/6/2049	****	30 Years			
(6)	Final Payment:	$7,066.17	+	$154.74	=			$7,220.91	
		9 Month(s)		6 Day(s)					
	***** Monthly X	Annual		Total of Installment Payments:	=			$303,240.71	

Minumum Lump Sum Calculation

.5 % X 27.00 % BB X $4,846.48 Monthly Wage from (A) above: $65,427.48

Minimum Lump Sum Amount

Lump Sum Calculation of Disability Up To and Including 30%

(Use form D-9b for disability greater 30%)

(7)	Effective Date of Award (year, month following 2b) Per NAC 616C.502	2019			1
(8)	Date of Birth (year, month)	1979			10
(9)	Injured Employee Age at Award Effective Date = (7) minus (8) (years, months)	39			3
(10)	Monthly Rate From (B)	$785.13			
(11)	Factor from Table for Present Value	235.717	X	=	$185,068.49
(12)	Insert Sum of (3). Add to sum of (11) only.			+	$13,373.00
(13)	Subtotal of (11) plus (12):				$198,441.49
(14)	Greater of (13) full Lump Sum or Minimum Lump Sum:				$198,441.49
(15)	Minus any applicable award payments previously paid:				✓ $13,989.39
(16)	Net Amount Payable:				$184,452.10

* Use the Average Monthly Wage or the State Average Wage, whichever is lower. If the average monthly wage (AMW) for TTD on this claim is subject to the frozen 1993 rate, recalculate the AMW for PPD purposes.

** Use .005 for injuries sustained before 07/01/81. Use .006 for injuries sustained after 07/01/81, through 06/17/93. Use .0054 for injuries sustained on or after 06/18/93. Use .006 for injuries sutained on or after 1/1/00.

*** Per NRS 616C.490(7), age at which entitlement ceases.

**** This must reflect the end of the month prior to election of the lump sum payment. Recalculation may be required to bring the award to present day value. If (2)(b) is December date, use caution on line (4) to assure correct number of years. (If subtracting dates, add one year)

***** Must pay monthly installments if monthly entitlement is $100 or more. May pay annual installment if monthly entitlement is then $100.

******Use date of claim reopening if TTD/TPD benefits were not paid after the claim was reopened (2)(a).

PREPARED BY: Mia Yonis Date:

CHECKED BY: Date: 1/24/19

D-9a (rev 12/16)

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that I am an employee of McDONALD CARANO LLP, and that on the 30th of April, 2019, I served the within **INSURER'S SECOND SUPPLEMENTAL DOCUMENTARY EVIDENCE** upon the following parties at the addresses and service as identified:

☐ U.S. Mail ☐ Email ☐ FedEx ☐ Hand Delivered/Filing ☒ Facsimile	Appeals Officer Department of Administration 1050 East William St., Suite 450 Carson City, NV 89701 Fax: 775.687.8421
☐ U.S. Mail ☐ Email ☐ FedEx ☐ Hand Delivered ☒ Facsimile	Herb Santos, Jr. 225 S. Arlington Ave., Ste. C Reno, NV 89501 Fax: 775.323.5211

Angela Shoults

Employee of McDonald Carano LLP

McDONALD CARANO
100 WEST LIBERTY STREET, TENTH FLOOR • RENO, NEVADA 89501
PHONE 775.788.2000 • FAX 775.788.2020

NEVADA DEPARTMENT OF ADMINISTRATION

BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim

of

KIMBERLY KLINE,

Claimant.
_____/

Claim No: 15853E839641

Hearing No: 1801761-JL

Appeal No: 1802418-RKN

INSURER'S THIRD SUPPLEMENTAL DOCUMENTARY EVIDENCE

AFFIRMATION
Pursuant to NRS 239B.030

The undersigned does hereby affirm that the preceding **INSURER'S THIRD SUPPLEMENTAL DOCUMENTARY EVIDENCE**, filed in Nevada Department of Administration Appeal No. 1802418-RKN does not contain the social security number of any person.

Lisa Wiltshire Alstead
Attorneys for Employer
CITY OF RENO
Administered by: CCMSI

5/29/18
Date

McDONALD CARANO
100 WEST LIBERTY STREET, TENTH FLOOR • RENO, NEVADA 89501
PHONE 775.788.2000 • FAX 775.788.2020

15953E939641

James C. Jempsa, DO
775-786-9072
Fax 775-787-6430

FACSIMILE TRANSMITTAL

To: Lisa Jones

From: James C Jempsa DO

Fax: 324-7893

Date: 5/14/2018

Total Pages (including cover): 14

Regarding: Kimberly Kline

JAMES C. JEMPSA, DO

Reno, Nevada
Telephone: 775-786-9072
Fax: 775-787-6430

Lisa Jones
CCMSI
PO Box 20068
Reno, NV 89515
Telephone: 775-324-3301
Fax: 775-324-9893

PERMANENT PARTIAL DISABILITY EVALUATION

RE:	CLAIMANT:	Kimberly Kline
	SSN:	
	CLAIM NO.:	15853E839641
	DOI:	06/25/2015
	EMPLOYER:	City of Reno
	DATE OF EXAM:	05/08/2018
	DATE OF REPORT:	05/14/2018
	BODY PARTS:	1. Cervical.

DIAGNOSIS:

1. Multilevel cervical fusion.

PLACE OF EXAMINATION: Reno, Nevada.

INTRODUCTION: The claimant presents to our office today for a Permanent Partial Disability rating performed in accordance with the Fifth Edition, Sixth Printing, AMA Guides to the evaluation of Permanent Impairment. The claimant was informed with regards to the purpose of this examination. It is understood that there is no patient/treating physician relationship established on the basis of today's examination. It was explained that the evaluation was requested by the referral source and the report will be sent to the referral source upon completion.

Dear Lisa Jones:

Kimberly Kline sustained industrial injury to her neck on June 25, 2015. She subsequently went on to have a multilevel fusion of her cervical spine. She presents today for a PPD evaluation of the cervical spine.

PERSONAL DATA:

The claimant was identified by her picture on a Nevada Driver's License #0701144556. She gives a birth date of 10/07/1979 making the claimant 38 years of age at the time of this evaluation.

The claimant has lived in Reno for approximately the last 38 years.

She has completed school greater than 16 years.

The claimant has not served in the military.

REVIEW OF MEDICAL RECORDS:

All significant medical records provided were reviewed.

On June 25, 2015 initial evaluation at St. Mary's Regional Medical Center. History of Present Illness: Chief Complaint: Back injury and back pain. It is described as being moderate degree of pain in the upper lumbar mid lumbar and lower lumbar spine radiating into the right thigh and the left thigh. No bladder dysfunction, bowel dysfunction, sensory loss or motor loss. Past History: The patient had prior back pain. Physical Exam: Neck: Normal inspection. Neck nontender. Painless range of motion. Back: Mild vertebral point tenderness over the upper, mid and lower lumbar spine. Neuro: No motor deficit. No sensory deficit. Reflexes normal. Impression: Acute lumbar radiculopathy. Sprain of lumbar spine. Acute pain in the lower back. Prescription Medications: Flexeril, Norco and prednisone.

On June 30, 2015 evaluation at Specialty Health Clinic. Chief Complaint: Back-2nd MVA 6-25-15. History of Present Illness: Patient was involved in a second motor vehicle accident on June 25, 2015 when she was rear-ended at high-speed. Currently the patient reports: 1. Neck discomfort-moderate, diffuse, radiation into the right shoulder, associated stiffness. 2. Lumbar and thoracic pain-diffuse, nonradiating, no red flags, no numbness or weakness reported and legs. Physical Exam: Cervical exam-mild diffuse muscular tenderness to palpation, normal inspection, normal strength and sensation in both arms, normal reflexes throughout both arms, range of motion, flexion 40°, extension 50°, lateral rotation 70° bilaterally with pain at extremes. Assessment: Sprain of neck. Plan: Chiropractic, full duty, return in two weeks.

On May 11, 2015 initial evaluation by Dr. Men-Muir. He evaluated her low back.

On July 14, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports ongoing lumbar and neck pain, moderate to severe, associated sleep disruption and stiffness, minimal improvement with chiropractic care, no numbness or weakness. Physical Exam: Musculoskeletal: Neck-normal inspection, mild diffuse muscular tenderness to palpation, grossly normal strength and sensation. Assessment: Sprain of neck. Plan: Physical therapy, Full duty, return in two weeks.

On August 20, 2015 follow-up visit at Specialty Health Clinic. Chief Complaint: Cervical strain. History of Present Illness: Patient notes improvement in her neck symptoms and describes only mild muscular tightness currently. She reports no arm symptoms. Physical therapy has been helpful and continues. Physical Exam: Musculoskeletal: Exam-normal inspection, mild muscular tenderness palpation over the trapezius, full motion with grossly normal strength and sensation in arms. Assessment: Sprain of neck. Plan: Full duty, MMI.

On September 23, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports improving neck discomfort, rated 3/10, Central without radiation, improving with conservative care including physical therapy and occasional muscle relaxants, no associated symptoms. Physical Exam: Musculoskeletal: Neck exam-normal inspection, minimal muscle tenderness to palpation, full motion, normal strength and sensation in both arms. Assessment: Sprain of neck. Plan: Physical therapy, Full duty, return in two weeks.

On October 28, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports improvement in her neck without significant symptoms currently, no arm symptoms reported. Patient has completed treatment. Physical Exam: Musculoskeletal: Neck exam-normal inspection, nontender to palpation, full motion with grossly normal strength. Assessment: Sprain of ligament of the cervical spine Plan: Full duty, MMI.

On January 13, 2016 MRI of the cervical spine without contrast impression: Disc degeneration with large disc protrusion at the C5-C6 and C6-C7 levels resulting in complete effacement of CSF from the ventral and dorsal aspect of the cord with severe canal stenosis without cord compression or abnormal signal intensity in the cord to suggest cord edema or myelomalacia.

On January 13, 2016 chiropractic treatment by Dr. Hansen.

On January 14, 2016 chiropractic treatment by Dr. Hansen.

On January 15, 2016 chiropractic treatment by Dr. Hansen.

On January 18, 2016 chiropractic treatment by Dr. Hansen.

On January 19, 2016 chiropractic treatment by Dr. Hansen.

On January 20, 2016 chiropractic treatment by Dr. Hansen.

On January 21, 2016 chiropractic treatment by Dr. Hansen.

On January 25, 2016 chiropractic treatment by Dr. Hansen.

On January 26, 2016 chiropractic treatment by Dr. Hansen.

On January 27, 2016 chiropractic treatment by Dr. Hansen.

On January 28, 2016 chiropractic treatment by Dr. Hansen.

On February 1, 2016 chiropractic treatment by Dr. Hansen.

On February 2, 2016 chiropractic treatment by Dr. Hansen

On February 5, 2016 chiropractic treatment by Dr. Hansen

On February 8, 2016 chiropractic treatment by Dr. Hansen

On February 10, 2016 chiropractic treatment by Dr. Hansen

On February 12, 2016 chiropractic treatment by Dr. Hansen

On February 16, 2016 chiropractic treatment by Dr. Hansen

On February 19, 2016 chiropractic treatment by Dr. Hansen

On February 24, 2016 chiropractic treatment by Dr. Hansen

On March 16, 2016 follow-up visit at Specialty Health Clinic.

On April 28, 2016 chiropractic treatment by Dr. Hansen

On July 5, 2016 neurosurgical evaluation. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: When I saw her today, she has neck pain and stiffness. She has a pressure feeling in the neck. She rates this as a 5/10. She has aching in the left arm again it is 5/10. She maps out numbness and aching in the forearm down to the thumb in the C6 distribution. Her right arm is okay. She feels she has plateaued. She is done extensive physical therapy. Physical Examination: Cervical: Neck, shoulders and low back have normal range of motion with no scars. Palpation for tenderness. Arms have normal range of motion with no scars. She has a reduce range of motion of the cervical spine. She has numbness of the left forearm in the C6 distribution. On physical examination, she has 4/5 weakness in external rotators in the left, biceps and triceps on the left. She has diminished reflexes in the upper extremities. Impression/Plan: 1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord

compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. 4. Minimal spondylosis, L3-4, L4-5 and L5-S1. Kimberly has a cord compression and weakness. I think it is reasonable to offer her surgery. She states she never had these arm symptoms before the accident and although she may have had pre-existing spondylosis, the accident had probably exacerbated her underlined stenosis. I offered her C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On April 3, 2017 follow-up neurosurgical visit. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: She has continued with posterior neck pain and pressure. The pain continues to extend down the left arm following the left C-6 distribution. Most of his symptoms are in the left arm and rated at times at a 9/10. Continues to limit her ability to sleep at night the symptoms may be slightly improved but overall are very similar to the intensity she had the last allied. Physical Exam: She had a reduce range of motion of the cervical spine. She has numbness of the left form in the C6 distribution. On physical examination, she has 4/5 weakness in external rotators on the left, biceps and triceps on the left. She has depressed reflexes in the upper extremity. Assessment and Plan: 1. Neck pain. 2. Cervical spondylosis. 3. Spinal stenosis and cervical region. Plan: 1. Repeat MRI and C-spine x-rays. 2. Follow-up in 2-4 weeks.

On April 21, 2017 x-rays of the cervical spine. Impression: 1. Mild disc space narrowing and facet degenerative change of the lower cervical spine. 2. Development of retrolisthesis of 2 mm of retrolisthesis C4 on 5 and 1 mm retrolisthesis of C6 on 7 upon extension.

On April 21, 2017 MRI of the cervical spine without contrast. Impression: Moderate posterior disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis.

On April 25, 2017 follow-up neurosurgical visit. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: Returns. Arm worse. Options discussed. Wants surgery. Physical Exam: She has a reduce range of motion of the cervical spine. She has numbness of the left forearm and the C6 distribution. Physical examination, she has 4/5 weakness in external rotators on the left, biceps and triceps on the left. She has depressed reflexes in the left upper extremity. Impression: 1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. 4. Minimal spondylosis, L3-4, L4-5 and L5-worsening symptoms and stenosis on MR. 6. Cord compression and failed conservative therapy. I offered her C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On June 8, 2017 follow-up neurosurgical visit chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: She has stopped all blood thinning medications. She does again request surgery. She would like to remain off work first six weeks as was discussed. Physical Exam: She has a reduce range of motion of the cervical spine. She has numbness of the left form in the C6 distribution. On physical examination, she has 4/5 weakness

in external rotators on the left, brought biceps and triceps on the left. She has depressed reflexes in the upper extremity. Impression: 1. Cervical spine bond low doses, C4-5, C5-6 and C6-7 with cord compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. She was offered C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On June 12, 2017 operative report by Dr. Sekhon. Preoperative Diagnosis: Cervical stenosis. Postoperative Diagnosis: Cervical stenosis. Title of the Procedure: 1. C4/5, C5/6, and C6/7 Anterior cervical decompression using a left-sided approach and the microscope. 2. C4/5, C5/6 and C6/7 interbody fusion using peak interbody cages and bone graft substitute. 3. C4-7 anterior segment fusion using a cervical locking plate. 4. Microscopic microdissection. 5. Fluoroscopic guidance for placement of the screws.

On June 26, 2017 postop neurosurgical visit. Chief Complaint: 1. Two weeks status post C4-C 7 ACDF. 2. Left upper extremity radiculopathy. History of Present Illness: She has noticed some improvement to the left upper extremity symptoms. The numbness in her arm and hand specifically have improved. She still has some achiness posteriorly of her neck. She has some mild dysphasia that slowly seems to be improving. She has been wearing her soft collar when she is up and about, but she states that she is actually feeling quite well for two weeks after surgery. The strength in her arms is good. Overall, she takes about one pain tablet towards the end of the day, but otherwise the pain is very manageable. Physical Exam: On physical exam, the wound is clean, dry and intact. There is no evidence of infection. There is minor superficial edema and swelling that is non-concerning. Upper extremity motor strength is 5/5 throughout bilaterally. Sensation is grossly intact. The equivalent and normal bilaterally. Impression: 1. Two weeks status post C4-C7 ACDF. 2. Improvement to preoperative symptomatology in the left upper extremity. 3. Stable postoperative course. Plan: 1. Follow-up in four weeks with static and dynamic cervical x-rays. 2. Call with any questions or concerns or changes in her condition.

On July 24, 2017 x-rays of the cervical spine with flexion and extension. Impression: Anterior interbody fusion C4 through C7 with no instability with flexion/extension views.

On July 26, 2017 follow-up postoperative neurosurgical visit. Chief Complaint: 1. Two week status post C4-C7 ACDF. 2. Left upper extremity radiculopathy. History of Present Illness: Today, she presents to six weeks postoperative review. She continues to notice improvement to the left upper extremity symptoms. Left arm is overall much improved, but she has noticed some ongoing numbness in the left hand and forearm. Her posterior neck pain has mostly settled and her swallowing is not problematic. She occasionally takes about one pain tablet towards the end of the day, but otherwise the pain is very manageable. Physical Exam: On physical exam, the wound is clean, dry, and intact. There is no evidence of infection. Upper extremity motor strengths are 5/5 throughout bilaterally. Sensation is grossly intact. DTRs are equivalent and normal bilaterally. Impression: 1. 6 weeks status post C4-C7 ACDF. 2. Improvement in postoperative symptomatology in the left upper extremity. 3. Stable postoperative course. Plan:

1. Follow-up in 6 weeks with static and dynamic cervical x-rays. Physical therapy. Release to work without restrictions on 7/31/17.

On September 5, 2017 x-rays of the cervical spine with flexion-extension views. Impression: ACDF C 4-C7 without evidence of hardware complication.

On September 6, 2017 follow-up postop neurosurgical visit. Chief Complaint: 1. 12 weeks status post C4-C7 ACDF. History of Present Illness: Today, she presents 12-weeks postoperative. Her symptoms continue to much improved. There is slight numbness in her left hand but it is very manageable. She also has some occasional posterior neck pain. She is not having the shooting pains that she once did. She has done physical therapy which she believes is helping. She also believes that the pressure in her neck has settled as well. She is very pleased with her recovery at this stage. Physical exam: On physical exam, the wound is clean, dry and intact. There is no evidence of infection. Upper extremity motor strengths are 5/5 throughout bilaterally. Sensation is grossly intact. DTRs are equivalent and normal bilaterally. Impression: 1. 12 weeks status post C4-C7 ACDF. 2. Improvement to preoperative symptomatology in the left upper extremity. 3. Stable postoperative course.

On September 11, 2017. She was placed at maximum medical improvement. She was retumed to full duty. She had a ratable impairment.

PRESENT SYMPTOMS AND COMPLAINTS:

The claimant states that she has a tight/sore neck, tight/sore shoulders, daily headaches, weak neck, and numbness down her left arm to her left thumb. She states that her current neck pain is a 4/10 and at its worse 8/10 and at its best 2/10.

As far as activities of daily living are concerned:

As far as self-care/personal hygiene is concerned: She states no difficulty with brushing teeth, eating, urinating and bowel movements. She states mild difficulty with dressing and combing hair. She states moderate difficulty with bathing.

As far as communication is concerned: She states no difficulty with speaking, hearing and writing.

As far as physical activity is concerned: She states no difficulty walking and climbing stairs. She states mild difficulty with standing, sitting, changing positions.

As far sensory function is concerned: She states no diff code was seeing, smelling, tasting, feeling sharp versus dull and feeling hot versus cold except for her left thumb.

As far as hand activities are concerned: She states no difficulty with coordination. She states mild difficulty with grasping and lifting.

As far as advanced activities are concerned: She states no difficulty with preparing meals, managing money/checkbook, taking medications, and using public transportation. She states mild difficulty with working around the house/housework, using the phone or writing letters, shopping/carrying groceries, social activities, sexual activities and vigorous physical activity. She states moderate difficulty with driving a car. She states severe difficulty with restful sleep secondary to pain.

PAST MEDICAL HISTORY:

Past Medical History: She has no history of chronic illnesses. She states that she had no problems with her neck prior to her industrial injury of June 25, 2015.

Past Surgical History: Right ankle surgery 2013.

Medications: Advil.

Allergies to Medications: No known drug allergies.

PHYSICAL EXAMINATION:

On May 8, 2018 the claimant stood 67" tall and weighed 178 pounds. The claimant is right hand dominant.

This person's general appearance is that of a well-hydrated, well-nourished adult female in no acute distress. Her mood and manner were appropriate. She was well oriented and cooperative throughout the examination. She was not wearing an orthotic device.

On visual inspection of the cervical spine there was normal development. There was a 7 cm surgical scar located over the left anterior inferior aspect of the neck. The scar was generally straight in appearance and normal in color. On palpation of the neck there was muscle tightness along the paravertebral musculature. On strength testing, motor strength was 5/5 in all muscle groups of the right and left upper extremities. On sensory testing there was intact sensation to light and sharp touch except for the left thumb which was 4.56 on monofilament testing. Deep tendon reflexes at the biceps and triceps were +2/+4 bilaterally. The right and left upper extremities have normal temperature color and pulses. There was no evidence of atrophy, upper arm and forearm circumferences were equal bilaterally.

Range of motion of the cervical spine:

The claimant was informed not to perform any motions that were painful or that she was uncomfortable performing or that might cause her harm. The claimant was also informed that she can take a rest break during any part of the examination.

Warm-up exercise were performed as described on page 399.

Range of motion of the cervical spine was performed according to Section 15.11 Range of Motion: Cervical Spine. Starting on page 417.

Movement	Description	Range					
Cervical Flexion	Calvarium angle	40	40	40			
	T1 ROM	20	20	20			
	Maximum cervical flexion angle	20	20	20			
	±10% or 5°	*Yes	No				
	Maximum cervical flexion angle	20					
	% Impairment	3					

Movement	Description	Range					
Cervical Extension	Calvarium angle	20	20	20			
	T1 ROM	5	5	5			
	Cervical extension angle	15	15	15			
	±10% or 5°	*Yes	No				
	Maximum cervical extension angle	15					
	% Impairment	5					

Movement	Description	Range					
Cervical Left Lateral Bending	Calvarium angle	30	30	30			
	T1 ROM	10	10	10			
	Cervical left lateral flexion angle	20	20	20			
	±10% or 5°	*Yes	No				
	Maximum cervical left lateral flexion angle	20					
	% Impairment	2					

Movement	Description	Range					
Cervical Right Lateral Bending	Calvarium angle	30	30	30			
	T1 ROM	10	10	10			
	Cervical right lateral flexion angle	20	20	20			
	±10% or 5°	*Yes	No				
	Maximum cervical right lateral flexion angle	20					
	% Impairment	2					

Movement	Description	Range					
Cervical Left Rotation	Cervical left rotation angle	40	40	40			
	±10% or 5°	*Yes	No				
	Maximum cervical left rotation angle	40					
	% Impairment	2					

Movement	Description	Range					
Cervical Right Rotation	Cervical right rotation angle	40	40	40			
	±10% or 5°	*Yes	No				
	Maximum cervical right rotation angle	40					
	% Impairment	2					

SUMMARY AND DISCUSSION:

STABILITY OF MEDICAL CONDITION: The claimant was placed at maximum medical improvement on September 11, 2017 permanent and stationary, stable and ratable by Dr. Sekhon.

APPORTIONMENT: There is no prior history of disease, injury, or impairment to the affected body part necessitating apportionment consideration.

IMPAIRMENT EVALUATION ACCORDING TO THE GUIDES:

Impairment rating was done according to the Fifth Edition, Sixth Printing AMA Guides to the Evaluation of Permanent Impairment. The examination, measurements, and impairment percentages were compiled by me. The history and medical records provided were reviewed by me and any discrepancies were discussed with the claimant.

Body Part: The claimant is rated according to the cervical spine.

On page 380 right hand column. Range of motion method if: b. there is radiculopathy bilaterally or at multiple levels in the same spinal region.

In this case, there was multiple levels in the same spinal region. Therefore, the claimant will be rated by range of motion.

On page 398 Section 13.8 Range-of-Motion Method. Although called the range of motion method, this evaluation method action consists of three elements that need to be assessed: (1) the range of motion of the impaired spinal region; (2) accompanying diagnosis (Table 15-7); and (3)

any spinal nerve deficit, which is described in this chapter and in chapter 13. The whole person impairment rating is obtained by combining ratings from all three components, using the combined values chart (p. 604).

On page 404, Table 15-7, Criteria for Rating Whole Person Impairment Percentage Due to Specific Spine Disorders to Be Used As Part of the Range of Motion Method. The claimant fits into the Category IV D. Single-level spinal fusion with or without decompression with residual signs and symptoms. Also Category IV E. multiple levels, operated on, with residual, medically documented pain and rigidity. Add 1% per level. Therefore, an additional 2% will be added for the additional levels. Therefore, the total equals 12% whole person impairment from Table 15-7.

On page 418, Table 15-12, Cervical Region Impairment from Abnormal Flexion or Extension or Ankylosis. Therefore, flexion of 20° equals 3% whole person impairment. Extension of 15° equals 5% whole person impairment. Total impairment due to abnormal flexion and extension equals 8% whole person impairment.

On page 420 Table 15-13, Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Lateral Bending. Right lateral bending of 20° equals 2% whole person impairment. Left lateral bending of 20° equals 2% whole person impairment. Therefore, total impairment due to lateral bending equals 4% whole person impairment.

On page 421 Table 15-14 Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Rotation. Right rotation of 40° equals 2% whole person impairment. Left rotation of 40° equals 2% whole person impairment. Therefore, total impairment due to abnormal rotation equals 4% whole person impairment.

Therefore 16% whole person impairment for abnormal motion.

On page 423 Section 15.12 Nerve Root and/or Spinal Cord. The claimant has decreased sensation along the C6 nerve root on the left. She best fits into grade 3 30% Sensory Deficit. On page 424, Table 15-17 Maximum % Loss of Function Due to Sensory Deficit or Pain is 8% for the C6 nerve root. Therefore, multiplying 30% times 8% equals 2.4% upper extremity impairment rounded to 2% upper extremity impairment. On page 439 Table 16-3 Conversion of Impairment of the Upper Extremity to Impairment of the Whole person. Therefore, 2% upper extremity impairment equals 1% whole person impairment.

The total whole person impairment for accompanying diagnoses from Table 15-7 equals 12%.

The total whole person impairment for loss of motion equals 16%.

The total whole person impairment for sensory loss equals 1%.

Therefore, combining the whole person impairment for accompanying diagnoses from Table 15-7 12% with impairment for loss of motion 16% with impairment for sensory loss of 1% equals 27% whole person impairment from the combined values chart on page 604.

ESTIMATED WHOLE PERSON IMPAIRMENT: Upon review of the available medical records and after examining the claimant, apportionment does not appear to be an issue with regards to this claim. **It is my recommendation that the claim be closed with 27% whole person impairment.**

If there are any further questions regarding the impairment rating provided, please do not hesitate to contact me.

Sincerely,

James C. Jempsa, DO
Board Certified American Board of Osteopathic Family Physicians; Member, American College of Osteopathic Family Physicians, DIR Designated Rating Physician, State of Nevada.

C C M S I

May 15, 2018

Dr. James Jempsa
Fax # 775-787-6430

RE:	Claimant:	Kimberly Kline
Re:	Claim No.:	15853E839641
	D.O.I.:	6/25/2015
	Body Part:	Cervical
	Employer:	City of Reno

Dear Dr. Jempsa:

Thank you for your permanent partial disability report (PPD) dated May 8, 2018. Enclosed please find a copy of Dr. Anderson's PPD report dated November 10, 2017. Please review Dr. Anderson's PPD evaluation and advise if you agree with apportionment and provide an addendum report.

Thank you for your time and consideration regarding this matter. Please fax your report to (775) 324-9893.

Respectfully

Lisa Jones
Claims Representative

CC: City of Reno, Herb Santos, Esq. Lisa Wiltshire Alstead, Esq.

Enc. Dr. Anderson PPD report

LJ

Russell N. Anderson, DC
290 SE Court Street
Prineville, OR 97754
(541) 903-1444 (541) 362-4090-FAX

PERMANENT PARTIAL DISABILITY EVALUATION

Claimant: Kimberly Kline
Claim #: 15853E839641
CCMSI
Lisa Jones-Claims Representative
Date of Injury: 06\25\2015
Date of Evaluation: November 10th, 2017

Kimberly Kline presented to my Reno Office for a formal PPD evaluation on Friday, November 10th, 2017 at 8:30 AM. The insurance company approved the evaluation of her cervical spine.

Treatment History

5\11\2015: Brett Men-Muir, MD: She is here for BL lower back pain. This is not work related. She has been complaining of LBP for several months. It was exacerbated last month. It is 8\10 in severity. She takes diclofenac, Zoloft, and ibuprofen. A history of depression. X-rays show L4-S disc DJD. DX: discogenic back pain. Plan: PT and voltaren.

6\25\2015: Richard Law, MD: Moderate pain in the upper lumbar spine, mid lumbar, and lower lumbar spine; radiates to the right thigh and left thigh. She had similar symptoms recently; had an MRI 1 month ago; hx of herniated disc at L3-4 and L4-5. She has had previous chronic LBP; intervertebral disc disease. Her meds include Zoloft. Exam show tenderness in the lumbar spine. Impression: acute lumbar radiculopathy, lumbar sprain, and acute lumbar pain. Plan: ice, limited activity, flexeril, norco, prednisone, follow up.
06\25\2015: This is a C-4 form that states "I was rear-ended". The claimant was seen at St. Mary's regional Medical Center ER. Her initial DX was acute lumbar sprain; MVA".
6\30\2015: Scott Hall, MD: She presents for her back after a (2nd) MVA on 6\25\15. She now reports: neck pain, lumbar and thoracic pain. Assessment: neck and back sprain. Plan: chiropractic care, full duty work, return in 2 weeks.
7\14\2015: Scott Hall, MD: She continues with neck and back issues. Plan: PT, full duty, conservative treatment.
8\20\2015: Scott Hall, MD: Her neck has improved and she describes only muscular tightness that is mild. She has no arm symptoms; PT has been helpful. Plan: complete her PT and monitor.
8\26\2015: Custom PT: She had a PT re-eval today; 12 more visits are recommended over the next 4 weeks.
9\23\2015: Scott Hall, MD: She reports improving NP; a 3\10. She is getting PT.
10\28]\2015: Scott Hall, MD: Her neck has improved; no current significant symptoms. No arm symptoms.

PAGE 2: Kim Kline continued

1\3\2016: *MRI of the C-Spine:* Impression: Disc degeneration with large protrusions at C5-6 and at C6-7; this results in complete effacement of the CSF from the dorsal and the ventral aspects of the cord with severe canal stenosis without cord compression or abnormal signal intensity to suggest cord edema or myelomalacia.

1\13\2016: Bryan Hansen, MS DC (Leading Edge Chiropractic): She presents with NP with associated weakness and numbness. Her symptoms started 7 days ago, but there is "high likelihood that her symptoms are related to the MVA she recently sustained". She was released from care for that several weeks ago. Her DX is disc displacement. Plan: cold pack to the neck; spinal decompression; E-stim; laser therapy.

1\14\2016: She reports symptoms of numbness and weakness. She was treated again with cold, decompression table, E-stim, and laser.

1\15\2015: She states NP, numbness, and weakness; same treatment.

01\18\2016: The notes are about the same today.

01\19\2016: Decompression treatment and therapies.

1\20\2016: She continues with chiropractic treatment.

1\21\2016: Nothing new.

1\25\2016: Same notes and treatment.

01\27\1016: A re-exam was done today. Continue treatment plan. There were further chiropractic, traction, and therapy modalities on: 1\28\16, 2\1\16, 2\2\16, 2\5\16, 2\8\16, 2\10\16, 2\12\16, 2\16\16, 2\19\16, 2\24\16, 3\16\2016: She has completed the 20 visits of prescribed treatment; non-surgical spinal decompression to address the C6-7 and C5-6 radiculitis to the left. She has improved greatly and has only mild pain in the left UE. She is to do HEP.

3\16\3016: Scott Hall, MD: There was no evidence of neurologic involvement after the MVA. She responded to conservative care with resolution of her symptoms. The new onset of quite severe symptoms started spontaneously and it is uncertain if there is any relation to the industrial injury. She had sought treatment from an orthopedist prior to the WC injury. All indication are that the claimant had completely recovered from the industrial injury by the end of October, 2015.

4\28\2016: Bryan Hansen, DC: She presents with NP, weakness, and numbness. She is to do HEP.

7\5\2016: Lali Sekhon, MD: Her CC is NP, stiffness, and left arm numbness and pain. She previously had neck and back issues that were manageable in the past until she was in the car accident in June, 2015. There were actually 2 accidents. She had physical therapy and chiropractic treatments. She had an epidural that really did not help. She rates her NP, HA and pressure feeling in the neck as 5\10 in severity. The left arm symptoms are in a C6 distribution. Her right arm is OK. She feels that she has plateaued. Assessment: cervicalgia, cervical spine stenosis, C4-5 spondylolisthesis, failed conservative therapy, minimal spondylosis at L3-4 to L5-S1. She has cord compression and weakness; Dr. Sekhon thinks that it is reasonable to offer her surgery; the accident probably exacerbated her underlying stenosis. She was offered C4-5 to C6-7 decompression and fusion.

Page 3: Kim Kline continued

4\3\2017: Kurt Erickson, PA-C: Dr. Sekhon and I were able to review Kim Kline again today. She has continued with posterior neck pain and pressure. The pain continues to extend down the left arm following a C6 distribution. The left arm symptoms are rated as 9\10. She has trouble sleeping. The intensity is about the same as last July. She has cervical spondylosis with cord pressure at C5-6 and C6-7. She has failed conservative treatment. It is reasonable to offer her surgery. The plan is to repeat C-spine MRI and X-rays.

4\21\2017: *C-Spine MRI:* Impression: Moderate disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis.

C-Spine X-rays: Impression: mild disc narrowing and facet degenerative changes of the lower C-spine; development of retrolisthesis of 2mm, C4 on C5 and 1mm retro of C6 on C7 on extension of the C-spine.

4\25\2017: Lali Sekhon, MD: Her arm is worse. Her options were discussed, she wants surgery.

6\8\2017: Lali Sekhon, MD: She returns for review and all of her questions were answered. She again requests surgery.

6\12\2017: Lali Sekhon, MD: Operative Report: Procedures: C4-5, C5-6, and C6-7 anterior cervical decompression, interbody fusion using interbody cages and bone graft substitute; C4-C7 anterior fixation using a cervical locking plate. The X-ray shows "anterior cervical fusion and placement of disc devices"

6\26\2017: Curt Erickson, PA-C: She still has achiness in her neck; the left arm symptoms have improved. Follow in 4 weeks.

7\26\2017: Curt Erickson, PA-C (For Dr. Sekhon): The X-rays show no instability. She has ongoing numbness in the left hand and forearm; not as bad as before.

8\10\2017: Amanda Cowles, PT (Custom PT): She is having some trouble with ADLs. She can flex to 25 degrees, extend to 20, left bending to 20, right bending to 25, rotation to 60. She had about 7 PT follow ups. On the 9\14\17 visit, Kim could flex to 40, extend to 30, left rotation 55, right rotation 70, left bending 15, right bending to 20.

9\5\2017: Curt Erickson, PA-C: Her symptoms are much improved; there is slight numbness in her left hand; very manageable. She has occasional neck pain. She believes the PT is helping. Cervical spine X-rays today show fusion from C4 to C7 with no evidence of hardware complications.

9\11\2017: Dr. Sekhon fills out a questionnaire from Specialty Health. He says the claimant is stable and reached maximum medical improvement. She is released to full duty. Her restrictions are "common sense". She is ratable.

The above represents all of the medical records that were presented for my review.

PAST MEDICAL HISTORY

Prior to this work related injury\accident, Kimberly has previously received some chiropractic care. She tells me that this was mostly for lower back pain. She would get her neck (C-spine)

adjusted sometimes, but denies any significant prior neck pain, disability, or radiation upper

extremity symptoms. She was treating in the months before this accident (2015) for LBP that was not work related. Ms. Kline previously used Zoloft for depression. She denies any current prescription medications. She currently takes OTC Advil.

Ms. Kline previously suffered a work-related right wrist injury and right shoulder injury. She did not receive impairment ratings for this. Her surgical history includes an ankle surgery to re-attach tendons.

CURRENT SYMPTOMS

Currently, Ms. Kline has a chief complaint of frequent, daily headaches and limited mobility in her neck. She complains particularly of limitations with looking up to either side. She is also complaining of numbness in the left wrist and hand effecting the ring and little fingers in a C6 and\or ulnar nerve pattern.

Kim is having some difficulty with looking up to rinse in the shower. When driving, it is difficult for her to look into the back seat or behind her. Her neck seems to get tired quickly when driving and when working on the computer. Her neck gets tired when reading.

Physical Examination

Cervical Spine

Inspection reveals no cervical antalgia. She is in no distress. I observe a surgical scar on the anterior\left cervical region. It measures 7.2 CM.

Palpating the cervical spine soft tissue structures, I find the right splenius to by hypertonic. The right SCM muscle is tight and tender.

Passive motion of the cervical spine is noticeably limited on right rotation. There is a tight end-feel.

Measuring the muscle girth of the forearms, I find the right forearm to be 26.6 CM at the area of greatest circumference. The left forearm measures 25.2 CM.

The claimant performed a brief warm-up of cervical spine motions, after which we measured active ranges of motion using dual inclinometers. The claimant did appear to give her best effort on all ROM measurements.

Cervical Spine Active Ranges of Motion

Flexion: Calvarium: 1. 48 2. 48 3. 46

PAGE 5 (KIMBERLY KLINE)

T1: 1. 8 2. 4 3. 8
Max ROM = 48-4= 44 degrees (1% WPI)
Extension: Calvarium: 1. 38 2. 38 3. 38
T1: 1. 8 2. 10 3. 8
Max ROM = 38-8= 30 degrees (3% WPI)
Right Bending: Head: 1. 38 2. 40 3. 44 4. 40
T1: 1. 4 2. 6 3. 6
Max ROM = 44-6= 38 degrees (no impairment)
Left Bending: Calvarium: 1. 38 2. 36 3. 36
T1: 1. 4 2 3. 4
Max ROM = 38-4= 34 degrees (1% WPI)
Right Rotation: 1. 64 2 64 3 62
Max ROM = 64 degrees (1% WPI)
Left Rotation: 1. 56 2. 58 3. 58
Max ROM = 56 degrees (1% PWI)

Whole person impairments from motion loss at various cervical spine motions are added: 1+3+1+1+1= 7% WPI from motion loss in the cervical spine.

I can elicit equal, +2 deep tendon reflexes at Right and Left biceps, brachioradialis, and triceps.

The claimant can demonstrate 5\5 strength, equal bilaterally at shoulder, elbow, wrist, and fingers.

She has some decreased sensibility to light touch over the C6 dermatome on the left. This includes partial loss of 2 point discrimination over the palmar left right and little fingers (2 point sense at 9mm). This is grade 3 sensory loss, 25% sensory deficit of the C6 nerve root (Table 15-15); we multiply this to the maximum upper extremity impairment for sensory loss at C6 (8%, Table 15-17) and we get *2% left upper extremity impairment, 1% WPI.*

Impairment Calculation

If we are to use the diagnosis related estimate in this case (due to multi-level involvement and multilevel fusion), then; using Table 15-7, part IV, Ms. Kline has 10% WPI from spinal fusion with residual signs and symptoms. We add 1% for each additional level (2 additional) to get *12% whole person impairment from Specific Spine Disorder*

As described above, this claimant has a cumulative total of *7% whole person impairment from motion loss* in the cervical spine.

She has *1% WPI for sensory loss* coming from the C6 nerve root.

Combining 12% with 7%, we get 18%; this is then combined with 1% to get a total of *19% whole person impairment from the cervical spine.*

PAGE 6 (KIMBERLY KLINE)

Using the DRE method, this claimant would be easily placed in Cervical Spine DRE category IV due to loss of motion segment integrity. This is ***25% impairment of the whole person*** and this method should be used since it results in a higher rating (AMA Guides, 5th Edition, page 380).

MMI AND MEDICAL STABILITY

The claimant has reached a stable plateau of medical improvement. Her condition has not changed over the last 45 days. Her condition is not likely to change significantly over the next 12 months with or without treatment
She has reached maximum medical improvement.

APPORTIONMENT

The claimant had underlying cervical spine issues that pre-date this work related car accident and injury. Namely, the MRI and radiographic reports show cervical spine degenerative discs with large protrusions at C5-6, C6-7; effacement of the CSF, and severe canal stenosis (MRI of 1\3\2016). It is not logical to believe that these findings are related to the car accident that she was involved in 6 months earlier.

This claimant's 25% whole person impairment is based upon the surgery that was performed. The surgery was performed due to cervical spine spondylosis, stenosis, and cord pressure at C4-5 to C6-7.

75% of this claimant's whole person impairment (cervical spine) is apportioned as non-industrial
25% of her impairment is industrial and related to the work injury that occurred on 6\25\2015 because:

- The claimant had no documented cervical spine injury or pain immediately after the accident (symptoms began 6\30\2015). After that, the cervical strain could be described as slight.
- The findings of cervical spine spondylosis, stenosis, and disc bulges cannot be logically attributable to this car accident\work injury. These findings provided the indication for fusion surgery in the cervical spine.
- The claimant had responded well to physical therapy and medical treatment and had nearly completely resolved her cervical spine complaints prior to December, 2015. She had no upper extremity symptoms at the time of release from care.

On the other hand, the claimant denies any prior upper extremity symptoms (radiculopathy) before this injury. This work injury likely played some role in the onset of symptoms that led to surgery, but was not the primary cause.

PAGE 7 (CUMBERLY KLINE)

So, apportioning 75% of this claimant's impairment as non-industrial, we take 25% of this claimant's whole person impairment (which was 25% WPI), and we get ***6% WPI related to this work injury (that occurred on 6\25\2015).***

PERMANENT IMPAIRMENT SUMMARY

The claimant has 25% whole person impairment coming from the cervical spine. Of this , ***6% WPI is related to the work related injury that occurred on 6\25\2015.***

This is reasonable, should be awarded, and case closure should occur.

Respectfully,

Russell N. Anderson, DC

11

15853E839641

James C. Jempsa, DO
775-786-9072
Fax 775-787-6430

FACSIMILE TRANSMITTAL

To: Lisa Jones

From: James C Jempsa DO

Fax: 324-9893

Date: 5/18/2018

Total Pages (including cover): 2

Regarding: Klein Addendum

JAMES C. JEMPSA, DO

Reno, Nevada
Telephone: 775-786-9072
Fax: 775-787-6430

Lisa Jones
CCMSI
PO Box 20068
Reno, NV 89515
Telephone: 775-324-3301
Fax: 775-324-9893

PERMANENT PARTIAL DISABILITY EVALUATION ADDENDUM

RE:		
	CLAIMANT:	Kimberly Kline
	SSN:	
	CLAIM NO.:	15853E839641
	DOI:	06/25/2015
	EMPLOYER:	City of Reno
	DATE OF EXAM:	05/08/2018
	DATE OF REPORT:	05/18/2018
	BODY PARTS:	1. Cervical.

In regards to your letter dated May 15, 2018. You will need to contact Dr. Anderson concerning his rationale for apportionment of Ms. Kline. I will provide you my opinion as far as apportionment is concerned with Ms. Kline. The claimant stated that she had no problems with her neck prior to her industrial injury of June 25, 2015. I have not received any medical records prior to the industrial injury of June 25, 2015. In accordance with NAC 616C.490 it is my opinion that apportionment is not necessary in this case. Therefore, 0% whole person impairment for apportionment. I recommend that the case should be closed with 27% whole person impairment for her cervical spine.

If there are any further questions regarding the impairment rating provided, please do not hesitate to contact me.

Sincerely,

James C. Jempsa, DO
Board Certified American Board of Osteopathic Family Physicians; Member, American College of Osteopathic Family Physicians, DIR Designated Rating Physician, State of Nevada.

C C M S I

May 24, 2018

KIMBERLY KLINE
305 Puma Dr
Washoe Valley, NV 89704-9739

Re: Claim No.: 15853E839641
D.O.I.: 6/25/2015
Employer: City of Reno
Body Parts: cervical

Dear Ms. Kline;

We are in receipt of Dr. Jempsa's PPD rating dated 5/14/2018. We have asked Dr. Betz to review Dr. Anderson's and Dr. Jempsa's PPD report and provide an opinion regarding apportionment.

Please be advised that we are holding the Permanent Partial Disability award in abeyance pursuant to NAC 616C.103. Upon receipt of Dr. Betz response, a new determination will be rendered regarding the permanent partial disability award.

If you disagree with this determination, you may request a hearing before a Hearing officer by completing the enclosed "Request For Hearing:" form within seventy (70) days after the date on which this notice was mailed and sending it to the State of Nevada, Department of Hearings, Carson City.

Sincerely,
CCMSI

Lisa Jones
Claims Representative

cc: City of Reno, Herb Santos, Esq. Lisa Wiltshire Alstead, Esq.

Enc: D-12a (Appeal Rights) PPD report, addendum report

REQUEST FOR HEARING - CONTESTED CLAIM

(Pursuant to NAC 616C.274)

REPLY TO:

Department of Administration
Hearings Division
1050 E. William Street, Ste. 400
Carson City, NV 89701
(775) 687-8440

OR

Department of Administration
Hearings Division
2200 S. Rancho Drive, Suite 210
Las Vegas, NV 89102
(702) 486-2525

Employee Information	
Employee's Name and Address KIMBERLY KLINE 305 Puma Dr WASHOE VALLEY, NV 89704	
Employee's Telephone Number 775-326-6637	Claim No. 15853E839641 Date of Injury 06/25/2015
Insurer Information	
Insurer's Name and Address	
Insurer's Telephone Number	

Employer Information
Employer's Name and Address CITY OF RENO 1 EAST FIRST STREET RENO, NV 89505
Employer's Telephone Number 775-326-6637
Third-Party Administrator Information
Third-Party Administrator's Name and Address
Third-Party Administrator's Telephone Number

Do Not Complete or Mail This Form Unless You Disagree With the Insurer's Determination.

YOU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARING WILL NOT BE SCHEDULED PURSUANT TO NRS 616C.315.

Briefly explain the basis for this appeal:

_____

_____

_____

This request for hearing is filed by, or on behalf of: **The Injured Employee** / **The Employer**

and is dated this _____ day of _____, 20_____.

_____
Signature of Injured Employee/Employer

_____
Injured Employee's/Employer's Rep. (Advisor)

D-12a (Rev. 12/07)

JAMES C. JEMPSA, DO

Reno, Nevada
Telephone: 775-786-9072
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Lisa Jones
CCMSI
PO Box 20068
Reno, NV 89515
Telephone: 775-324-3301
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PERMANENT PARTIAL DISABILITY EVALUATION ADDENDUM

RE:	CLAIMANT:	Kimberly Kline
	SSN:	
	CLAIM NO.:	15853E839641
	DOI:	06/25/2015
	EMPLOYER:	City of Reno
	DATE OF EXAM:	05/08/2018
	DATE OF REPORT:	05/18/2018
	BODY PARTS:	1. Cervical.

In regards to your letter dated May 15, 2018. You will need to contact Dr. Anderson concerning his rationale for apportionment of Ms. Kline. I will provide you my opinion as far as apportionment is concerned with Ms. Kline. The claimant stated that she had no problems with her neck prior to her industrial injury of June 25, 2015. I have not received any medical records prior to the industrial injury of June 25, 2015. In accordance with NAC 616C.490 it is my opinion that apportionment is not necessary in this case. Therefore, 0% whole person impairment for apportionment. I recommend that the case should be closed with 27% whole person impairment for her cervical spine.

If there are any further questions regarding the impairment rating provided, please do not hesitate to contact me.

Sincerely,

James C. Jempsa, DO
Board Certified American Board of Osteopathic Family Physicians; Member, American College of Osteopathic Family Physicians, DIR Designated Rating Physician, State of Nevada.

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PERMANENT PARTIAL DISABILITY EVALUATION

RE:	CLAIMANT:	Kimberly Kline
	SSN:	
	CLAIM NO.:	15853E839641
	DOI:	06/25/2015
	EMPLOYER:	City of Reno
	DATE OF EXAM:	05/08/2018
	DATE OF REPORT:	05/14/2018
	BODY PARTS:	1. Cervical.

DIAGNOSIS:

1. Multilevel cervical fusion.

PLACE OF EXAMINATION: Reno, Nevada.

INTRODUCTION: The claimant presents to our office today for a Permanent Partial Disability rating performed in accordance with the Fifth Edition, Sixth Printing, AMA Guides to the evaluation of Permanent Impairment. The claimant was informed with regards to the purpose of this examination. It is understood that there is no patient/treating physician relationship established on the basis of today's examination. It was explained that the evaluation was requested by the referral source and the report will be sent to the referral source upon completion.

Dear Lisa Jones:

Kimberly Kline sustained industrial injury to her neck on June 25, 2015. She subsequently went on to have a multilevel fusion of her cervical spine. She presents today for a PPD evaluation of the cervical spine.

PERSONAL DATA:

The claimant was identified by her picture on a Nevada Driver's License #0701144556. She gives a birth date of 10/07/1979 making the claimant 38 years of age at the time of this evaluation.

The claimant has lived in Reno for approximately the last 38 years.

She has completed school greater than 16 years.

The claimant has not served in the military.

REVIEW OF MEDICAL RECORDS:

All significant medical records provided were reviewed.

On June 25, 2015 initial evaluation at St. Mary's Regional Medical Center. History of Present Illness: Chief Complaint: Back injury and back pain. It is described as being moderate degree of pain in the upper lumbar mid lumbar and lower lumbar spine radiating into the right thigh and the left thigh. No bladder dysfunction, bowel dysfunction, sensory loss or motor loss. Past History: The patient had prior back pain. Physical Exam: Neck: Normal inspection. Neck nontender. Painless range of motion. Back: Mild vertebral point tenderness over the upper, mid and lower lumbar spine. Neuro: No motor deficit. No sensory deficit. Reflexes normal. Impression: Acute lumbar radiculopathy. Sprain of lumbar spine. Acute pain in the lower back. Prescription Medications: Flexeril, Norco and prednisone.

On June 30, 2015 evaluation at Specialty Health Clinic. Chief Complaint: Back-2nd MVA 6-25-15. History of Present Illness: Patient was involved in a second motor vehicle accident on June 25, 2015 when she was rear-ended at high-speed. Currently the patient reports: 1. Neck discomfort-moderate, diffuse, radiation into the right shoulder, associated stiffness. 2. Lumbar and thoracic pain-diffuse, nonradiating, no red flags, no numbness or weakness reported and legs. Physical Exam: Cervical exam-mild diffuse muscular tenderness to palpation, normal inspection, normal strength and sensation in both arms, normal reflexes throughout both arms, range of motion, flexion 40°, extension 50°, lateral rotation 70° bilaterally with pain at extremes. Assessment: Sprain of neck. Plan: Chiropractic, full duty, return in two weeks.

On May 11, 2015 initial evaluation by Dr. Men-Muir. He evaluated her low back.

On July 14, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports ongoing lumbar and neck pain, moderate to severe, associated sleep disruption and stiffness, minimal improvement with chiropractic care, no numbness or weakness. Physical Exam: Musculoskeletal: Neck-normal inspection, mild diffuse muscular tenderness to palpation, grossly normal strength and sensation. Assessment: Sprain of neck. Plan: Physical therapy, Full duty, return in two weeks.

On August 20, 2015 follow-up visit at Specialty Health Clinic. Chief Complaint: Cervical strain. History of Present Illness: Patient notes improvement in her neck symptoms and describes only mild muscular tightness currently. She reports no arm symptoms. Physical therapy has been helpful and continues. Physical Exam: Musculoskeletal: Exam-normal inspection, mild muscular tenderness palpation over the trapezius, full motion with grossly normal strength and sensation in arms. Assessment: Sprain of neck. Plan: Full duty, MMI.

On September 23, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports improving neck discomfort, rated 3/10, Central without radiation, improving with conservative care including physical therapy and occasional muscle relaxants, no associated symptoms. Physical Exam: Musculoskeletal: Neck exam-normal inspection, minimal muscle tenderness to palpation, full motion, normal strength and sensation in both arms. Assessment: Sprain of neck. Plan: Physical therapy, Full duty, return in two weeks.

On October 28, 2015 follow-up visit at Specialty Health Clinic. History of Present Illness: Patient reports improvement in her neck without significant symptoms currently, no arm symptoms reported. Patient has completed treatment. Physical Exam: Musculoskeletal: Neck exam-normal inspection, nontender to palpation, full motion with grossly normal strength. Assessment: Sprain of ligament of the cervical spine Plan: Full duty, MMI.

On January 13, 2016 MRI of the cervical spine without contrast impression: Disc degeneration with large disc protrusion at the C5-C6 and C6-C7 levels resulting in complete effacement of CSF from the ventral and dorsal aspect of the cord with severe canal stenosis without cord compression or abnormal signal intensity in the cord to suggest cord edema or myelomalacia.

On January 13, 2016 chiropractic treatment by Dr. Hansen.

On January 14, 2016 chiropractic treatment by Dr. Hansen.

On January 15, 2016 chiropractic treatment by Dr. Hansen.

On January 18, 2016 chiropractic treatment by Dr. Hansen.

On January 19, 2016 chiropractic treatment by Dr. Hansen.

On January 20, 2016 chiropractic treatment by Dr. Hansen.

On January 21, 2016 chiropractic treatment by Dr. Hansen.

On January 25, 2016 chiropractic treatment by Dr. Hansen.

On January 26, 2016 chiropractic treatment by Dr. Hansen.

On January 27, 2016 chiropractic treatment by Dr. Hansen.

On January 28, 2016 chiropractic treatment by Dr. Hansen.

On February 1, 2016 chiropractic treatment by Dr. Hansen.

On February 2, 2016 chiropractic treatment by Dr. Hansen

On February 5, 2016 chiropractic treatment by Dr. Hansen

On February 8, 2016 chiropractic treatment by Dr. Hansen

On February 10, 2016 chiropractic treatment by Dr. Hansen

On February 12, 2016 chiropractic treatment by Dr. Hansen

On February 16, 2016 chiropractic treatment by Dr. Hansen

On February 19, 2016 chiropractic treatment by Dr. Hansen

On February 24, 2016 chiropractic treatment by Dr. Hansen

On March 16, 2016 follow-up visit at Specialty Health Clinic.

On April 28, 2016 chiropractic treatment by Dr. Hansen

On July 5, 2016 neurosurgical evaluation. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: When I saw her today, she has neck pain and stiffness. She has a pressure feeling in the neck. She rates this as a 5/10. She has aching in the left arm again it is 5/10. She maps out numbness and aching in the forearm down to the thumb in the C6 distribution. Her right arm is okay. She feels she has plateaued. She is done extensive physical therapy. Physical Examination: Cervical: Neck, shoulders and low back have normal range of motion with no scars. Palpation for tenderness. Arms have normal range of motion with no scars. She has a reduce range of motion of the cervical spine. She has numbness of the left forearm in the C6 distribution. On physical examination, she has 4/5 weakness in external rotators in the left, biceps and triceps on the left. She has diminished reflexes in the upper extremities. Impression/Plan: 1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord

compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. 4. Minimal spondylosis, L3-4, L4-5 and L5-S1. Kimberly has a cord compression and weakness. I think it is reasonable to offer her surgery. She states she never had these arm symptoms before the accident and although she may have had pre-existing spondylosis, the accident had probably exacerbated her underlined stenosis. I offered her C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On April 3, 2017 follow-up neurosurgical visit. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: She has continued with posterior neck pain and pressure. The pain continues to extend down the left arm following the left C-6 distribution. Most of his symptoms are in the left arm and rated at times at a 9/10. Continues to limit her ability to sleep at night the symptoms may be slightly improved but overall are very similar to the intensity she had the last allied. Physical Exam: She had a reduce range of motion of the cervical spine. She has numbness of the left form in the C6 distribution. On physical examination, she has 4/5 weakness in external rotators on the left, biceps and triceps on the left. She has depressed reflexes in the upper extremity. Assessment and Plan: 1. Neck pain. 2. Cervical spondylosis. 3. Spinal stenosis and cervical region. Plan: 1. Repeat MRI and C-spine x-rays. 2. Follow-up in 2-4 weeks.

On April 21, 2017 x-rays of the cervical spine. Impression: 1. Mild disc space narrowing and facet degenerative change of the lower cervical spine. 2. Development of retrolisthesis of 2 mm of retrolisthesis C4 on 5 and 1 mm retrolisthesis of C6 on 7 upon extension.

On April 21, 2017 MRI of the cervical spine without contrast. Impression: Moderate posterior disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis.

On April 25, 2017 follow-up neurosurgical visit. Chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: Returns. Arm worse. Options discussed. Wants surgery. Physical Exam: She has a reduce range of motion of the cervical spine. She has numbness of the left forearm and the C6 distribution. Physical examination, she has 4/5 weakness in external rotators on the left, biceps and triceps on the left. She has depressed reflexes in the left upper extremity. Impression: 1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. 4. Minimal spondylosis, L3-4, L4-5 and L5-worsening symptoms and stenosis on MR. 6. Cord compression and failed conservative therapy. I offered her C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On June 8, 2017 follow-up neurosurgical visit chief Complaint: 1. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illness: She has stopped all blood thinning medications. She does again request surgery. She would like to remain off work first six weeks as was discussed. Physical Exam: She has a reduce range of motion of the cervical spine. She has numbness of the left form in the C6 distribution. On physical examination, she has 4/5 weakness

in external rotators on the left, brought biceps and triceps on the left. She has depressed reflexes in the upper extremity. Impression: 1. Cervical spine bond low doses, C4-5, C5-6 and C6-7 with cord compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. She was offered C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

On June 12, 2017 operative report by Dr. Sekhon. Preoperative Diagnosis: Cervical stenosis. Postoperative Diagnosis: Cervical stenosis. Title of the Procedure: 1. C4/5, C5/6, and C6/7 Anterior cervical decompression using a left-sided approach and the microscope. 2. C4/5, C5/6 and C6/7 interbody fusion using peak interbody cages and bone graft substitute. 3. C4-7 anterior segment fusion using a cervical locking plate. 4. Microscopic microdissection. 5. Fluoroscopic guidance for placement of the screws.

On June 26, 2017 postop neurosurgical visit. Chief Complaint: 1. Two weeks status post C4-C 7 ACDF. 2. Left upper extremity radiculopathy. History of Present Illness: She has noticed some improvement to the left upper extremity symptoms. The numbness in her arm and hand specifically have improved. She still has some achiness posteriorly of her neck. She has some mild dysphasia that slowly seems to be improving. She has been wearing her soft collar when she is up and about, but she states that she is actually feeling quite well for two weeks after surgery. The strength in her arms is good. Overall, she takes about one pain tablet towards the end of the day, but otherwise the pain is very manageable. Physical Exam: On physical exam, the wound is clean, dry and intact. There is no evidence of infection. There is minor superficial edema and swelling that is non-concerning. Upper extremity motor strength is 5/5 throughout bilaterally. Sensation is grossly intact. The equivalent and normal bilaterally. Impression: 1. Two weeks status post C4-C7 ACDF. 2. Improvement to preoperative symptomatology in the left upper extremity. 3. Stable postoperative course. Plan: 1. Follow-up in four weeks with static and dynamic cervical x-rays. 2. Call with any questions or concerns or changes in her condition.

On July 24, 2017 x-rays of the cervical spine with flexion and extension. Impression: Anterior interbody fusion C4 through C7 with no instability with flexion/extension views.

On July 26, 2017 follow-up postoperative neurosurgical visit. Chief Complaint: 1. Two week status post C4-C7 ACDF. 2. Left upper extremity radiculopathy. History of Present Illness: Today, she presents to six weeks postoperative review. She continues to notice improvement to the left upper extremity symptoms. Left arm is overall much improved, but she has noticed some ongoing numbness in the left hand and forearm. Her posterior neck pain has mostly settled and her swallowing is not problematic. She occasionally takes about one pain tablet towards the end of the day, but otherwise the pain is very manageable. Physical Exam: On physical exam, the wound is clean, dry, and intact. There is no evidence of infection. Upper extremity motor strengths are 5/5 throughout bilaterally. Sensation is grossly intact. DTRs are equivalent and normal bilaterally. Impression: 1. 6 weeks status post C4-C7 ACDF. 2. Improvement in postoperative symptomatology in the left upper extremity. 3. Stable postoperative course. Plan:

1. Follow-up in 6 weeks with static and dynamic cervical x-rays. Physical therapy. Release to work without restrictions on 7/31/17.

On September 5, 2017 x-rays of the cervical spine with flexion-extension views. Impression: ACDF C 4-C7 without evidence of hardware complication.

On September 6, 2017 follow-up postop neurosurgical visit. Chief Complaint: 1. 12 weeks status post C4-C7 ACDF. History of Present Illness: Today, she presents 12-weeks postoperative. Her symptoms continue to much improved. There is slight numbness in her left hand but it is very manageable. She also has some occasional posterior neck pain. She is not having the shooting pains that she once did. She has done physical therapy which she believes is helping. She also believes that the pressure in her neck has settled as well. She is very pleased with her recovery at this stage. Physical exam: On physical exam, the wound is clean, dry and intact. There is no evidence of infection. Upper extremity motor strengths are 5/5 throughout bilaterally. Sensation is grossly intact. DTRs are equivalent and normal bilaterally. Impression: 1. 12 weeks status post C4-C7 ACDF. 2. Improvement to preoperative symptomatology in the left upper extremity. 3. Stable postoperative course.

On September 11, 2017. She was placed at maximum medical improvement. She was returned to full duty. She had a ratable impairment.

PRESENT SYMPTOMS AND COMPLAINTS:

The claimant states that she has a tight/sore neck, tight/sore shoulders, daily headaches, weak neck, and numbness down her left arm to her left thumb. She states that her current neck pain is a 4/10 and at its worse 8/10 and at its best 2/10.

As far as activities of daily living are concerned:

As far as self-care/personal hygiene is concerned: She states no difficulty with brushing teeth, eating, urinating and bowel movements. She states mild difficulty with dressing and combing hair. She states moderate difficulty with bathing.

As far as communication is concerned: She states no difficulty with speaking, hearing and writing.

As far as physical activity is concerned: She states no difficulty walking and climbing stairs. She states mild difficulty with standing, sitting, changing positions.

As far sensory function is concerned: She states no diff code was seeing, smelling, tasting, feeling sharp versus dull and feeling hot versus cold except for her left thumb.

As far as hand activities are concerned: She states no difficulty with coordination. She states mild difficulty with grasping and lifting.

As far as advanced activities are concerned: She states no difficulty with preparing meals, managing money/checkbook, taking medications, and using public transportation. She states mild difficulty with working around the house/housework, using the phone or writing letters, shopping/carrying groceries, social activities, sexual activities and vigorous physical activity. She states moderate difficulty with driving a car. She states severe difficulty with restful sleep secondary to pain.

PAST MEDICAL HISTORY:

Past Medical History: She has no history of chronic illnesses. She states that she had no problems with her neck prior to her industrial injury of June 25, 2015.

Past Surgical History: Right ankle surgery 2013.

Medications: Advil.

Allergies to Medications: No known drug allergies.

PHYSICAL EXAMINATION:

On May 8, 2018 the claimant stood 67" tall and weighed 178 pounds. The claimant is right hand dominant.

This person's general appearance is that of a well-hydrated, well-nourished adult female in no acute distress. Her mood and manner were appropriate. She was well oriented and cooperative throughout the examination. She was not wearing an orthotic device.

On visual inspection of the cervical spine there was normal development. There was a 7 cm surgical scar located over the left anterior inferior aspect of the neck. The scar was generally straight in appearance and normal in color. On palpation of the neck there was muscle tightness along the paravertebral musculature. On strength testing, motor strength was 5/5 in all muscle groups of the right and left upper extremities. On sensory testing there was intact sensation to light and sharp touch except for the left thumb which was 4.56 on monofilament testing. Deep tendon reflexes at the biceps and triceps were +2/+4 bilaterally. The right and left upper extremities have normal temperature color and pulses. There was no evidence of atrophy, upper arm and forearm circumferences were equal bilaterally.

Range of motion of the cervical spine:

The claimant was informed not to perform any motions that were painful or that she was uncomfortable performing or that might cause her harm. The claimant was also informed that she can take a rest break during any part of the examination.

Warm-up exercise were performed as described on page 399.

Range of motion of the cervical spine was performed according to Section 15.11 Range of Motion: Cervical Spine. Starting on page 417.

Movement	Description	Range					
Cervical Flexion	Calvarium angle	40	40	40			
	T1 ROM	20	20	20			
	Maximum cervical flexion angle	20	20	20			
	±10% or 5°	*Yes	No				
	Maximum cervical flexion angle	20					
	% Impairment	3					

Movement	Description	Range					
Cervical Extension	Calvarium angle	20	20	20			
	T1 ROM	5	5	5			
	Cervical extension angle	15	15	15			
	±10% or 5°	*Yes	No				
	Maximum cervical extension angle	15					
	% Impairment	5					

Movement	Description	Range					
Cervical Left Lateral Bending	Calvarium angle	30	30	30			
	T1 ROM	10	10	10			
	Cervical left lateral flexion angle	20	20	20			
	±10% or 5°	*Yes	No				
	Maximum cervical left lateral flexion angle	20					
	% Impairment	2					

Movement	Description	Range					
Cervical Right Lateral Bending	Calvarium angle	30	30	30			
	T1 ROM	10	10	10			
	Cervical right lateral flexion angle	20	20	20			
	±10% or 5°	*Yes	No				
	Maximum cervical right lateral flexion angle	20					
	% Impairment	2					

Movement	Description	Range					
Cervical Left Rotation	Cervical left rotation angle	40	40	40			
	±10% or 5°	*Yes	No				
	Maximum cervical left rotation angle	40					
	% Impairment	2					

Movement	Description	Range					
Cervical Right Rotation	Cervical right rotation angle	40	40	40			
	±10% or 5°	*Yes	No				
	Maximum cervical right rotation angle	40					
	% Impairment	2					

SUMMARY AND DISCUSSION:

STABILITY OF MEDICAL CONDITION: The claimant was placed at maximum medical improvement on September 11, 2017 permanent and stationary, stable and ratable by Dr. Sekhon.

APPORTIONMENT: There is no prior history of disease, injury, or impairment to the affected body part necessitating apportionment consideration.

IMPAIRMENT EVALUATION ACCORDING TO THE GUIDES:

Impairment rating was done according to the Fifth Edition, Sixth Printing AMA Guides to the Evaluation of Permanent Impairment. The examination, measurements, and impairment percentages were compiled by me. The history and medical records provided were reviewed by me and any discrepancies were discussed with the claimant.

Body Part: The claimant is rated according to the cervical spine.

On page 380 right hand column. Range of motion method if: b. there is radiculopathy bilaterally or at multiple levels in the same spinal region.

In this case, there was multiple levels in the same spinal region. Therefore, the claimant will be rated by range of motion.

On page 398 Section 13.8 Range-of-Motion Method. Although called the range of motion method, this evaluation method action consists of three elements that need to be assessed: (1) the range of motion of the impaired spinal region; (2) accompanying diagnosis (Table 15-7); and (3)

any spinal nerve deficit, which is described in this chapter and in chapter 13. The whole person impairment rating is obtained by combining ratings from all three components, using the combined values chart (p. 604).

On page 404, Table 15-7, Criteria for Rating Whole Person Impairment Percentage Due to Specific Spine Disorders to Be Used As Part of the Range of Motion Method. The claimant fits into the Category IV D. Single-level spinal fusion with or without decompression with residual signs and symptoms. Also Category IV E. multiple levels, operated on, with residual, medically documented pain and rigidity. Add 1% per level. Therefore, an additional 2% will be added for the additional levels. Therefore, the total equals 12% whole person impairment from Table 15-7.

On page 418, Table 15-12, Cervical Region Impairment from Abnormal Flexion or Extension or Ankylosis. Therefore, flexion of 20° equals 3% whole person impairment. Extension of 15° equals 5% whole person impairment. Total impairment due to abnormal flexion and extension equals 8% whole person impairment.

On page 420 Table 15-13, Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Lateral Bending. Right lateral bending of 20° equals 2% whole person impairment. Left lateral bending of 20° equals 2% whole person impairment. Therefore, total impairment due to lateral bending equals 4% whole person impairment.

On page 421 Table 15-14 Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Rotation. Right rotation of 40° equals 2% whole person impairment. Left rotation of 40° equals 2% whole person impairment. Therefore, total impairment due to abnormal rotation equals 4% whole person impairment.

Therefore 16% whole person impairment for abnormal motion.

On page 423 Section 15.12 Nerve Root and/or Spinal Cord. The claimant has decreased sensation along the C6 nerve root on the left. She best fits into grade 3 30% Sensory Deficit. On page 424, Table 15-17 Maximum % Loss of Function Due to Sensory Deficit or Pain is 8% for the C6 nerve root. Therefore, multiplying 30% times 8% equals 2.4% upper extremity impairment rounded to 2% upper extremity impairment. On page 439 Table 16-3 Conversion of Impairment of the Upper Extremity to Impairment of the Whole person. Therefore, 2% upper extremity impairment equals 1% whole person impairment.

The total whole person impairment for accompanying diagnoses from Table 15-7 equals 12%.

The total whole person impairment for loss of motion equals 16%.

The total whole person impairment for sensory loss equals 1%.

Therefore, combining the whole person impairment for accompanying diagnoses from Table 15-7 12% with impairment for loss of motion 16% with impairment for sensory loss of 1% equals 27% whole person impairment from the combined values chart on page 604.

ESTIMATED WHOLE PERSON IMPAIRMENT: Upon review of the available medical records and after examining the claimant, apportionment does not appear to be an issue with regards to this claim. **It is my recommendation that the claim be closed with 27% whole person impairment.**

If there are any further questions regarding the impairment rating provided, please do not hesitate to contact me.

Sincerely,

James C. Jempsa, DO
Board Certified American Board of Osteopathic Family Physicians; Member, American College of Osteopathic Family Physicians, DIR Designated Rating Physician, State of Nevada.

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that I am an employee of McDONALD CARANO LLP, and that on the 29th of May 2018, I served the within **INSURER'S THIRD SUPPLEMENTAL DOCUMENTARY EVIDENCE** upon the following parties at the addresses and service as identified:

☐ U.S. Mail ☐ Email ☐ FedEx ☒ Hand Delivered/Filing	Appeals Officer Department of Administration 1050 East William St., Suite 450 Carson City, NV 89701
☒ U.S. Mail ☐ Email ☐ FedEx ☐ Hand Delivered ☐ Facsimile	Herb Santos, Jr. 225 S. Arlington Ave., Ste. C Reno, NV 89501

Kelsey R Heller
Employee of McDonald Carano LLP

McDONALD CARANO
100 WEST LIBERTY STREET, TENTH FLOOR • RENO, NEVADA 89501
PHONE 775.788.2000 • FAX 775.788.2020

NEVADA DEPARTMENT OF ADMINISTRATION

BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim

of

KIMBERLY KLINE,

Claimant.

_____/

Claim No: 15853E839641

Hearing No: 1801761-JL

Appeal No: 1802418-RKN

INSURER'S FOURTH SUPPLEMENTAL DOCUMENTARY EVIDENCE

AFFIRMATION
Pursuant to NRS 239B.030

The undersigned does hereby affirm that the preceding **INSURER'S FOURTH SUPPLEMENTAL DOCUMENTARY EVIDENCE**, filed in Nevada Department of Administration Appeal No. 1802418-RKN does not contain the social security number of any person.

Lisa Wiltshire Alstead
Attorneys for Employer
CITY OF RENO
Administered by: CCMSI

6/8/18
Date

Nevada Occupational

Jay E. Betz, MD
Medical Director

Occupational Medicine
Injury Care
Employer Services

June 4, 2018

Lisa Jones
CCMSI
PO Box 20068
Reno, NV 89515

Re: Kimberly Kline
DOI: 6/25/2015
Claim # 15853E839641

PPD/CHART REVIEW

Dear Ms. Jones,

At your request, I reviewed the medical record of Kimberly Kline including 2 PPDs, one performed by Dr. Russell Anderson, DC on 11/10/2017 and the second by Dr. James Jempsa, DO on 5/8/2018.

This review was performed in conjunction with the *AMA Guides to the Evaluation of Permanent Impairment, 5th edition* and NAC 616C.490.

The opinions expressed in this review are stated to a reasonable degree of medical probability based on the medical records provided and may be altered by additional information or examination of the patient.

HISTORY:
Approximately 6 weeks prior to her subsequent occupational injury, Ms. Kimberly Kline was evaluated by Dr. Men-Muir on May 11, 2015 complaining of bilateral low back pain as result of a non-work-related auto accident several months previous. X-ray showed degenerative changes at L4-5. She was diagnosed with discogenic back pain. Voltaren and physical therapy were recommended.

Ms. Kline was then involved in a work related vehicular accident on June 25, 2015 when she was rear-ended at 20 mph. She was initially seen at Saint Mary's Regional Medical Center complaining of pain in the low back with radiation to both thighs. Her history of prior vehicular accident with back pain was noted. It was also noted that a lumbar MRI scan 1 month previous had shown a

herniated disc at L3-4 and L4-5 but that her symptoms nearly resolved in the intervening period. On examination Ms. Kline's neck was normal with painless range of motion and no tenderness. There was mild tenderness over the lumbar spine. No neurologic deficits were found. She was diagnosed with an acute lumbar radiculopathy and sprain of the lumbar spine. She was given medication for pain and spasm as well as prednisone.

In followup at Specialty Health Clinic on June 30, 2015, it was noted that Ms. Kline had been evaluated by Dr. Men-Muir for low back pain related to a previous auto accident about 6 weeks prior to the 2nd motor vehicle accident on June 25, 2015. Ms. Kline was now complaining of neck, upper back and low back pain. After examination she was diagnosed with neck sprain. Chiropractic care was recommended.

Ms. Kline underwent several chiropractic treatments with Maria Brady, DC, RN.

In followup with Dr. Hall on July 14, 2015, the patient reported minimal improvement with chiropractic adjustments and complained of persistent lumbar and neck pain. Conservative measures including physical therapy were continued.

On August 20, 2015 Ms. Kline reported she was improving with therapy. She had full range of motion and was intact neurologically. Completion of physical therapy followed by monitoring was recommended.

In follow-up with Dr. Hall at Specialty Health Clinic on September 23, 2015, Ms. Kline again reported improving but persistent mild neck pain. Additional physical therapy was recommended.

She improved and was discharged from care on October 28, 2015.

A little over 2 months later, on January 13, 2016, MRI scan the patient's cervical spine was obtained to further evaluate significant recurrent neck pain with radiation to the left arm. MRI was remarkable for disc degeneration with large disc protrusions at C5-6 and C6-7 resulting in complete effacement of the cerebral spinal fluid from the ventral and dorsal aspects of the cord with severe canal stenosis.

In follow up with Dr. Hall on March 16, 2016, he noted that Ms. Kline had essentially no symptoms on October 28, 2015 when she was discharged but was complaining of acute onset of neck pain of 7 days duration when she was seen by Dr. Hansen on January 13, 2016 with radiation to the left arm and associated neurologic signs. He noted the MRI results and that the chiropractor had recommended physiatry evaluation for further treatment. Dr. Hall concluded that the patient likely had degenerative disc changes prior to the industrial injury which may have been exacerbated by the industrial injury but that there was no evidence of neurologic symptoms during treatment for the industrial injury and again noted that the patient had improved with conservative measures. He concluded there is no objective evidence to connect the significant MRI findings of January 13,

2016 with the industrial injury. He again indicated that Ms. Kline had recovered completely from the industrial injury of June 25, 2015 by the end of October 2015.

Ms. Kline received multiple chiropractic treatments from Dr. Hansen between January 14th and April 28, 2016 without lasting benefit.

Neurosurgical consultation was obtained from Dr. Sekhon on July 5, 2016. He indicated the patient had pre-existing spondylosis C4 through C7 with cord compression C5-6 and C6-7, mobile spondylolisthesis at C4-5 and failed conservative therapy. He felt the accident exacerbated her underlying stenosis. He offered anterior cervical decompression and fusion C4 through C7.

In neurosurgical follow-up on April 3, 2017, repeat MRI and cervical x-rays were recommended.

Repeat x-rays on April 21, 2017 showed mild disc space narrowing and facet degenerative changes of the lower cervical spine with development of retrolisthesis of 2 millimeters C4 on 5 and 1 millimeters C6 on 7. MRI on the same day showed moderate posterior disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis.

In followup with the neurosurgeon on April 25, 2017, surgery was again recommended. He noted Ms. Kline had some weakness and depressed reflexes in the left arm.

On June 12, 2017 Dr. Sekhon performed an anterior cervical decompression C4 through C7 followed by interbody fusion.

In followup Dr. Sekhon felt the patient was improving and physical therapy was recommended.

X-rays on September 5, 2017 showed no hardware complications.

On September 6, 2017, 12 weeks postop, the patient reported improvement. Exam showed intact motor function throughout the upper extremities and grossly intact sensation. DTRs were equal and normal bilaterally.

On September 11, 2017 Dr. Sekhon felt Ms. Kline was MMI and she was released to full duty.

A rating evaluation was then performed by Dr. Russell Anderson, chiropractor, on June 25, 2015. He noted the patient still had headaches and limited mobility of her neck with numbness in the left wrist and hand affecting the C6 distribution. On exam he found limited range of motion of the cervical spine and concluded she was best assessed on the range of motion method. He allowed 12% whole person impairment for specific spine disorders which included 10% for spinal fusion at one level and 1% each for additional 2 levels. He found 7% impairment related to losses of range of

motion and 1% for sensory changes in the C6 nerve root. The combined total was 19% whole person impairment.

However, Dr. Anderson noted that under the DRE method the patient would be allowed a minimum a 25% whole person impairment and suggested that 25% be the appropriate allowance.

Regarding apportionment, he noted Ms. Kline had significant pre-existing degenerative cervical spine spondylosis and suggested 75% of the whole person impairment be apportioned to non-industrial factors leaving 6% whole person impairment related to the occupational injury.

A 2nd impairment evaluation was performed on May 8, 2018 by Dr. James Jempsa, D.O. He noted Ms. Kline still had a tight sore neck, shoulders and daily headaches with numbness in the left arm to the thumb. On examination he found normal strength in the upper extremities and symmetrical reflexes but decreased sensation over the left thumb. Range of motion measurements found significant losses in flexion and extension and moderate losses in lateral flexion and rotation bilaterally.

Utilizing the range of motion method he allowed 12% whole person impairment for specific spine disorders including 10% for single level fusion and 1% each for 2nd and 3rd levels. Range of motion impairments total 16% and sensory deficits total 1% whole person impairment. The combined total was 27% whole person impairment. Apportionment was not allowed.

DISCUSSION/CONCLUSIONS:

Both Dr. Anderson and Dr. Jempsa initially utilized the range of motion method in this case which is proper considering that a multilevel fusion was performed. They also agreed there is 12% whole person impairment utilizing Table 15 – 7 and both concluded there was 1% whole person impairment for sensory deficit in the left C6 distribution. These conclusions are appropriate and supported by the medical record and known pathologies in this case.

However, there was a large discrepancy between the active range of motion findings of Dr. Anderson versus Dr. Jempsa allowing 7% and 16% respectively.

As noted on page 399 of the Guides, "the physician should seek consistency when testing active motion.... Tests with inconsistent results should be repeated. Results that remain inconsistent should be disregarded." On page 375 the Guides it notes: "The physician should record and discuss any physical findings that are inconsistent with the history. Many physical findings are subjective, ie, potentially under the influence of the individual. It is important to appreciate this and not confuse such observations with truly objective findings."

Clearly, Dr. Jempsa's findings were inconsistent with those of Dr. Anderson which are now part of the medical record. He provides no discussion or explanation for the substantial variation. It is well recognized that patients learn from prior rating experience. This can have a great effect when

findings are "under the influence of the individual" such as active range of motion which requires the full effort and cooperation of the patient to be valid. Consequently, absent an objective basis for the variation, Dr. Anderson's range of motion findings should have priority.

Making an adjustment for the range of motion inconsistency, however, has minimal effect on the final whole person impairment considering that Dr. Anderson recommended the minimum allowance of 25% for fusion under the DRE section. This recommendation is supported on page 380 of the Guides which states: "In the small number of instances in which the range of motion and DRE methods can both be utilized, evaluate the individual with both methods and award the higher rating."

The 2nd issue of concern is apportionment which has a greater impact in this case. Dr. Anderson correctly points out that the patient's cervical pathologies were primarily degenerative in nature and preexisting. This conclusion is further supported by Dr. Hall's opinion on March 16, 2016, in which he noted Ms. Kline's cervical symptoms were initially consistent with a sprain strain and that she recovered completely from the industrial injury with conservative treatments by the end of October 2015. He went on to conclude there is no objective evidence to connect the patient's significant MRI findings of January 13, 2016 with the industrial injury. It is also informative that Ms. Kline had no symptoms or examination findings of neck injury at time of her initial presentation to the ER and was not found to have acute injury related pathologies on MRI.

If the occupational incident had significantly aggravated the patient's preexisting pathologies, the development of radiculopathy symptoms and findings would be expected in the first few days or weeks, not 5 months later. Consequently, it is likely that the patient's radicular symptoms were the result of a natural progression of her significant multilevel degenerative changes rather than the injury.

At any rate, the ultimate need for surgery was primarily the result of pre-existing pathologies. Absent those pre-existing pathologies the patient would not have been a candidate for multilevel cervical diskectomy and fusion. It is the fusion that now forms the basis for the patient's substantial permanent partial impairment. NAC 616C.490, paragraph 6 states that "an apportionment may be allowed if at least 50% of the total present impairment is due to a pre-existing or intervening injury, disease or condition."

Consequently, Dr. Anderson's conclusion that 70% of the patient's impairment allowance should be apportioned to pre-existing pathologies is reasonable and supported by the Guides and NAC 616C.490.

In summary, the impairment conclusions reached by Dr. Anderson are well supported by the medical record, known pathologies, AMA guides and Nevada Administrative Code.

3488 Goni Road, Suite #141, Carson City, NV 89706
Phone (775) 887-5030 Fax (775) 887-5040 NvOHC.com

I hope this review has been of assistance. If you have further questions or concerns, please do not hesitate to contact me.

Sincerely,

Jay E. Betz, MD, CIME, CHCQM, FABQAURP
Certified Independent Medical Examiner
Certified Medical Examiner, Federal Motor Carrier Safety Administration
Certified Healthcare Quality Manager
Fellow American Board of Quality Assurance & Utilization Review Physicians

3488 Goni Road, Suite #141, Carson City, NV 89706
Phone (775) 887-5030 Fax (775) 887-5040 NvOHC.com

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that I am an employee of McDONALD CARANO LLP, and that on the 8th of June 2018, I served the within **INSURER'S FOURTH SUPPLEMENTAL DOCUMENTARY EVIDENCE** upon the following parties at the addresses and service as identified:

☒ U.S. Mail ☐ Email ☐ FedEx ☐ Hand Delivered/Filing	Appeals Officer Department of Administration 1050 East William St., Suite 450 Carson City, NV 89701
☒ U.S. Mail ☐ Email ☐ FedEx ☐ Hand Delivered ☐ Facsimile	Herb Santos, Jr. 225 S. Arlington Ave., Ste. C Reno, NV 89501

Kelsey R Heller

Employee of McDonald Carano LLP

4816-3768-7399, v. 1

NEVADA DEPARTMENT OF ADMINISTRATION

BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim

of

KIMBERLY KLINE,

Claimant.

_____/

Claim No: 15853E839641

Hearing No: 1801761-JL

Appeal No: 1802418-RKN

INSURER'S FIFTH SUPPLEMENTAL DOCUMENTARY EVIDENCE

AFFIRMATION
Pursuant to NRS 239B.030

The undersigned does hereby affirm that the preceding **INSURER'S FIFTH SUPPLEMENTAL DOCUMENTARY EVIDENCE**, filed in Nevada Department of Administration Appeal No. 1802418-RKN does not contain the social security number of any person.

Lisa Wiltshire Alstead
Attorneys for Employer
CITY OF RENO
Administered by: CCMSI

6/20/18
Date

PHYSICIAN'S AND CHIROPRACTOR'S PROGRESS REPORT CERTIFICATION OF DISABILITY

Claim Number:

Social Security Number:

Patient's Name: Kimberly Kline

Date of Injury: 6/25/15

Employer: City of Reno

Name of MCO (if applicable):

Patient's Job Description/Occupation:

Previous Injuries/Diseases/Surgeries Contributing to the Condition: hx of herniated disc L3-5

Diagnosis: Acute lumbar strain

Related to the Industrial Injury? Explain: yes, rear ended

St Mary's Regional Medical Center
KLINE, KIMBERLY M
ATT DR
10/07/1979 F 35
V00008267251 ER
Rm.
MD01221557
06/25/15

Objective Medical Findings: tenderness (mild) L1-2-3-4-5 c (B) mild paraspinal tenderness.

☐ None - Discharged Stable ☐ Yes ☐ No Ratable ☐ Yes ☐ No

☐ Generally Improved ☐ Condition Worsened ☐ Condition Same

May Have Suffered a Permanent Disability ☐ Yes ☐ No

Treatment Plan: Rest, ice, medications. Rev WC 2-3 days. Return to ER PRN for any new concerns

☐ No Change in Therapy ☐ PT/OT Prescribed ☐ Medication May be Used While Working

☐ Case Management ☐ PT/OT Discontinued

☐ Consultation

☐ Further Diagnostic Studies: per WC

☐ Prescription(s): Norco, Flexeril, Prednisone

☐ Released to **FULL DUTY**/No Restrictions on (Date): _____

☐ Certified **TOTALLY TEMPORARILY DISABLED** (Indicate Dates) From: _____ To: _____

☒ Released to **RESTRICTED**/Modified Duty on (Date): From: 6/25/15 To: cleared by WC

Restrictions Are: ☐ Permanent ☐ Temporary

☐ No Sitting	☐ No Standing	☐ No Pulling	☐ Other:
☒ No Bending at Waist	☐ No Stooping	☐ No Lifting	
☒ No Carrying	☐ No Walking	☒ Lifting Restricted to (lbs.): 10 lbs	
☐ No Pushing	☐ No Climbing	☐ No Reaching Above Shoulders	

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CMSI - RENO

Date of Next Visit:	Date of this Exam:	Physician/Chiropractor Name:	Physician/Chiropractor Signature:
WC 2-3 days	6/25/15	Lan Richards	

D-39 (Rev. 7/99)

American Legalnet, Inc.
www.FormsWorkflow.com

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1197

Patient: KLINE, KIMBERLY M Clinical Report - Physicians/Mid Levels
MRN: M001221557Saint Mary's Regional Medical Center
VisitID: V00008267251235 West Sixth Street, Reno, NV 89503 775-770-3188
35y, FRegistration Date/Time: 06/25/2015 18:11

Time Seen: 19:37 Jun 25 2015.
Arrived- By private vehicle. Historian- patient.

HISTORY OF PRESENT ILLNESS
Chief Complaint: BACK INJURY and BACK PAIN. It is described as being moderate in degree (6) and in the area of the upper lumbar spine, mid lumbar spine and lower lumbar spine and radiating to the right thigh and to the left thigh (intermittant). Onset was today and it is still present. No bladder dysfunction, bowel dysfunction, sensory loss or motor loss.
Patient notes an injury. No other injury.

Similar symptoms previously: (had MRI 1 month ago, hx of herniated disc L34 and L45. was rear ended,1 month ago, sxs nearly resolved. immediate pain in low back after rear ended today while stopped, other car going about 20mph. no airbag deployment. intermittant radiation into B thighs. no radiation past knee. no incontinence. no saddle anesthesias.).

Recent medical care: (Sees chiropractor 2x per week for chronic low back pain).

REVIEW OF SYSTEMS
No fever, chills, difficulty with urination, urinary frequency or hematuria. No skin rash, headache, sore throat, cough or difficulty breathing. No chest pain, abdominal pain, nausea, vomiting or diarrhea.

PAST HISTORY
The patient has had prior back pain. Has had intervertebral disc disease.
PCP: Jennifer Leary.

Problems:
Herniated Disk.

Surgeries: Breast augmentation. (R ankle ligament reconstruction).

Medications:
Birth Control Pills.
Zoloft Oral.
Allergies:
No Known Drug Allergy.

SOCIAL HISTORY
Never smoker. Occasional alcohol use. No drug use.

ADDITIONAL NOTES
The nursing notes have been reviewed.

PHYSICAL EXAM
Vital Signs: Have been reviewed.
Appearance: Alert. Patient in mild distress.
HEENT: Normal external inspection.
Neck: Normal inspection. Neck nontender. Painless ROM.
CVS: Pulses normal.

Respiratory: No respiratory distress. Breath sounds normal.
Abdomen: No visible injury. Soft and nontender.
Back: Mild vertebral point tenderness over the upper, mid and lower lumbar spine (no stepoff or bony deformities). Mild soft tissue tenderness in the right upper, mid and lower, left upper, mid and lower and upper, mid and lower central lumbar area. No muscle spasm in the back or CVA tenderness.
Skin: Skin warm and dry. Normal skin color. No rash. Normal skin turgor.
Extremities: Extremities exhibit normal ROM. Extremities nontender.
Neuro: Oriented X 3. Mood/affect normal. No motor deficit. No sensory deficit. Reflexes normal.

LABS, X-RAYS, AND EKG
X-Rays: LS spine series.
LS-Spine X-rays: (CLINICAL DATA: pain s/p MVC, hx HNP.

TECHNICAL: AP, lateral, and oblique views the lumbar spine.

COMPARISON: None

FINDINGS:

Vertebral height and alignment are maintained. Disc degenerative changes are noted at L4-5.

If further evaluation is needed, MR is recommended if there are no contraindications.

IMPRESSION:

INTACT ALIGNMENT.

L4-5 DDD.

DICTATED BY: NOH,H M.D.
Date & Time: 06/25/15 2013). The X-rays were interpreted by the radiologist.

PROGRESS AND PROCEDURES
Course of Care: toradol 60mg IM.

20:37 06/25/15. discussed results, tx options, precautions, work limitations, and return ASAP for worsening pain, numbness, weakness, incontinence, saddle anesthesia etc.
Differential Diagnosis:
I considered injury, Musculo-skeletal strain, contusion, disk protrusion, vertebral fracture, sacroiliac joint strain, sciatica and other etiology as a possible cause of back pain in this patient. This is a partial list of diagnoses considered.

Disposition: Discharged. Condition: stable.

CLINICAL IMPRESSION
Acute lumbar radiculopathy.
Sprain of the lumbar spine.
Acute pain in the lower back.

INSTRUCTIONS

Apply ice. No lifting greater than 10 lbs or no bending or stooping. No strenuous activity.

Warnings: GENERAL WARNINGS: Return or contact your physician immediately if your condition worsens or changes unexpectedly, if not improving as expected, or if other problems arise. SPECIFICALLY, return if you develop weakness of the foot or leg, numbness, tingling, pain or incontinence of feces (loss of bowel control) or urine (loss of bladder control).

Prescription Medications:
Flexeril 10 mg: take 1 orally every 12 hours as needed for muscle spasm. Dispense fifteen (15). No refills. Substitution is permissible.

Norco 5 mg / 325 mg tablets: take 1 to 2 orally every 6 hours as needed for pain. Dispense fifteen (15). No refills. Substitution is permissible.

Prednisone 20 mg: take 2 orally every day for 5 days. Dispense ten (10). No refills.

Follow-up:
Return to the emergency department if not better. Follow up with a worker's compensation doctor in two days.

Understanding of the discharge instructions verbalized by patient.

(Electronically signed by Jessica Starr, PA-C 06/25/2015 23:41)

Co-signature 6/25/2015 23:26
Agree with PA-C/Mid-level finding and plans.
(Electronically signed by Richard Law M.D. - 6/25/2015 23:26)

SAINT MARY'S REGIONAL MEDICAL CENTER
235 W 6th St, Reno, NV 89503
Ph: (775) 770-3000

IMAGING REPORT

PATIENT: KLINE,KIMBERLY M ACCT: V00008267251 MRN: M001221557
DOB: 10/07/1979 LOC: ED ROOM / BED: /
AGE: 35 SEX: F STATUS: REG ER

ORDERING PHYSICIAN: STARR,JESSICA PA-C
ATTENDING PHYSICIAN:
CC: [rep ct name]
PROCEDURE(S): RADIOLOGY - LUMBAR SPINE
EXAM DATE/TIME: 06/25/15 1947
REASON: pain s/p MVC, hx HNP
ORDER NUMBER(s): 0625-0249, ACCESSION NUMBER(s): 327322.001

CLINICAL DATA: pain s/p MVC, hx HNP.

TECHNICAL: AP, lateral, and oblique views the lumbar spine.

COMPARISON: None

FINDINGS:

Vertebral height and alignment are maintained. Disc degenerative changes are noted at L4-5.

If further evaluation is needed, MR is recommended if there are no contraindications.

IMPRESSION:

INTACT ALIGNMENT.

L4-5 DDD.

DICTATED BY: NOH,H M.D.
Date Time: 06/25/15 2013

ELECTRONICALLY SIGNED BY: NOH, H M.D.
Date Time: 06/25/15 2017

15853E839641

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DoB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 06/30/2015 11:15AM	**Chart:** KLKI000001

Chief Complaint: back - 2nd mva 6-25-15

History of Present Illness:

KIMBERLY KLINE is a 35 female who presents for : back - 2nd mva 6-25-15.
Patient was involved in a 2nd motor vehicle accident on June 25, 2015 when she was rear-ended at high speed. She was initially seen and treated in the emergency room with x-rays demonstrating degenerative changes in the lower lumbar spine but normal alignment.
Currently the patient reports
1. Neck discomfort -moderate, diffuse, radiation into the right shoulder, associated stiffness.
2. Lumbar and thoracic pain -diffuse, nonradiating, no red flags, no numbness or weakness reported in legs.
Previously patient and responding to chiropractic treatment.

Review of Systems:

GENERAL: Negative
MUSCULOSKELETAL: muscle pain,Stiffness,spine pain
NEUROLOGICAL: Negative

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Medical / Family / Social History:

MEDICAL HISTORY: HEALTHY
Marital Status: Single. Tobacco use: Non-smoker.

Medications & Allergies:

Allergy	Reaction
No Known Drug Allergies (NKDA)	N/A

The emergency room prescribed a prednisone burst, muscle relaxant, and pain medications

Physical Exam:

Height	Weight	BMI	Blood Pressure	Pulse	Respiratory Rate	Pain	Smoking Status
67.00 in	155.00 lbs	24.30	139/87	78 bpm	14 rpm	6/10	Never smoker

E-signed by Dr. Scott Hall, MD on 06/30/2015 11:32AM

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By SHMCO at 1:24 pm, Jun 30, 2015

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SpecialtyHealth
SPECIALISTS IN MANAGED HEALTHCARE & PREVENTION

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE **DoB:** 10/07/1979 **Sex:** F
Provider: Dr. Scott Hall, MD **Visit:** 06/30/2015 11:15AM **Chart:** KLKI000001

CONST: well-appearing, NAD
EYES: EOMI, normal conjunctiva
EARS: grossly normal hearing
RESP: normal respiratory effort
MS: normal gait and station
SKIN: no observed rash/erythema/jaundice
PSYCH: euthymic mood, reactive affect, AO x 3, intact memory, good judgment and insight
Cervical exam- mild diffuse muscular tenderness to palpation, normal inspection, normal strength and sensation in both arms, normal reflexes throughout both arms , range of motion, flexion 40 degrees, extension 50 degrees, lateral rotation 70 degrees bilaterally with pain at extremes
Lumbar exam - mild diffuse muscular tenderness to palpation, Ford flexion 80 degrees, extension to 10 degrees with pain, normal strength sensation and reflexes in both legs, negative straight-leg test

Assessment:

Type	Code	Description
ICD-9-CM Condition	847.0	SPRAIN OF NECK
ICD-9-CM Condition	847.2	SPRAIN LUMBAR REGION

Plan:

Imaging: Imaging reviewed and discussed with pt.
Chiropractic
Work status: Full duty
Return visit: 2,week(s)
Additional health information: Previous records reviewed as summarized above
Treatment plan: Conservative treatment

Type	Code	Modifiers	Quantity	Description
CPT	99214		1.00 UN	OFFICE/OUTPATIENT VISIT EST

***RETURN TO WORK:

RETURN TO WORK FOR: KIMBERLY KLINE
DATE OF APPOINTMENT: 06/30/2015 11:15AM
BODY PART: back - 2nd mva 6-25-15

E-signed by Dr. Scott Hall, MD on 06/30/2015 11:32AM

SpecialtyHealth
SPECIALISTS IN MANAGED HEALTHCARE & PREVENTION

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DoB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 06/30/2015 11:15AM	**Chart:** KLKI000001

EMPLOYER: CITY OF RENO

Date of injury:06/3/2015

It is the injured worker's responsibility to inform the employer of current work status.
CURRENT RESTRICTIONS: Full duty without restrictions
CONDITION STABLE? NO
CONDITION RATABLE: NO
Patient missed work on June 29, 2015 because of pain and use of pain medications. Please excuse.

RETURN VISIT: 2 weeks
SIGNED: Scott Hall, MD

REFERRAL SHEET:

Referral from:
SpecialtyHealth, 330 E. Liberty st. #100, Reno, NV 89501
Ph # (775) 398-3630, Fax # (775) 322-2663

Patient name: KIMBERLY KLINE
Home phone #: 775-815-5790
Cell Phone #: 7758155790

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CCMSI - RENO

Insurer:
Insurance #:

Date of injury if applicable: 06/3/2015
Claim # if applicable:
Referral for: Chiropractor, evaluate and treat - 6 visits

Referral from: Dr. Scott Hall, MD

E-signed by Dr. Scott Hall, MD on 06/30/2015 11:32AM

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM - PROVIDE ALL INFORMATION REQUESTED

First Name	M.I.	Last Name	Birthdate	Sex	Claim Number (Insurer's Use Only)
Kimberly	M	Kline	10/07/79	☐M ☒F	

Home Address	Age	Height	Weight	Social Security Number
305 Puma Drive	35	5'7"	160	

City	State	Zip	Telephone
Washoe Valley	NV	89704	775-815-5790

Mailing Address	City	State	Zip	Primary Language Spoken
SAME				

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
		Parking Enforcement

Employer's Name/Company Name	Telephone
City of Reno	334-2424

Office Mail Address (Number and Street): 1640 E Commercial Row

Date of Injury (if applicable)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
6/25/15	am 330pm	6/25/15		Tim Hendricks

Address or Location of Accident (if applicable): W 6th St @ Virginia

What were you doing at the time of the accident? (if applicable): In truck - stopped

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)
I was rear-ended

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?

Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
Car Accident	mid back/neck

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date 6/25/15 Place Employee's Signature Pamela M Kline

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place: Saint Mary's Regional Medical Center ER — Name of Facility

Date / Hour	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident?
6/25/15 20:00	acute lumbar strain s/p MVC	☒ No ☐ Yes (if yes, please explain)

Treatment: Meds, rest, ice, Rev MC 2-3 days

Have you advised the patient to remain off work five days or more?
☐ Yes Indicate dates: from _____ to _____
☒ No If no, is the injured employee capable of: ☐ full duty ☒ modified duty

X-Ray Findings: L-spine: L4-5 DDD, intact alignment

If modified duty, specify any limitations/restrictions: no bending, carrying or lifting > 10lbs until cleared by MC

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☒ Yes ☐ No

Is additional medical care by a physician indicated? ☒ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date	Print Doctor's Name	I certify that the employer's copy of this form was mailed to the employer on:
6/25/15	Law Richards	

Address				INSURER'S USE ONLY
235 W. 6th St				
City	State	Zip	Provider's Tax I.D. Number	Telephone
Reno	NV	89503		7703185
Doctor's Signature			Degree	
			MD	

ORIG... TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev 10/07)

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By SHMCO at 1:51 pm, Jul 01, 2015

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1205

Reno Orthopaedic Clinic
555 North Arlington Ave Reno, NV 89503
(775) 786-3040

July 1, 2015
Page 1
Office Visit

KIMBERLY KLINE Home: (775) 815-5790
Female DOB: 10/07/1979 AGE:35 Years Old INSURANCE: CDS-WCSD- PHCN/ Saint Mary's network
PATIENT ID: 176038

05/11/2015 - Office Visit: Initial Office Visit
Provider: Brett Men-Muir
Location of Care: Reno Orthopaedic Clinic

Primary Care Physician: Leary, Jennifer M
Chief Complaint: bilateral lower back

Patient indicated on intake form that this is not a work related injury.

History of Present Illness:
The patient is a pleasant 35-year-old female who has been complaining of back pain for the last several months. She reports that she has had a recent exacerbation over the last month. She reports that bending and sitting increase her symptoms. She rates her pain as about an 8 out of 10. She reports no leg pain. No numbness or tingling. No weakness. She reports that bending increases her symptomatology. She constantly has to shift around to get comfortable. She has not had any injections or any therapy. She has had no skin issues or psychological issues. No leg swelling. She does not smoke. She reports that her pain is about an 8 out of 10 when severe. She reports no mechanical symptoms. She reports no grinding, locking, or popping of her back.

Medications
ADVIL 200 MG ORAL TABS (IBUPROFEN) otc PRN
MULTI FOR HER ORAL PACK (MULTIPLE VITAMINS-MINERALS) Prescribed by an outside physician. DAILY
JUNEL 1/20 1-20 MG-MCG ORAL TABS (NORETHINDRONE ACET-ETHINYL EST) Prescribed by an outside physician. DAILY
ZOLOFT 100 MG ORAL TABS (SERTRALINE HCL) Prescribed by an outside physician. DAILY
DICLOFENAC SODIUM 75 MG TBEC (DICLOFENAC SODIUM) 1 TAB PO BID W/ FOOD

Past Medical History (Responses from intake form)
Patient indicates a past history of:
None

Family History (Responses from intake form)
Patient indicates a family history of:
Mother (biol.) - Family History of Anaesthetic Complications
Father (biol.) - Family History of Arthritis

Social History/PQRS Review
Never smoker

Pain assessment on a scale of 0 to 10 based on VRNS: 7

Patient's use of anti-inflammatory/ OTC medications was reviewed.
Patient states that their alcohol consumption is 0 drinks.
Patient's current BMI is: 24.27

Review of Systems (Responses from intake form)
General: Indicates no symptoms of: sweats, chills, fevers, weight gain, weight loss, appetite loss.
HEENT: Indicates no symptoms of: headaches, bloody nose, sore throat, blurring, decreased hearing,

Reno Orthopaedic Clinic
555 North Arlington Ave Reno, NV 89503
(775) 786-3040

KIMBERLY KLINE Home: (775) 815-5790
Female DOB: 10/07/1979 AGE:35 Years Old INSURANCE: CDS-WCSD- PHCN/ Saint Mary's network
PATIENT ID: 176039

hoarseness, difficulty swallowing.
Cardiovascular: Indicates no symptoms of: chest pain, swelling of feet, palpitations, fainting, difficulty breathing while lying down, skipping heart beats, shortness of breath.
Respiratory: Indicates no symptoms of: wheezing, coughing, chest discomfort, coughing up blood or sputum.
Gastrointestinal: Indicates no symptoms of: vomiting, constipation, diarrhea, nausea, cramps, abdominal pain.
Genitourinary: Indicates no symptoms of: urinary urgency, urinary frequency, incontinence, blood in urine.
Musculoskeletal: Complains of: backpain.
Indicates no symptoms of:joint swelling, stiffness, joint pain, back pain, muscle weakness, neck pain.
Skin: Indicates no symptoms of: lesions, rash, lumps.
Neurologic: Indicates no symptoms of: headaches, brief paralysis, numbness, seizures, tremors, dizziness, fainting, weakness.
Psychiatric: Complains of: depression.
Indicates no symptoms of:drug abuse, anxiety, nervousness.
Endocrine: Indicates no symptoms of: obesity, excessive thirst, weight change, excessive urination.
Hematologic: Indicates no symptoms of: enlarged lymph nodes, Bleeding, Abnormal bruising.
Allergic / Immunologic: Complains of: seasonal allergies.
Indicates no symptoms of:persistent infections.

Lumbar Exam-Left Side
Appearance Normal

Motor-Left Side
Hip Flexors 5
Hip Extensors 5
Hip Adductors 5
Hip Abductors 5
Quadriceps 5
Hamstrings 5
Anterior Tibialis 5
Extensor Hallucis Longus 5
Gastrocsoleus 5

Straight Leg Raising
Sitting Negative
Supine Negative
Femoral Nerve Stretch Negative

Range of Motion and Stability-Left Side
Lateral Bending Bend to knee
Rotation 30

Reflexes
Babinski Negative
Achilles 0
Patellar 0
Clonus 0

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July 1, 2015
Page 3
Office Visit

KIMBERLY KLINE Home: (775) 815-5790
Female DOB: 10/07/1979 AGE:35 Years Old INSURANCE: CDS-WCSD- PHCN/ Saint Mary's network
PATIENT ID: 176039

Integument
Scars No
Infection No
Lesions No
Rash No

Vascular
Dorsalis Pedis Pulse 2+
Posterior Tibialis 2+

Sensory
L1 Light Touch: Normal
L1 Pain: Normal
L2 Light Touch: Normal
L2 Pain: Normal
L3 Light Touch: Normal
L3 Pain: Normal
L4 Light Touch: Normal
L4 Pain: Normal
L4 Light Touch: Normal
L5 Pain: Normal
S1 Light Touch: Normal
S1 Pain: Normal
Tenderness
L-S Junction

Provocative Testing

Gait
Antalgic Gait No
Faber Test Negative
Trendelenburg No

Girth
Thigh Symmetric
Calf Symmetric

Lumbar Exam-Right Side
Appearance Normal

Motor-Right Side
Hip Flexors 5
Hip Extensors 5
Hip Adductors 5
Hip Abductors 5
Quadriceps 5
Hamstrings 5
Anterior Tibialis 5
Extensor Hallucis Longus 5

Reno Orthopaedic Clinic
555 North Arlington Ave Reno, NV 89503
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July 1, 2015
Page 4
Office Visit

KIMBERLY KLINE Home: (775) 815-5790
Female DOB: 10/07/1979 AGE:35 Years Old INSURANCE: CDS-WCSD- PHCN/ Saint Mary's network
PATIENT ID: 176039

Gastrocsoleus 5

Straight Leg Raising
Sitting Negative
Supine Negative
Femoral Nerve Stretch Negative

Range of Motion and Stability-Right Side
Lateral Bending Bend to knee
Rotation 30

Reflexes
Babinski Negative
Achilles 0
Patellar 0
Clonus 0

Integument
Scars No
Infection No
Lesions No
Rash No

Vascular
Dorsalis Pedis Pulse 2+
Posterior Tibialis 2+

Sensory
L1 Light Touch: Normal
L1 Pain: Normal
L2 Light Touch: Normal
L2 Pain: Normal
L3 Light Touch: Normal
L3 Pain: Normal
L4 Light Touch: Normal
L4 Pain: Normal
L4 Light Touch: Normal
L5 Pain: Normal
S1 Light Touch: Normal
S1 Pain: Normal
Tenderness
L-S Junction

Provocative Testing

Gait
Antalgic Gait No
Faber Test Negative
Trendelenburg No

Reno Orthopaedic Clinic
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July 1, 2015
Page 5
Office Visit

KIMBERLY KLINE Home: (775) 815-5790
Female DOB: 10/07/1979 AGE:35 Years Old INSURANCE: CDS-WCSD- PHCN/ Saint Mary's network
PATIENT ID: 176039

Girth
Thigh Symmetric
Calf Symmetric

Range of Motion and Stability-Right Side
Flexion Bend to touch toes
Flexion Pain Painful
Extension 10
Extension Pain Painful
Spinal Rhythm Normal

Provocative Testing

Gait
Heel Walk Yes
Toe Walk Yes
Squat Yes
Tandem Walk Yes

Waddell's
Distraction No
Overreation No
Regional No
Tenderness No
Stimulation No

Imaging Studies
AP and lateral as well as flexion and extension views show disc degeneration mostly at L4-L5. Some minor disc osteophyte complex is seen at L3-L4. No instability is noted.

Impression
1. Discogenic back pain.
2. Disc degeneration, L4-L5.

Plan
At this point in time, we would recommend a therapy program for Kimberly Kline. We would switch her to a Voltaren regimen instead of the Advil. She does not need any injections right now. If she wants to delve a little bit deeper into this and her therapy and the antiinflammatory does not help her, then I would recommend an MRI of which she does not want to pursue right now. For now she can come back to clinic as needed. She does not meet any criteria for any surgery.

Prescriptions:
DICLOFENAC SODIUM 75 MG TBEC (DICLOFENAC SODIUM) 1 TAB PO BID W/ FOOD #60[Tablet] x 0

Entered by: Nichole Brooks

Reno Orthopaedic Clinic
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KIMBERLY KLINE Home: (775) 815-5790
Female DOB: 10/07/1979 AGE:35 Years Old INSURANCE: CDS-WCSD- PHCN/ Saint Mary's network
PATIENT ID: 176039

Authorized by: Brett Men-Muir
Electronically signed by: Nichole Brooks on 05/11/2015
Method used: Electronically to
Walgreens N Virginia* (retail)
750 N Virginia Street
Reno, NV 89501
Ph: (775) 337-8703
Fax: (775) 337-8730
RxID: 1746955991130940
Handout requested.

Xray Spine: Lumbar
4 view
Xray Technologist: Karen alves RT
Xray Technologist Comments: patient states not pregnant. kla

Finalized and approved by
Brett MenMuir, MD
BM:ghs:hm
MTID #: 5078578 D: 5/11/2015 T: 5/12/2015

Electronically signed by Jasmyne Tibulski on 05/18/2015 at 2:46 PM

Received
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SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DoB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 07/14/2015 10:45AM	**Chart:** KLKI000001

Chief Complaint: BACK2 WEEK FOLLOW UP

History of Present Illness:

KIMBERLY KLINE is a 35 female who presents for : BACK2 WEEK FOLLOW UP .
Patient reports ongoing lumbar and neck pain, moderate to severe, associated sleep disruption and stiffness, minimal improvement with chiropractic care, no numbness or weakness

Review of Systems:

GENERAL: trouble sleeping
MUSCULOSKELETAL: muscle pain,Stiffness,spine pain
NEUROLOGICAL: Negative

Medications & Allergies:

Allergy	Reaction
No Known Drug Allergies (NKDA)	N/A

The emergency room prescribed a prednisone burst, muscle relaxant, and pain medications

Physical Exam:

Height	Blood Pressure	Pulse	Respiratory Rate	Oxygen Saturation	Pain	Smoking Status
67.00 in	112/84	86 bpm	14 rpm	97.00 %	5/10	Never smoker

CONST: well-appearing, NAD
EYES: EOMI, normal conjunctiva
EARS: grossly normal hearing
RESP: normal respiratory effort
MS: normal gait and station
SKIN: no observed rash/erythema/jaundice
PSYCH: euthymic mood, reactive affect, AO x 3, intact memory, good judgment and insight
MSK: Neck- normal inspection, mild diffuse muscular tenderness to palpation, grossly normal strength and sensation

E-signed by Dr. Scott Hall, MD on 07/14/2015 11:08AM

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DoB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 07/14/2015 10:45AM	**Chart:** KLKI000001

Lumbar exam -mild tenderness to palpation across the lumbosacral junction bilaterally, normal strength and sensation, normal reflexes in both legs

Assessment:

Type	Code	Description
ICD-9-CM Condition	847.0	SPRAIN OF NECK
ICD-9-CM Condition	847.2	SPRAIN LUMBAR REGION

Plan:

Imaging: Imaging reviewed and discussed with pt, images reviewed with pt.
Physical therapy, Evaluate and Treat - 6 visits
Education: Patient informed about treatment plan and instructions
Work status: Full duty
Return visit: 2,week(s)
Treatment plan: Conservative treatment
Patient continues to have back and neck, minimal improvement with chiropractic care, recommendation to try physical therapy, records reviewed and discussed with the patient from her orthopedic evaluation prior to the work injury

Type	Code	Modifiers	Quantity	Description
CPT	99214		1.00 UN	OFFICE/OUTPATIENT VISIT EST

***RETURN TO WORK:

RETURN TO WORK FOR: KIMBERLY KLINE
DATE OF APPOINTMENT: 07/14/2015 10:45AM
BODY PART: BACK2 WEEK FOLLOW UP
EMPLOYER: CITY OF RENO

Date of injury:06/3/2015

It is the injured worker's responsibility to inform the employer of current work status.
CURRENT RESTRICTIONS: Full duty without restrictions
CONDITION STABLE? NO
CONDITION RATABLE: NO

E-signed by Dr. Scott Hall, MD on 07/14/2015 11:08AM

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DoB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 07/14/2015 10:45AM	**Chart:** KLKI000001

RETURN VISIT: 2 weeks
SIGNED: Scott Hall, MD

E-signed by Dr. Scott Hall, MD **on** 07/14/2015 11:08AM

12703
08-20-15 12:28pm

TREATMENT ENCOUNTER NOTE

Patient Information

Account #: 0026102075 Co - Pay: ______ OR Co - Insurance: ______

Name: Kline, Kimberly Injury #: 001 Dx: 8472 Sprains and strains of lumba

Payor Code: A0028 Payor Name: CCMSI Financial Class: WCOMP

Appointment Detail

Discipline: PT Tx Time In: 10:30

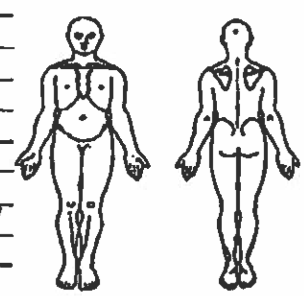
Tx Time Out: 11:35 Total Time Based Time: 65

Date: 08 / 20 / 15 # Visits Prior To Today: 3 of 12 Total Treatment Time: 96

RT Code	Description	Units	RT Code	Description	Units	RT Code	Description	Units
A001	PT Eval		F010	Vasopneumatic Device		C005	Gait Training	
A002	PT Re Eval		G001	Ultrasound		F006	Traction Mechanical	
A003	OT Eval		B001	Manual Therapy	2	H003	Custom WHFO Static	
A004	OT Re-Eval		C001	Therapeutic Activities		H008	Custom WHO Static	
F003	HP/CP	1	C002	Neuromuscular Re-Ed	1	H005	Custom WHFO Dynamic	
F004	Estim Unattend		C003	Therapeutic Exercise	2	H016	Custom HFO Static	
U001	Self Care/Home Management							

Additional Treatment Codes: ______

SOAP: S: Neck is feeling pretty good. Cont c̄ HA. Feels like a lot of pressure in L/S. No leg Sx.
O: Palp. Pelvis: ↑ post rotation
Hypertonic c̄ painful R psoas, ql
Hypomobile L/S c̄ pic
A: Did well c̄ manual Rx + lumbo pelvic stab.
↓ pain post
P: ✓ pelvis, lumbo-pelvic stab



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PAIN SCALE 0 — 10

Amy Cushs PT, DPT
THERAPIST / CREDENTIALS

LICENSE NO. #2149

NO. 0782 P. 11 Aug. 27. 2015 3:35PM

AA 1421
019
1215

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DoB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 08/20/2015 9:15AM	**Chart:** KLKI000001

Chief Complaint: CERVICAL STRAIN

History of Present Illness:

Disclaimer: Parts of this note may have been dictated by speech recognition. Minor errors in transcription may be present.

KIMBERLY KLINE is a 35 female who presents for : CERVICAL STRAIN.
Patient notes improvement in her neck symptoms and describes only mild muscular tightness currently. She reports no arm symptoms. Physical therapy has been helpful and continues.

Medications & Allergies:

Allergy	Reaction
No Known Drug Allergies (NKDA)	N/A

Physical Exam:

Height	Weight	BMI	Blood Pressure	Pulse	Oxygen Saturation	Pain	Smoking Status
67.00 in	155.00 lbs	24.30	116/64	72 bpm	97.00 %	3/10	Never smoker

CONST: well-appearing, NAD
EYES: EOMI, normal conjunctiva
EARS: grossly normal hearing
RESP: normal respiratory effort
MS: normal gait and station
SKIN: no observed rash/erythema/jaundice
PSYCH: euthymic mood, reactive affect, AO x 3, intact memory, good judgment and insight
MSK: Neck exam - normal inspection, mild muscular tenderness to palpation over the trapezius, full motion with grossly normal strength and sensation in the arms

Assessment:

Type	Code	Description
ICD-9-CM Condition	847.0	SPRAIN OF NECK

E-signed by Dr. Scott Hall, MD **on** 08/20/2015 10:25AM

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DoB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 08/20/2015 9:15AM	**Chart:** KLKI000001

Plan:

Education: Patient agreeable to treatment plan and instructions
Work status: Full duty, MMI
Return visit: Pt to call with questions/problems
Treatment plan: Supportive treatment with recheck if not better
I believe she has done very well with physical therapy and recommend she simply complete her currently approved therapy for her neck, we will monitor her and I have asked her to let me know how her neck does and notify me if there are significant issues.

Type	Code	Modifiers	Quantity	Description
CPT	99213		1.00 UN	OFFICE/OUTPATIENT VISIT EST

***RETURN TO WORK:

RETURN TO WORK FOR: KIMBERLY KLINE
DATE OF APPOINTMENT: 08/20/2015 09:15AM
BODY PART: CERVICAL STRAIN
EMPLOYER: CITY OF RENO

Date of injury:06/3/2015

It is the injured worker's responsibility to inform the employer of current work status.
CURRENT RESTRICTIONS: Full duty without restrictions
CONDITION STABLE? YES
CONDITION RATABLE: NO

RETURN VISIT: MMI
SIGNED: Scott Hall, MD

E-signed by Dr. Scott Hall, MD **on** 08/20/2015 10:25AM

FAXED 9/4/15

UPDATED PLAN OF CARE
For outpatient rehabilitation

PATIENT NAME: Kimberly Kline **DOB:** 10/07/79

REFERRING PHYSICIAN: Scott Hall, M.D. **THERAPIST:** Mark Bruesewitz, P.T.

DIAGNOSES: 1. Lumbosacral strain/sprain with pain and decreased ROM.
2 Cervical strain/sprain with pain.

DATE OF ONSET: 08/03/15
START OF CARE DATE: 08/05/15
TOTAL VISITS: 6 of 6 approved

DATE OF REEVALUATION: 08/25/15
RECOMMENDED ADDITIONAL VISITS: 12

Evaluation of Progress: Patient reports of steady improvement over the last few weeks. She reports the pain in the neck and low back is less consistent and it is not as intense as before. The neck tightness still comes and goes depending on her activity level. She still complains of pain and pressure across the low back. She has no pain going down the legs. She occasionally has trouble sleeping at night because she is unable to get comfortable. She has been able to look around better while driving, but still has tightness at end range of cervical rotation.

Patient Problems/Status:
1. Patient is becoming more aware of utilizing proper posture throughout the day.
2. Improving lumbar AROM: Flexion was fingers-to-toes with a "catch" at 80° when going into flexion, extension 35° with mild pain and side bending was fingers to knee joint line without pain.
3. Improving cervical AROM: Flexion 55° (was 50°), extension 55° (was 50°), right rotation 75° with tightness at end range (was 65°), left rotation 75° with tightness at range (was 70°), the right side bending 36° and left side bending 35°.
4. Palpation: There was tenderness and tightness noted in the suboccipitals and bilateral upper trapezius. There was tenderness noted in the lumbar paraspinals and gluteals. Pelvis asymmetry was noted with a posterior rotation of the left innominate.
5. Bilateral hip weakness (4+/5). Bilateral knee and ankle strength was 5/5. Bilateral upper extremity strength was 5/5.
6. Back index score improved to 38% (score was 52% at initial evaluation).
7. Neck index score remained about the same at 28%.

Were previous goals met? Patient met short-term goals and made good progress toward the long-term goals.

Updated plan of treatment: Modalities as needed for pain control, low back and neck stretching exercises, manual therapy techniques to decrease pain and improve mobility, progressive therapeutic exercise and therapeutic activity to increase strength, neuromuscular reeducation for spinal stabilization exercises, and home exercise program development.

Long-term goals: (4-6 weeks)
1. Decrease Back Index score to < 25% by discharge.
2. Decrease Neck Index score to ≤16% by discharge.
3. Patient will be able to forward bend during ADLs without back pain.
4. Patient will be able to drive the work vehicle throughout the day without increased pain.
5. Patient will be independent with home exercise program by discharge.

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Goals discussed with patient? Yes. **Rehabilitation potential is:** Good.

Frequency/Duration: 2x/week for 6 weeks.

I have reviewed this plan of care and recertify a continuing need for services and the patient is under my care. The above updated plan of care is herein established and will be reviewed every 30 days.

Therapist signature: MBruesewitz,PT **Date:** 8/25/15

Referring Physician's signature: [signature] 9/1/15 **Date:** _____

T: redmt.com/GV/MV

☐SPARKS LOCATION • 1450 E. Prater Way, Suite 103 • Sparks, NV 89434 • T: 775.331.1199 • F: 775.331.1160
☐NORTHWEST RENO 1610 Robb Drive, Ste. D5 • Reno, NV 89523 • T: 775.746.9222 • F: 775.746.9224
☐SOUTH RENO • 11331 South Virginia, Suite 3 • Reno, NV 89511 • T: 775.853.9969 • F: 775.853.9969

09-23-15 12:01pm

TREATMENT ENCOUNTER NOTE

Patient Information

Account #: 0026102075 Co - Pay: _____ OR Co - Insurance: _____

Name: Kline, Kimberly Injury #: 001 Dx: 8472 Sprains and strains of lumba

Payor Code: A0028 Payor Name: CCMSI Financial Class: WCOMP

Appointment Detail

LB Neck

Discipline: PT Tx Time In: 1004

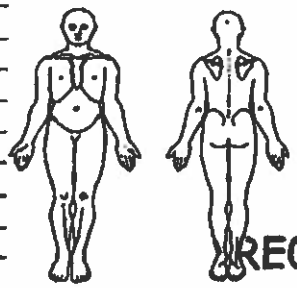
Tx Time Out: 1105 Total Time Based Time: 65

Date: 09 / 23 / 15 # Visits Prior To Today: 10 of 24 Total Treatment Time: 65

RT Code	Description	Units	RT Code	Description	Units	RT Code	Description	Units
A001	PT Eval		F010	Vasopneumatic Device		C005	Gait Training	
A002	PT Re Eval		G001	Ultrasound		F008	Traction Mechanical	
A003	OT Eval		S001	Manual Therapy	2	H003	Custom WHFO Static	
A004	OT Re Eval		C001	Theraputic Activities		H006	Custom WHO Static	
F003	H/N/CP		C002	Neuromuscular Re-Ed		H005	Custom WRFO Dynamic	
F004	Estim Unattend		C003	Therapeutic Exercise	3	H010	Custom HFO Static	
D001	Self Care/Home Management							

Additional Treatment Codes:

SOAP: S: The neck is still tight but getting better - Right (R) UT knot
My UE is steadily improving
O: Per Treatment log
↑ Trigger point in (R) UT - limits RT rotation
P: Re Eval



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MBaumgartPT
THERAPIST / CREDENTIALS
LICENSE NO. 0773

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE | **DoB:** 10/07/1979 | **Sex:** F
Provider: Dr. Scott Hall, MD | **Visit:** 09/23/2015 8:45AM | **Chart:** KLKI000001

Chief Complaint: NECK CLAIM

History of Present Illness:

Disclaimer: Parts of this note may have been dictated by speech recognition. Minor errors in transcription may be present

KIMBERLY KLINE is a 35 female who presents for : NECK CLAIM .
Patient reports improving neck discomfort, rated 3/10, central without radiation, improving with conservative care including physical therapy and occasional muscle relaxants, no associated symptoms.

Medications & Allergies:

Allergy	Reaction
No Known Drug Allergies (NKDA)	N/A

Physical Exam:

Height	Weight	BMI	Blood Pressure	Pulse	Respiratory Rate	Oxygen Saturation	Pain	Smoking Status
67.00 in	155.00 lbs	24.30	100/70	86 bpm	14 rpm	98.00 %	3/10	Never smoker

CONST: well-appearing, NAD
EYES: EOMI, normal conjunctiva
EARS: grossly normal hearing
RESP: normal respiratory effort
MS: normal gait and station
SKIN: no observed rash/erythema/jaundice
PSYCH: euthymic mood, reactive affect, AO x 3, intact memory, good judgment and insight
MSK: Neck exam - normal inspection, minimal muscular tenderness to palpation, full motion, normal strength and sensation in both arms

Assessment:

Type	Code	Description
ICD-9-CM Condition	847.0	SPRAIN OF NECK

E-signed by Dr. Scott Hall, MD on 09/23/2015 9:00AM

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE **DoB:** 10/07/1979 **Sex:** F
Provider: Dr. Scott Hall, MD **Visit:** 09/23/2015 8:45AM **Chart:** KLKI000001

Plan:

Referral: Physical therapy, Evaluate and Treat - 6 visits
Work status: Full duty
Return visit: 2,week(s)
Treatment plan: Conservative treatment

Type	Code	Modifiers	Quantity	Description
CPT	99213		1.00 UN	OFFICE/OUTPATIENT VISIT EST

*****RETURN TO WORK:**

RETURN TO WORK FOR: KIMBERLY KLINE
DATE OF APPOINTMENT: 09/23/2015 08:45AM
BODY PART: NECK CLAIM
EMPLOYER: CITY OF RENO

Date of injury:06/03/2015

It is the injured worker's responsibility to inform the employer of current work status.
CURRENT RESTRICTIONS: Full duty without restrictions
CONDITION STABLE? NO
CONDITION RATABLE: NO

RETURN VISIT: 2 weeks
SIGNED: Scott Hall, MD

REFERRAL SHEET 2:

Referral from:
SpecialtyHealth, 330 E. Liberty st. #100, Reno, NV 89501
Ph # (775) 398-3630, Fax # (775) 322-2663

Patient name: KIMBERLY KLINE
Home phone #: 775-815-5790

E-signed by Dr. Scott Hall, MD **on** 09/23/2015 9:00AM

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DoB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 09/23/2015 8:45AM	**Chart:** KLKI000001

Cell Phone #: 7758155790

Insurer:
Insurance #:

Date of injury if applicable: 06/03/2015
Claim # if applicable:
Referral for: Physical therapy, evaluate and treat - 6 visits
Neck and back strain

Referral from: Dr. Scott Hall, MD

E-signed by Dr. Scott Hall, MD **on** 09/23/2015 9:00AM

CUSTOM PHYSICAL THERAPY
RELIEVING PAIN. RESTORING FUNCTION

UPDATED PLAN OF CARE
For outpatient rehabilitation

PATIENT: Kimberly Kline **DOB:** 10/07/79

REFERRING PHYSICIAN: Scott Hall, M.D. **THERAPIST:** Mark Bruesewitz, P.T.

DIAGNOSES: 1. Lumbosacral strain/sprain with pain and decreased ROM.
2 Cervical strain/sprain with pain.

DATE OF ONSET: 08/03/15

START OF CARE DATE: 08/06/15 **DATE OF REEVALUATION:** 09/29/15
TOTAL VISITS: 12 **RECOMMENDED ADDITIONAL VISITS:** 10

Evaluation of Progress: Patient reports of good improvement in her low back pain. Low back pain has decreased to an intermittent basis with APS scale 0-1/10. She reports of decreasing pain in the low back along with improving lumbar mobility. She still gets a mild catch in the low back when coming up from a forward flexed position. She still has mild difficulty and mild low back pain when trying to stand and get her pants on. Patient states that her neck pain was improving until her flare-up approximately 1-1/2 weeks ago. Patient is not sure of what happened, but she began to have increased pain, tightness and spasms in the right neck and upper trapezius area. She had significant tightness with decreased right rotation of the neck for about a week and then symptoms have slowly improved. She continues to report of tightness and pain in the posterior shoulder, upper trapezius region and right neck that limit her neck mobility. She has difficulty lying on her sides because of neck pain and thus has disturbed sleep. Patient has difficulty turning her head to the right to look around while driving or look behind her when backing her car up at work. Neck pain averages 5/10 now (pain was 7-8/10 during the flare-up).

Patient Problems/Status:
1. Patient demonstrates a normal gait pattern. She is more aware of utilizing proper posture during work and daily activities.
2. Improving lumbar AROM: Flexion was fingers-to-the floor with a mild catch in the low back on the way back up, extension 45° and side bending was fingers-to-knee joint line.
3. Limited cervical AROM: Flexion 65° with mild pinch on the right, extension 60°, right rotation 60° with pinching pain in the right neck and upper trapezius area, left rotation 75°, right side bending 45° and left side bending with tightness in the right upper trapezius.
4. Palpation: There was tenderness and tightness noted in the right suboccipitals, C5-C7 paraspinals, right scalenes, right upper trapezius, and right levator scapula. Patient had no tenderness around the low back today.
5. Right shoulder AROM was within normal limits. Right upper extremity strength was 5/5. Right shoulder impingement test was negative.
6. Back Index score was 32% (score was 52% at initial evaluation).
7. Neck Index score remained at 28%.

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☐ NORTHWEST RENO • 1610 Robb Drive, Suite D5 • Reno, NV 89523 • T: 775.746.9222 • F: 775.746.9224
☐ SOUTH RENO • 734 South Meadows Pkwy., Suite 101 • Reno, NV 89521 • T: 775.853.9966 • F: 775.853.9969

Were previous goals met? Patient has made good progress in her lumbar pain and symptoms, but made minimal progress in her neck symptoms because of flare-up of symptoms about 1-1/2 weeks ago. Patient is still limited with cervical rotation to the right during ADLs and work activities.

Updated plan of treatment: Modalities as needed for pain control, neck AROM and stretching exercises, manual therapy techniques to decrease pain and improve mobility of the neck and low back, progressive therapeutic exercise and therapeutic activity to increase neck and low back strength, neuromuscular reeducation for spinal stabilization exercises, and home exercise progression.

Long-term goals: (4-6 weeks)
1. Decrease Back Index score to < 25% by discharge.
2. Decrease Neck Index score to < 15% by discharge.
3. Patient will be able to look to the right when driving without neck pain.
4. Patient will be able to sleep for 4-6 hours without increase neck pain.
5. Patient will be independent with home exercise program by discharge.

Goals discussed with patient? Yes. **Rehabilitation potential is:** Good.

Frequency/Duration: 2x/week for 5 weeks.

I have reviewed this plan of care and recertify a continuing need for services and the patient is under my care. The above updated plan of care is herein established and will be reviewed every 30 days.

Therapist signature: [signature] PT Date: 9/29/15

Referring Physician's signature: [signature] 9/30/15 Date: _____

T: rsdmt.com/GV/MV

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A0221
09-29-15 01:40pm

TREATMENT ENCOUNTER NOTE

Patient Information

Account #: 0026102075 Co - Pay: _____ OR Co - Insurance: _____

Name: Kline, Kimberly Injury #: 001 Dx: 8472 Sprains and strains of lumba

Payor Code: A0028 Payor Name: CCMSI Financial Class: WCOMP

Appointment Detail

Neck Back

Discipline: PT Tx Time In: 235

Tx Time Out: 340 Total Time Based Time: 65

Date: 09 / 29 / 15 # Visits Prior To Today: 11 of 24 Total Treatment Time: 65

RT Code	Description	Units	RT Code	Description	Units	RT Code	Description	Units
A001	PT Eval		E010	Vasopneumatic Device		C005	Gait Training	
A002	PT Re Eval		G001	Ultrasound		E008	Traction Mechanical	
A003	OT Eval		S001	Manual Therapy	2	H003	Custom WHFO Static	
A004	OT Re Eval		C001	Theraputic Activities		H006	Custom WRO Static	
F003	HP/CP		C002	Neuromuscular Re-Ed		H005	Custom WHFO Dynamic	
F004	Estim Unattend		C003	Therapeutic Exercise	3	H018	Custom HFO Static	
D001	Self Care/Home Management							

Additional Treatment Codes:

SOAP: S: My neck is hurting a lot. Still sharp pain and tightness in (R) neck and post (R) shld. Can move the neck better but still hurts. APS – 5/10

O: Guarding in superior shld & arm elevation ROM- aching/cramp in wrist & intermittent LB – seems to be settling better. Intermittent pain now – not as bad APS 0.1/10.

O. Per treatment log
Re Eval – see UPOC
Back Index: 32%

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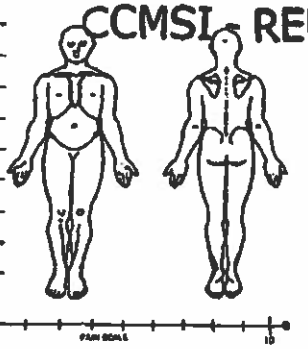
Neck Index: 28%

A: Improving UB pain and mobility (R) neck continues to be painful and limits @ abd right rotation and limits ADL's sleeping

P: Continue 2x/wk x 5 wks



PAIN SCALE 10

VN Beeeeeeeeeg PT
THERAPIST / CREDENTIALS

LICENSE NO. 0773

Sep. 30. 2015 1:18PM No. 1690 P. 6

TREATMENT ENCOUNTER NOTE

Patient Information

Account #: 0026102075 Co - Pay: _____ OR Co - Insurance: _____

Name: Kline, Kimberly Injury #: 001 Dx: B472 Sprains and strains of lumbo

Payor Code: A0028 Payor Name: CCMSI Financial Class: WCOMP

Appointment Detail

c/s

Discipline: PT Tx Time In: 11:30

Tx Time Out: 12:30 Total Time Based Time: 60

Date: 10 / 05 / 15 # Visits Prior To Today: 12 of 24 Total Treatment Time: 60

RT Code	Description	Units	RT Code	Description	Units	RT Code	Description	Units
A001	PT Eval		F010	Vasopneumatic Device		C005	Gait Training	
A002	PT Re Eval		G001	Ultrasound		F008	Traction Mechanical	
A003	OT Eval		B001	Manual Therapy	2	H003	Custom WHFO Static	
A004	OT Re Eval		C001	Therapeutic Activities		H006	Custom WFO Static	
F003	HP/CP		C002	Neuromuscular Re-Ed	1	H008	Custom WHFO Dynamic	
F004	Estim Unattend		C003	Therapeutic Exercise	2	H018	Custom HFO Static	
D001	Self Care/Home Management							

Additional Treatment Codes:

SOAP: S: My neck is a little better - last 5 pill light on (R) side

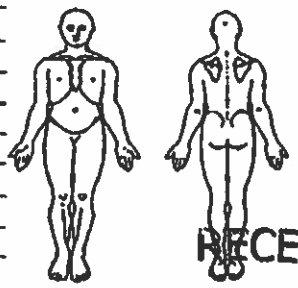
My LB is a little tight today - more pain when bending forward to tie shoes. I have trouble getting up from the floor after sitting in my kids Rm 5-10 min 2° to LB pain after treatment log

c/s Ant Flex = to toes - E + catch/pain at 30°

A: decreased tightness in (R) c/s paraspinals

Right L4-5 S1 paraspinals

P: Monitor response



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15853E839641

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DoB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 10/06/2015 4:00PM	**Chart:** KLKI000001

*****RETURN TO WORK:**

RETURN TO WORK FOR: KIMBERLY KLINE
DATE OF APPOINTMENT: 10/06/2015 04:00PM
BODY PART: LUMBAR FOLLOW UP
EMPLOYER: CITY OF RENO

Date of injury:6-25-15

It is the injured worker's responsibility to inform the employer of current work status.
CURRENT RESTRICTIONS: Full duty without restrictions
CONDITION STABLE? NO
CONDITION RATABLE: NO

RETURN VISIT: 4 weeks
SIGNED: Scott Hall, MD

E-signed by Dr. Scott Hall, MD on 10/06/2015 4:17PM

10217

10-07-15 11:02am

TREATMENT ENCOUNTER NOTE

Patient Information

Account #: 0026102075 Co - Pay: _____ OR Co - Insurance: _____

Name: Kline, Kimberly Injury #: 001 Dx: 8472 Sprains and strains of lumba

Payor Code: A0028 Payor Name: CCMSI Financial Class: WCOMP

Appointment Detail

c/s c/s

Discipline: PT Tx Time In: 900

Tx Time Out: 10:00 Total Time Based Time: 60

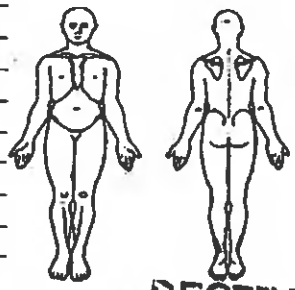
Date: 10 / 07 / 15 # Visits Prior To Today: 12 of 24 Total Treatment Time: 60

RT Code	Description	Units	RT Code	Description	Units	RT Code	Description	Units
A001	PT Eval		F010	Vasopneumatic Device		C005	Gait Training	
A002	PT Re Eval		G001	Ultrasound		F008	Traction Mechanical	
A003	OT Eval		B001	Manual Therapy	2	H003	Custom WHFO Static	
A004	OT Re Eval		C001	Therapeutic Activities		H006	Custom WHO Static	
F003	HP/CP		C002	Neuromuscular Re-Ed	1	H005	Custom WHFO Dynamic	
F004	Estim Unattend		C003	Therapeutic Exercise	2	H016	Custom HFO Static	
0001	Self Care/Home Management							

Additional Treatment Codes:

SOAP: S: Neck is not too bad today — stiff & sore/achy & forward bending movement

After treatment Log
A: Hypomobile L4-5-S1.
Trigger point in (R) UT
P: STM/MFR core stabi / Strengthening



PAIN SCALE

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THERAPIST / CREDENTIALS

LICENSE NO. 0773

12837
10-14-15 11:04am

TREATMENT ENCOUNTER NOTE

Patient Information

Account #: 0026102075 Co - Pay: ______ OR Co - Insurance: ______

Name: Kline, Kimberly Injury #: 001 Dx: 8472 Sprains and strains of lumba

Payor Code: A0028 Payor Name: CCMSI Financial Class: WCOMP

Appointment Detail

c/s LB

Discipline: PT Tx Time In: 900

Tx Time Out: 10:10 Total Time Based Time: 70

Date: 10 / 14 / 15 # Visits Prior To Today: 12 of 24 Total Treatment Time: 70

RT Code	Description	Units	RT Code	Description	Units	RT Code	Description	Units
A001	PT Eval		F010	Vasopneumatic Device		C005	Gait Training	
A002	PT Re Eval		G004	Ultrasound		F008	Traction Mechanical	
A003	OT Eval		B001	Manual Therapy	1	H003	Custom WHFO Static	
A004	OT Re Eval		C001	Therapeutic Activities	1	H006	Custom WHO Static	
F003	HP/CP		C002	Neuromuscular Re-Ed	1	H005	Custom WHFO Dynamic	
F004	Estim Unattend		C003	Therapeutic Exercise	2	N018	Custom HFO Static	
D001	Self Care/Home Management							

Additional Treatment Codes:

SOAP: S: Neck is improving — but (R) side of neck is still tighter than the (L).
LB stiffness is improving — still has tightness with leaning over activities.

Order treatment [illegible]
Focused on core stab exs and neck exs
New home exs — see pt handouts

A: Pt's shlds and upper back fatigue quickly c the exs

P: Cont c core stab 5am/[illegible]

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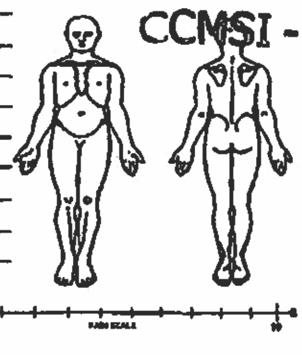

THERAPIST / CREDENTIALS: [signature] PT

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No. 2251 P. 2 Oct. 15. 2015 9:05AM

AA 1435
033
1229

A0221
10-21-15 01:00pm

TREATMENT ENCOUNTER NOTE

Patient Information

Account #: 0026102075 Co - Pay: ______ OR Co - Insurance: ______

Name: Kline, Kimberly Injury #: 001 Dx: S33.5XXSprain of ligaments of lumba

Payor Code: A0028 Payor Name: CCMSI Financial Class: WCOMP

Appointment Detail

Discipline: PT Tx Time In: 1105

Tx Time Out: 1210 Total Time Based Time: 45

Date: 10 / 21 / 15 # Visits Prior To Today: 4 of 8 Total Treatment Time: 65

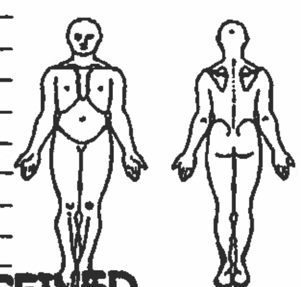
RT Code	Description	Units	RT Code	Description	Units	RT Code	Description	Units
A001	PT Eval		F010	Vasopneumatic Device		C005	Gait Training	
A002	PT Re Eval		G001	Ultrasound		F005	Traction Mechanical	
A003	OT Eval		B001	Manual Therapy	1	H003	Custom WHFO Static	
A004	OT Re Eval		C001	Theraputic Activities		H006	Custom WHO Static	
F003	HP/CP		C002	Neuromusculer Re-Ed	1	H005	Custom WHFO Dynamic	
F004	Estim Unattend		C003	Therapeutic Exercise	3	H018	Custom HFO Static	
D001	Self Care/Home Management							

Additional Treatment Codes: ______

SOAP: S: Continued improvement in neck and LB pain.
Neck tightness and pain has significantly improved.
Pt can turn her head during ADL's c̄ minimal
to no pain. Neck can flare up occ if she does
too much. LB is doing better — but still
has a 'catch' at 30° with forward
flexion activities. Still gets LB pain when
trying to put on pants/shoes
O: Per treatment log
Re Goal — see upon
Neck Index = 6% Back Index: 32%

A: Good ↑ in c/s AROM.
Still mild LB pain c̄ forward bending activity

P: Continue 1 more visit to
finalize and progress HEP



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TREATMENT ENCOUNTER NOTE

Patient Information

Account #: 0025102075 Co - Pay: _____ OR Co - Insurance: _____

Name: Kline, Kimberly Injury #: 001 Dx: 833.5XXBsprain of ligaments of lumba

Payor Code: A0028 Payor Name: CCMSI Financial Class: WCOMP

Appointment Detail

a/s 4/

Discipline: PT Tx Time In: 300

Tx Time Out: 350 Total Time Based Time: 50

Date: 10 / 26 / 15 # Visits Prior To Today: 5 of 8 Total Treatment Time: 50

RT Code	Description	Units	RT Code	Description	Units	RT Code	Description	Units
A001	PT Eval		F010	Vasopneumatic Device		C005	Gait Training	
A002	PT Re Eval		G001	Ultrasound		F008	Traction Mechanical	
A003	OT Eval		B001	Manual Therapy	1	H003	Custom WHFO Static	
A004	OT Re Eval		C001	Therapuitic Activities		H006	Custom WHO Static	
F003	HP/CP		C002	Neuromuscular Re-Ed		H005	Custom WHFO Dynamic	
F004	Estim Unattend		C003	Therapeutic Exercise	3	H016	Custom HFO Static	
D001	Self Care/Home Management							

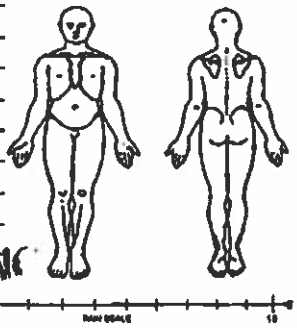
Additional Treatment Codes:

SOAP: S: Pt have been very sick all weekend.
Pt saw MD - last week and was released from his care.
Pt stated the neck is feeling much better.
Pt is doing home exs w/o problems.
The LB is doing better - still occ tightness in LB & forward bending activities (similar to before the accidents).
Pt ready to be discharged to HEP

O: Per treatment log
Finalized home exs - reviewed all exs and stretches - corrected ex technique as needed
Added a few exs - see pt handout
Latest objective findings not in the updated eval dated 8/26/15

A: Pt met her rehab goals

P: Pt discharged to HEP



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LICENSE NO 6773

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE | **DoB:** 10/07/1979 | **Sex:** F
Provider: Dr. Scott Hall, MD | **Visit:** 10/28/2015 2:15PM | **Chart:** KLKI000001

Chief Complaint: CERVICAL CLAIM

History of Present Illness:

Disclaimer: Parts of this note may have been dictated by speech recognition. Minor errors in transcription may be present.

KIMBERLY KLINE is a 36 female who presents for : CERVICAL CLAIM .
Patient reports improvement in her neck without significant symptoms currently, no arm symptoms reported.
She has completed treatment

Medications & Allergies:

Allergy	Reaction
No Known Drug Allergies (NKDA)	N/A

Physical Exam:

Height	Weight	BMI	Blood Pressure
67.00 in	155.00 lbs	24.30	120/68
Pulse	**Respiratory Rate**	**Oxygen Saturation**	**Smoking Status**
87 bpm	14 rpm	97.00 %	Never smoker

CONST: well-appearing, NAD
EYES: EOMI, normal conjunctiva
EARS: grossly normal hearing
RESP: normal respiratory effort
MS: normal gait and station
SKIN: no observed rash/erythema/jaundice
PSYCH: euthymic mood, reactive affect, AO x 3, intact memory, good judgment and insight
MSK: Neck exam -normal inspection, nontender to palpation, full motion with grossly normal strength

Assessment:

Type	Code	Description
ICD-10-CM Condition	S13.4XXA	Sprain of ligaments of cervical spine, initial encounter

E-signed by Dr. Scott Hall, MD on 10/28/2015 3.14PM

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE **DoB:** 10/07/1979 **Sex:** F
Provider: Dr. Scott Hall, MD **Visit:** 10/28/2015 2:15PM **Chart:** KLKI000001

Plan:

Work status: Full duty, MMI

Type	Code	Modifiers	Quantity	Description
CPT	99212		1.00 UN	OFFICE/OUTPATIENT VISIT EST

*****RETURN TO WORK:**

RETURN TO WORK FOR: KIMBERLY KLINE
DATE OF APPOINTMENT: 10/28/2015 02:15PM
BODY PART: CERVICAL CLAIM
EMPLOYER: CITY OF RENO

Date of injury:6-25-15

It is the injured worker's responsibility to inform the employer of current work status.
CURRENT RESTRICTIONS: Full duty without restrictions
CONDITION STABLE? YES
CONDITION RATABLE: NO

RETURN VISIT: MMI
SIGNED: Scott Hall, MD

E-signed by Dr. Scott Hall, MD on 10/28/2015 3:14PM

Reno Diagnostic Centers

RDC SIERRA ROSE
625 Sierra Rose Drive
Reno, NV 89511
Phone: (775) 323-5083
Fax: (775) 333-2776

|5853E839641|

Exam requested by:
Bryan Hansen DC
10635 Professional Circle Ste B
Reno NV 89521

Patient: Kline, Kimberly
Date of Birth: 10-07-1979
Phone: (775) 815-5790
MRN: 407766 **Acc:** 5111686
Date of Exam: 01-13-2016

MR-Spine Cervical without contrast [16265] - SPINE_C

CLINICAL INDICATION: Motor vehicle collision May 2015. Patient complains of neck pain which has since subsided. Neck pain started again 2 weeks ago with left arm pain, numbness and weakness down to the fingers.

TECHNIQUE: Multiple acquisition parameters were performed to evaluate the cervical spine utilizing the Siemens Espree Wide Bore 1.5 T MRI.

COMPARISON: None.

FINDINGS:
There is straightening of the normal cervical lordosis. There is no malalignment. The vertebral body heights are maintained with degenerative changes at the C5-C6 and C6-C7 levels. The bone marrow signal intensity is preserved. The spinal cord appears normal in caliber and signal intensity. There is no Chiari 1 malformation. The cervical spine is otherwise unremarkable through the C3-C4 level.

C4-C5: There is a shallow disc osteophyte complex indenting upon the thecal sac causing mild canal stenosis (axial series 5 image 13). There is mild right-sided neural foraminal narrowing. There is no significant left-sided neural foraminal narrowing.

C5-C6: There is a large disc protrusion in the left paracentral to subarticular zones causing moderate to severe canal stenosis and left lateral recess stenosis (axial series 5 image 19). There is no significant neural foraminal narrowing bilaterally.

C6-C7: There is a disc protrusion exiting from the central to left subarticular zones (axial series 5 images 23 and 24) indenting upon the cord resulting in effacement of CSF from the ventral and dorsal aspects of the cord causing severe canal stenosis without cord compression. There is bilateral uncovertebral arthropathy causing mild bilateral neural foraminal narrowing.

C7-T1: Unremarkable.

IMPRESSION:
Disc degeneration with large disc protrusions at the C5-C6 and C6-C7 levels resulting in complete effacement of CSF from the ventral and dorsal aspects of the cord with severe canal stenosis without cord compression or abnormal signal intensity in the cord to suggest cord edema or myelomalacia.

Thank you for referring your patient to RDC SIERRA ROSE
Electronically Signed by Swanger, Ronald MD 01-13-2016 8:50 PM

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S.O.A.P. Notes
1005

Leading Edge Chiropractic
15853E839641

Kimberly Kline
305 Puma Dr
Washoe Valley, NV 89704

Patient Information	
Patient	179019 - Kline, Kimberly - COVL
Date of Birth	10/7/1979
Patient Gender	Female
Social Security	- -2795
Marital Status	Divorced
Occupation	
Illness	1/9/2016
Employed Status	Employed
Employer	

Wednesday, June 07, 2017

Narrative Encounter - Exam - Initial (Auto-Recovered) Kline, Kimberly

Wednesday, January 13, 2016 3:19 PM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 10 of 10.)

History of Present Illness

- The patient presents with neck pain.

Associated symptoms: The patient reports associated symptoms of weakness and numbness.

Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

Duration: Current symptoms started approximately 7 days ago.

Timing: Onset of symptoms: abrupt.

Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

Narrative Encounter - Exam - Initial (Auto-Recovered) Kline, Kimberly
Wednesday, January 13, 2016 3:19 PM

- ***Grip Strength.*** Right hand dominant: first test right hand (75 pounds of force), second test right hand (72 pounds of force), and third test right hand (68 pounds of force), average for right hand is 71.66666 pounds of force first test left hand (40 pounds of force), second test left hand (38 pounds of force), third test left hand (40 pounds of force), average for left hand is 39.33333 pounds of force.
- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (severe indications). A combination of static and motion palpation reveal: mid lumbar spine, lower lumbar spine articular fixation bilaterally (moderate severity), and SI joint articular fixation bilaterally (moderate severity). Hypertonic musculature is moderate to severe in the muscles of the posterior neck bilaterally, the occipital muscles bilaterally, and the muscles of the upper back bilaterally. Muscle spasm is moderate to severe in the muscles of the upper back bilaterally and the muscles of the posterior neck bilaterally.
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is severe bilaterally and cervical paraspinals spasm, tenderness, and trigger point is severe.
- ***Range of Motion.*** Active cervical range of motion evaluation reveals left lateral flexion of 5/40 degrees with pain, flexion of 15/45 degrees with pain, and extension of 10/55 degrees with pain.
- ***Cervical Orthopedic Tests.*** Maximum cervical compression test for cervical nerve root compression is positive with radiating pain on the left. Cervical distraction maneuver alleviating neck pain or causing pain irritation is positive with pain relief.
- ***Lumbar Orthopedic Tests.*** Straight leg raise (positive need not imply neurologic dysfunction - must rule out hamstring injury, lumbar facet injury, sacroiliac injury) is negative. Fajersztajn's well leg raising test for lumbar intervertebral disc herniation or dural sleeve adhesions is negative. Braggard's test for sciatic pain elicitation is negative.

Neurological

- ***Sensation.*** Dermatome evaluation of the upper extremity reveal: C5 left, C6 left hypoesthesia, and all remaining upper extremity dermatomes are within normal limits. Dermatome evaluation of the lower extremity reveal: dermatome distribution patterns for L1 - S1 vertebral levels are within normal limits bilaterally.
- ***Reflexes.*** Upper extremity deep tendon reflexes reveal: biceps (C5) on the left +1 (trace/sluggish response) and brachioradialis (C6) on the left +1 (trace/sluggish response). All other cervical spine deep tendon reflexes are within normal limits. Lower extremity deep tendon reflexes reveal: All deep tendon reflexes are within normal limits bilaterally. The pathological reflexes are noted: Babinski's sign: normal and negative. Hoffmann's sign: negative and normal. Ankle clonus: negative and normal.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 30lbs with a 20 to 25 degree angle.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Prognosis

- Prognosis - guarded.

Narrative Encounter - Exam - Initial (Auto-Recovered) Kline, Kimberly

Wednesday, January 13, 2016 3:19 PM

Assessment

- The patient's response to conservative care - is marginal.

Diagnostic Impressions

- Impression - Examination indicates manifestations of a disc injury between the intervertebral disc space of C5, C6, and C7. Addendum: (2/11/2016) Examination indicates manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. The MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level and is consistent with a rear-end motor vehicle collision. We will attempt non-surgical spinal decompression at said areas of injury as well as refer her for pain management as she is tearful and cannot seem to find a comfortable position. Should NSSD not prove to eliminate her pain and resolve the numbness, we will refer to a neurosurgeon for a consultation and treatment.

Rationale For Care / Treatment Objectives

- Rationale for treatment and treatment objectives - The cervical short term goals are to decrease level of acute pain, decrease the inflammation, improve activities of daily living, and improve overall function of the affected areas.

Schedule of Care

- Schedule of care - As outlined in previous report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly

Thursday, January 14, 2016 11:06 AM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 10 of 10.)

History of Present Illness

Narrative Encounter - Decompression — Kline, Kimberly

Thursday, January 14, 2016 11:06 AM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (severe indications). A combination of static and motion palpation reveal: mid lumbar spine, lower lumbar spine articular fixation bilaterally (moderate severity), and SI joint articular fixation bilaterally (moderate severity).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is severe bilaterally and cervical paraspinals spasm, tenderness, and trigger point is severe.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 40lbs with a 20 to 25 degree angle.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Prognosis

- Prognosis - guarded.

Narrative Encounter - Decompression Kline, Kimberly
Thursday, January 14, 2016 11:06 AM

Assessment

- The patient's response to conservative care - is marginal.

Diagnostic Impressions

- Impression - Patient continues treatment for manifestations of a disc injury between the intervertebral disc space of C5, C6, and C7. Addendum: (2/11/2016) Examination indicates manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As outlined in previous report.

Referrals

- Referred to Zollinger DO, Jeffery (012267) for evaluation, treatment, patient is in a significant amount of pain with numbness in the left UE. She has an MRI on file at RDC which reveals two large disc protrusions at C5-6 and C6-7 with pain consistent with C5-6. If you can get this patient in immediately, I would greatly appreciate it. Meds and or an epidural for pain per your expertise would be terrific.

  Thank you,

Printed Documents

Narratives, Reports, and Letters

- Patient Referrals - New Full Page was printed by Hansen, Bryan C..

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jarilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly
Friday, January 15, 2016 2:16 PM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 9 of 10.)

History of Present Illness

Narrative Encounter - Decompression Kline, Kimberly

Friday, January 15, 2016 2:16 PM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (severe indications). A combination of static and motion palpation reveal: mid lumbar spine, lower lumbar spine articular fixation bilaterally (moderate severity), and SI joint articular fixation bilaterally (moderate severity).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is severe bilaterally and cervical paraspinals spasm, tenderness, and trigger point is severe.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 50lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Narrative Encounter - Decompression Kline, Kimberly

Friday, January 15, 2016 2:16 PM

Prognosis

- Prognosis - remains guarded.

Diagnostic Impressions

- Impression - Patient continues treatment for manifestations of a disc injury between the intervertebral disc space of C5, C6, and C7. Addendum: (2/11/2016) Examination indicates manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As outlined in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jarilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly

Monday, January 18, 2016 10:16 AM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 8 of 10.)

History of Present Illness

Narrative Encounter - Decompression Kline, Kimberly

Monday, January 18, 2016 10:16 AM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (severe indications). A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (severe indications). A combination of static and motion palpation reveal: mid lumbar spine, lower lumbar spine articular fixation bilaterally (moderate severity), and SI joint articular fixation bilaterally (moderate severity).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is severe bilaterally and cervical paraspinals spasm, tenderness, and trigger point is severe.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 50lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

Narrative Encounter - Decompression Kline, Kimberly
Monday, January 18, 2016 10:16 AM

- The patient's response to conservative care - is marginal and Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good and continues to show improvement with treatment.

Diagnostic Impressions

- Impression - Patient continues treatment for manifestations of a disc injury between the intervertebral disc space of C5, C6, and C7. Addendum: (2/11/2016) Examination indicates manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As previously stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly
Tuesday, January 19, 2016 3:41 PM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 8 of 10.)

History of Present Illness

Narrative Encounter - Decompression — Kline, Kimberly
Tuesday, January 19, 2016 3:41 PM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (severe indications). A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (severe indications). A combination of static and motion palpation reveal: mid lumbar spine, lower lumbar spine articular fixation bilaterally (moderate severity), and SI joint articular fixation bilaterally (moderate severity).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is severe bilaterally and cervical paraspinals spasm, tenderness, and trigger point is severe.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

Narrative Encounter - Decompression Kline, Kimberly

Tuesday, January 19, 2016 3:41 PM

- The patient's response to conservative care - is marginal.

Prognosis

- Prognosis - remains good.

Diagnostic Impressions

- Impression - Patient continues treatment for manifestations of a disc injury between the intervertebral disc space of C5, C6, and C7. Addendum: (2/11/2016) Examination indicates manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - Continue as outlined in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jarilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly

Wednesday, January 20, 2016 10:24 AM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 7 of 10.)

History of Present Illness

Narrative Encounter - Decompression — Kline, Kimberly

Wednesday, January 20, 2016 10:24 AM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (moderate to severe indications). A combination of static and motion palpation reveal: mid lumbar spine, lower lumbar spine articular fixation bilaterally (moderate severity), and SI joint articular fixation bilaterally (moderate severity).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is severe bilaterally and cervical paraspinals spasm, tenderness, and trigger point is moderate to severe.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Narrative Encounter - Decompression Kline, Kimberly
Wednesday, January 20, 2016 10:24 AM

Prognosis

- Prognosis - remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression - Patient continues treatment for manifestations of a disc injury between the intervertebral disc space of C5, C6, and C7. Addendum: (2/11/2016) Examination indicates manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - Continue as stated in initial report.

Discussion Subjects:

- Patients reports numbness in her left bicep is gone but continues in her left forearm and thumb.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly
Thursday, January 21, 2016 2:37 PM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 6 of 10.)

History of Present Illness

Narrative Encounter - Decompression — Kline, Kimberly

Thursday, January 21, 2016 2:37 PM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (moderate to severe indications). A combination of static and motion palpation reveal: mid lumbar spine, lower lumbar spine articular fixation bilaterally (moderate severity), and SI joint articular fixation bilaterally (moderate severity).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is severe bilaterally and cervical paraspinals spasm, tenderness, and trigger point is moderate to severe.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Narrative Encounter - Decompression Kline, Kimberly

Thursday, January 21, 2016 2:37 PM

Prognosis

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression - Patient continues treatment for manifestations of a disc injury between the intervertebral disc space of C5, C6, and C7. Addendum: (2/11/2016) Examination indicates manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - Continue as stated in initial report.

Discussion Subjects:

- Patients reports numbness in her left forearm has subsided, however there is some numbness in her left thumb.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly

Monday, January 25, 2016 11:05 AM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 6 of 10.)

History of Present Illness

Narrative Encounter - Decompression — Kline, Kimberly

Monday, January 25, 2016 11:05 AM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (moderate to severe indications). A combination of static and motion palpation reveal: mid lumbar spine, lower lumbar spine articular fixation bilaterally (moderate severity), and SI joint articular fixation bilaterally (moderate severity).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is severe bilaterally and cervical paraspinals spasm, tenderness, and trigger point is moderate to severe.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Narrative Encounter - Decompression Kline, Kimberly

Monday, January 25, 2016 11:05 AM

Prognosis

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression - Patient continues treatment for manifestations of a disc injury between the intervertebral disc space of C5, C6, and C7. Addendum: (2/11/2016) Examination indicates manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - Continue as stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly

Tuesday, January 26, 2016 11:16 AM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 5 of 10.)

History of Present Illness

Narrative Encounter - Decompression Kline, Kimberly
Tuesday, January 26, 2016 11:16 AM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (moderate to severe indications). A combination of static and motion palpation reveal: mid lumbar spine, lower lumbar spine articular fixation bilaterally (moderate severity), and SI joint articular fixation bilaterally (moderate severity).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is severe bilaterally and cervical paraspinals spasm, tenderness, and trigger point is moderate to severe.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Narrative Encounter - Decompression Kline, Kimberly

Tuesday, January 26, 2016 11:16 AM

Prognosis

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression - Patient continues treatment for manifestations of a disc injury between the intervertebral disc space of C5, C6, and C7. Addendum: (2/11/2016) Examination indicates manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - Continue as stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Exam - Progress Kline, Kimberly

Wednesday, January 27, 2016 11:23 AM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 5 of 10.)

History of Present Illness

Narrative Encounter - Exam - Progress Kline, Kimberly

Wednesday, January 27, 2016 11:23 AM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (moderate indications). Hypertonic musculature is moderate in the muscles of the posterior neck bilaterally, the occipital muscles bilaterally, and the muscles of the upper back bilaterally. Muscle spasm is moderate in the muscles of the upper back bilaterally and the muscles of the posterior neck bilaterally.
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is moderate bilaterally and cervical paraspinals spasm, tenderness, and trigger point is moderate.
- ***Grip Strength.*** Right hand dominant: first test right hand (75 pounds of force), second test right hand (72 pounds of force), and third test right hand (68 pounds of force), average for right hand is 71.66666 pounds of force first test left hand (40 pounds of force), second test left hand (38 pounds of force), third test left hand (40 pounds of force), average for left hand is 39.33333 pounds of force.
- ***Range of Motion.*** Active cervical range of motion evaluation reveals left lateral flexion of 10/40 degrees with pain, flexion of 20/45 degrees with pain, and extension of 15/55 degrees with pain.
- ***Cervical Orthopedic Tests.*** Maximum cervical compression test for cervical nerve root compression is positive with radiating pain on the left. (50% Improved.) Cervical distraction maneuver alleviating neck pain or causing pain irritation is positive with pain relief. (50% Improved.)
- ***Lumbar Orthopedic Tests.*** Straight leg raise (positive need not imply neurologic dysfunction - must rule out hamstring injury, lumbar facet injury, sacroiliac injury) is negative. (No Change.) Fajersztajn's well leg raising test for lumbar intervertebral disc herniation or dural sleeve adhesions is negative. (No Change.) Braggard's test for sciatic pain elicitation is negative. (No Change.)

Neurological

Narrative Encounter - Exam - Progress — Kline, Kimberly
Wednesday, January 27, 2016 11:23 AM

- ***Sensation.*** Dermatome evaluation of the upper extremity reveal: C5 left, C6 left hypoesthesia, and all remaining upper extremity dermatomes are within normal limits. (No Change.) Dermatome evaluation of the lower extremity reveal: dermatome distribution patterns for L1 - S1 vertebral levels are within normal limits bilaterally. (No Change.)
- ***Reflexes.*** Upper extremity deep tendon reflexes reveal: biceps (C5) on the left +1 (trace/sluggish response) and brachioradialis (C6) on the left +1 (trace/sluggish response). All other cervical spine deep tendon reflexes are within normal limits. (No Change.) Lower extremity deep tendon reflexes reveal: All deep tendon reflexes are within normal limits bilaterally. (No Change.) The pathological reflexes are noted: Babinski's sign: normal and negative. Hoffmann's sign: negative and normal. Ankle clonus: negative and normal. (No Change.)

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression - Re-examination shows that the patient continues to suffer from but is improving for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision. We will continue with the current treatment plan as patient seems to be improving as expected.

Schedule of Care

- Schedule of care - Continue current treatment plan as outlined in initial exam. Patient will have a re-examination in approximately 2 weeks provided no unexpected issue arise.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jarilyn Cox
Finalizing User

Narrative Encounter - Decompression — Kline, Kimberly
Thursday, January 28, 2016 1:56 PM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 5 of 10.)

History of Present Illness

- The patient presents with neck pain.

Associated symptoms: The patient reports associated symptoms of weakness and numbness.

Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

Duration: Current symptoms started approximately 7 days ago.

Timing: Onset of symptoms: abrupt.

Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (moderate indications).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is moderate bilaterally and cervical paraspinals spasm, tenderness, and trigger point is moderate.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Narrative Encounter - Decompression Kline, Kimberly
Thursday, January 28, 2016 1:56 PM

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression -Patient continues treatment for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As previously stated.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly
Monday, February 01, 2016 2:06 PM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 5 of 10.)

History of Present Illness

Narrative Encounter - Decompression Kline, Kimberly

Monday, February 01, 2016 2:06 PM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (moderate indications).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is moderate bilaterally and cervical paraspinals spasm, tenderness, and trigger point is moderate.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

Narrative Encounter - Decompression Kline, Kimberly
Monday, February 01, 2016 2:06 PM

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression -Patient continues treatment for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly
Tuesday, February 02, 2016 10:16 AM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 4 of 10.)

History of Present Illness

- The patient presents with neck pain.

Associated symptoms: The patient reports associated symptoms of weakness and numbness.

Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

Duration: Current symptoms started approximately 7 days ago.

Timing: Onset of symptoms: abrupt.

Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Narrative Encounter - Decompression Kline, Kimberly

Tuesday, February 02, 2016 10:16 AM

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (mild to moderate indications).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is mild to moderate bilaterally and cervical paraspinals spasm, tenderness, and trigger point is mild to moderate.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression -Patient continues treatment for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Received
JUN 08 2017
CCMSI-Reno

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly

Friday, February 05, 2016 11:49 AM

Subjective

Chief Complaint

15853 F 839641

Narrative Encounter - Decompression — Kline, Kimberly
Friday, February 05, 2016 11:49 AM

- Neck pain. (Pain Scale 4 of 10.)

History of Present Illness

- The patient presents with neck pain.

Associated symptoms: The patient reports associated symptoms of weakness and numbness.

Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

Duration: Current symptoms started approximately 7 days ago.

Timing: Onset of symptoms: abrupt.

Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (mild to moderate indications).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is mild to moderate bilaterally and cervical paraspinals spasm, tenderness, and trigger point is mild to moderate.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

Narrative Encounter - Decompression Kline, Kimberly
Friday, February 05, 2016 11:49 AM

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression -Patient continues treatment for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly
Monday, February 08, 2016 4:37 PM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 3 of 10.)

History of Present Illness

Narrative Encounter - Decompression Kline, Kimberly

Monday, February 08, 2016 4:37 PM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (mild to moderate indications).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is mild to moderate bilaterally and cervical paraspinals spasm, tenderness, and trigger point is mild to moderate.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

Narrative Encounter - Decompression Kline, Kimberly
Monday, February 08, 2016 4:37 PM

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression -Patient continues treatment for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly
Wednesday, February 10, 2016 2:05 PM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 3 of 10.)

History of Present Illness

- The patient presents with neck pain.

Associated symptoms: The patient reports associated symptoms of weakness and numbness.

Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

Duration: Current symptoms started approximately 7 days ago.

Timing: Onset of symptoms: abrupt.

Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Narrative Encounter - Decompression Kline, Kimberly

Wednesday, February 10, 2016 2:05 PM

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (mild to moderate indications).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is mild to moderate bilaterally and cervical paraspinals spasm, tenderness, and trigger point is mild to moderate.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression -Patient continues treatment for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Received
JUN 08 2017
CCMSI-Reno

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly

Friday, February 12, 2016 11:41 AM

Subjective

Chief Complaint

S.O.A.P. Notes
1005

15853E839641

Leading Edge Chiropractic

Narrative Encounter - Decompression — Kline, Kimberly

Friday, February 12, 2016 11:41 AM

- Neck pain. (Pain Scale 3 of 10.)

History of Present Illness

- The patient presents with neck pain.

Associated symptoms: The patient reports associated symptoms of weakness and numbness.

Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

Duration: Current symptoms started approximately 7 days ago.

Timing: Onset of symptoms: abrupt.

Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (mild to moderate indications).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is mild to moderate bilaterally and cervical paraspinals spasm, tenderness, and trigger point is mild to moderate.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

Narrative Encounter - Decompression Kline, Kimberly
Friday, February 12, 2016 11:41 AM

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression -Patient continues treatment for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly
Tuesday, February 16, 2016 10:33 AM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 2 of 10.)

History of Present Illness

Received
JUN 08 2017
CCMSI-Reno

Narrative Encounter - Decompression — Kline, Kimberly

Tuesday, February 16, 2016 10:33 AM

- The patient presents with neck pain.

Associated symptoms: The patient reports associated symptoms of weakness and numbness.

Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

Duration: Current symptoms started approximately 7 days ago.

Timing: Onset of symptoms: abrupt.

Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (mild indications).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is mild bilaterally and cervical paraspinals spasm, tenderness, and trigger point is mild.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 60lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

Narrative Encounter - Decompression Kline, Kimberly
Tuesday, February 16, 2016 10:33 AM

- Prognosis - Remains good and continues to improve with treatment.

Diagnostic Impressions

- Impression -Patient continues treatment for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly
Friday, February 19, 2016 11:49 AM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 4 of 10.)

History of Present Illness

- The patient presents with neck pain.

Associated symptoms: The patient reports associated symptoms of weakness and numbness.

Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

Duration: Current symptoms started approximately 7 days ago.

Timing: Onset of symptoms: abrupt.

Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Narrative Encounter - Decompression Kline, Kimberly

Friday, February 19, 2016 11:49 AM

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (mild to moderate indications).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is mild to moderate bilaterally and cervical paraspinals spasm, tenderness, and trigger point is mild to moderate.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 70lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good.

Diagnostic Impressions

- Impression -Patient continues treatment for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As stated in initial report.

Miscellaneous Notes

- Patient has flare up of pain today, we are increasing her to 70lbs.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Received
JUN 08 2017
CCMSI-Reno

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression Kline, Kimberly

Wednesday, February 24, 2016 2:04 PM

Narrative Encounter - Decompression — Kline, Kimberly
Wednesday, February 24, 2016 2:04 PM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 4 of 10.)

History of Present Illness

- The patient presents with neck pain.

Associated symptoms: The patient reports associated symptoms of weakness and numbness.

Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

Duration: Current symptoms started approximately 7 days ago.

Timing: Onset of symptoms: abrupt.

Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (mild to moderate indications).
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is mild to moderate bilaterally and cervical paraspinals spasm, tenderness, and trigger point is mild to moderate.

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment

Physical Modalities

- Cold pack applied to: the muscles of the posterior neck.
- Non-Surgical Spinal Decompression therapy using the Z-Grav decompression table was applied to: C5 and C6 at 70lbs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.
- LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Narrative Encounter - Decompression Kline, Kimberly
Wednesday, February 24, 2016 2:04 PM

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good.

Diagnostic Impressions

- Impression -Patient continues treatment for manifestations of a disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. MRI done at RDC confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NFS at each level. These injuries do appear to be directly related to the recent rear-end type motor vehicle collision.

Schedule of Care

- Schedule of care - As stated in initial report.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Exam - Final Kline, Kimberly
Wednesday, March 16, 2016 5:12 PM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 2 of 10.)

History of Present Illness

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DOB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 03/16/2016 2:15PM	**Chart:** KLKI000001

letter:

KIMBERLY KLINE was seen at SpecialtyHealth for a medical evaluation on 03/16/2016 02:15PM.

I received written communication from the administrator including medical records from a local chiropractor and an MRI of her cervical spine with questions.

Mrs. Kline was injured in June of 2015 during a motor vehicle accident with subsequent treatment for a cervical strain. Her treatment included conservative care with medications and physical therapy. The patient reported pain centralized in her neck without significant radiation into her arms. No neurologic symptoms were identified in her arms. The last visit with me was October 28, 2015 when she reported essentially no symptoms and minimal pain.

The medical records I received demonstrate a visit to a local chiropractor on January 13, 2016 with the acute onset of cervical pain, 7 days duration, pain rated 10/10 with radiation into the left arm and associated neurologic signs. An MRI done also on January 13, 2016 demonstrates findings of disc degeneration and protrusions at the C5-6 and C6-7 levels. A recommendation was made by the chiropractor to see to physiatry evaluation for further treatment.

Questions from the administrator included my opinion about the disc degeneration and protrusions and their relationship to the industrial injury. It is likely the patient had disc degeneration prior to the industrial injury which may have been exacerbated by the industrial injury; however, there was no evidence of neurologic symptoms during treatment for the industrial injury noted by myself or her physical therapist. The patient responded to conservative care with resolution. The collective records from the industrial injury support appropriate treatment and resolution of the cervical strain. I find no objective evidence connecting the significant MRI findings from 1/13/16 and the industrial injury.

The medical records from the recent visit to the chiropractor demonstrate the acute onset of symptoms in her neck and left arm. Based on the most recent visit from the chiropractor, it would seem these symptoms started spontaneously without provocation. It is uncertain if there is a relation to the industrial injury. Prior to the industrial injury, the patient did seek treatment by an orthopedist and he noted degenerative changes in her lumbar spine. This suggests that the patient was having disc degeneration prior to the industrial injury in part of her spine.

The 2nd question is in regards to a maximum improvement after treatment for the industrial injury. As I outlined

Pending e-signature

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DOB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 03/16/2016 2:15PM	**Chart:** KLKI000001

above, all indications were the patient had recovered completely from the industrial injury on June 25, 2015 by the end of october 2015.

Signed: Scott Hall, MD

SpecialtyHealth

SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE	**DOB:** 10/07/1979	**Sex:** F
Provider: Dr. Scott Hall, MD	**Visit:** 03/16/2016 2:15PM	**Chart:** KLKI000001

Chief Complaint: cervical issue

Medications & Allergies:

Allergy	Reaction
No Known Drug Allergies (NKDA)	N/A

Assessment:

Type	Code	Description
ICD-10-CM Condition	S13.4XXA	Sprain of ligaments of cervical spine, initial encounter

letter:

KIMBERLY KLINE was seen at SpecialtyHealth for a medical evaluation on 03/16/2016 02:15PM.

I received written communication from the administrator including medical records from a local chiropractor and an MRI of her cervical spine with questions.

Mrs. Kline was injured in June of 2015 during a motor vehicle accident with subsequent treatment for a cervical strain. Her treatment included conservative care with medications and physical therapy. The patient reported pain centralized in her neck without significant radiation into her arms. No neurologic symptoms were identified in her arms. The last visit with me was October 28, 2015 when she reported essentially no symptoms and minimal pain.

The medical records I received demonstrate a visit to a local chiropractor on January 13, 2016 with the acute onset of cervical pain, 7 days duration, pain rated 10/10 with radiation into the left arm and associated neurologic signs. An MRI done also on January 13, 2016 demonstrates findings of disc degeneration and protrusions at the C5-6 and C6-7 levels. A recommendation was made by the chiropractor to see to physiatry evaluation for further treatment.

Questions from the administrator included my opinion about the disc degeneration and protrusions and their relationship to the industrial injury. It is likely the patient had disc degeneration prior to the industrial injury which may have been exacerbated by the industrial injury, however, there was no evidence of neurologic symptoms during treatment for the industrial injury noted by myself or her physical therapist. The patient responded to conservative care with resolution. The collective records from the industrial injury support

E-signed by Dr. Scott Hall, MD on 03/16/2016 2:25PM

appropriate treatment and resolution of the cervical strain. I find no objective evidence connecting the significant MRI findings from 1/13/16 and the industrial injury.

The medical records from the recent visit to the chiropractor demonstrate the acute onset of symptoms in her neck and left arm. Based on the most recent visit from the chiropractor, it would seem these symptoms started spontaneously without provocation. It is uncertain if there is a relation to the industrial injury. Prior to the industrial injury, the patient did seek treatment by an orthopedist and he noted degenerative changes in her lumbar spine. This suggests that the patient was having disc degeneration prior to the industrial injury in part of her spine.

The 2nd question is in regards to a maximum improvement after treatment for the industrial injury. As I outlined above, all indications were the patient had recovered completely from the industrial injury on June 25, 2015 by the end of october 2015.

Signed: Scott Hall, MD

E-signed by Dr. Scott Hall, MD on 03/16/2016 2:25PM

Narrative Encounter - Exam - Final — Kline, Kimberly

Wednesday, March 16, 2016 5:12 PM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (mild indications). Hypertonic musculature is mild in the muscles of the posterior neck bilaterally, the occipital muscles bilaterally, and the muscles of the upper back bilaterally. Muscle spasm is mild in the muscles of the upper back bilaterally and the muscles of the posterior neck bilaterally.
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is mild bilaterally and cervical paraspinals spasm, tenderness, and trigger point is mild.
- ***Range of Motion.*** Active cervical range of motion evaluation reveals left lateral flexion of 35/40 degrees with mild pain, flexion of 40/45 degrees with mild pain, and extension of 45/55 degrees with mild pain.
- ***Cervical Orthopedic Tests.*** Maximum cervical compression test for cervical nerve root compression is positive with radiating pain on the left. (75% Improved.) Cervical distraction maneuver alleviating neck pain or causing pain irritation is positive with pain relief. (75% Improved.)
- ***Lumbar Orthopedic Tests.*** Straight leg raise (positive need not imply neurologic dysfunction - must rule out hamstring injury, lumbar facet injury, sacroiliac injury) is negative. (No Change.) Fajersztajn's well leg raising test for lumbar intervertebral disc herniation or dural sleeve adhesions is negative. (No Change.) Braggard's test for sciatic pain elicitation is negative. (No Change.)

Neurological

- ***Sensation.*** Dermatome evaluation of the upper extremity reveal: C5 left, C6 left hypoesthesia, and all remaining upper extremity dermatomes are within normal limits. (No Change.) Dermatome evaluation of the lower extremity reveal: dermatome distribution patterns for L1 - S1 vertebral levels are within normal limits bilaterally. (No Change.)

Narrative Encounter - Exam - Final — Kline, Kimberly
Wednesday, March 16, 2016 5:12 PM

- ***Reflexes.*** Upper extremity deep tendon reflexes reveal: biceps (C5) on the left +1 (trace/sluggish response) and brachioradialis (C6) on the left +1 (trace/sluggish response). All other cervical spine deep tendon reflexes are within normal limits. (Resolving.) Lower extremity deep tendon reflexes reveal: All deep tendon reflexes are within normal limits bilaterally. (No Change.) The pathological reflexes are noted: Babinski's sign: normal and negative. Hoffmann's sign: negative and normal. Ankle clonus: negative and normal. (No Change.)

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good.

Diagnostic Impressions

- Impression - Patient has completed the 20 visit series of non-surgical spinal decompression to address the disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. She has improved greatly and has only mild pain in the left arm with the ability to perform all of her routine daily activities. She has been instructed to do home care exercises to strengthen her cervical spine muscles. It is expected that the disc remodeling and repair phases of healing will continue for the next 12-18 months. During this time, it is also expected that these healing processes can cause minor flare ups. She has been asked to return for additional treatment should a flare up lasting longer than three days occur.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerilyn Cox
Finalizing User

Narrative Encounter - Decompression -21 — Kline, Kimberly
Thursday, April 28, 2016 10:56 AM

Subjective

Chief Complaint

- Neck pain. (Pain Scale 3 of 10.)

History of Present Illness

Received
JUN 08 2017
CCMSI-Reno

Narrative Encounter - Decompression -21 Kline, Kimberly
Thursday, April 28, 2016 10:56 AM

- The patient presents with neck pain.

  Associated symptoms: The patient reports associated symptoms of weakness and numbness.

  Quality: The patient characterizes the pain as burning, shooting, sharp, and radiating to (the left shoulder, the left forearm, the left thumb, and the left index finger). The patient cannot remain still.

  Severity: The patient indicates that the pain is an estimated level ten on a scale of one to ten, ten being the most severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities, and household activities.

  Duration: Current symptoms started approximately 7 days ago.

  Timing: Onset of symptoms: abrupt.

  Context: Patient was recently involved in two MVAs while at work which resulted in WC treatment for neck pain and shoulder pain. She was released from care only a few weeks ago. There is a high probability within a medical degree of certainty that Ms. Kline's injuries are related to the rear-end collision she recently sustained.

  Modifying factors: The patient's condition is unchanged with therapy. Current medication Vicodin 5-325 with very little affect on symptoms.

Objective

Examination

Musculoskeletal

- ***Palpations.*** A combination of static and motion palpation reveal: lower cervical spine and mid cervical spine articular fixation bilaterally (mild indications). Hypertonic musculature is mild in the muscles of the posterior neck bilaterally, the occipital muscles bilaterally, and the muscles of the upper back bilaterally. Muscle spasm is mild in the muscles of the upper back bilaterally and the muscles of the posterior neck bilaterally.
- ***Trigger Point.*** Palpation of the cervical, thoracic and related spinal musculature reveal: upper trapezius spasm, tenderness, and trigger point is mild bilaterally and cervical paraspinals spasm, tenderness, and trigger point is mild.
- ***Range of Motion.*** Active cervical range of motion evaluation reveals left lateral flexion of 35/40 degrees with mild pain, flexion of 40/45 degrees with mild pain, and extension of 45/55 degrees with mild pain.
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- ***Lumbar Orthopedic Tests.*** Straight leg raise (positive need not imply neurologic dysfunction - must rule out hamstring injury, lumbar facet injury, sacroiliac injury) is negative. (No Change.) Fajersztajn's well leg raising test for lumbar intervertebral disc herniation or dural sleeve adhesions is negative. (No Change.) Braggard's test for sciatic pain elicitation is negative. (No Change.)

Neurological

- ***Sensation.*** Dermatome evaluation of the upper extremity reveal: C5 left, C6 left hypoesthesia, and all remaining upper extremity dermatomes are within normal limits. (No Change.) Dermatome evaluation of the lower extremity reveal: dermatome distribution patterns for L1 - S1 vertebral levels are within normal limits bilaterally. (No Change.)

Narrative Encounter - Decompression -21 Kline, Kimberly
Thursday, April 28, 2016 10:56 AM

- ***Reflexes.*** Upper extremity deep tendon reflexes reveal: biceps (C5) on the left +1 (trace/sluggish response) and brachioradialis (C6) on the left +1 (trace/sluggish response). All other cervical spine deep tendon reflexes are within normal limits. (Resolving.) Lower extremity deep tendon reflexes reveal: All deep tendon reflexes are within normal limits bilaterally. (No Change.) The pathological reflexes are noted: Babinski's sign: normal and negative. Hoffmann's sign: negative and normal. Ankle clonus: negative and normal. (No Change.)

Dx Codes

- M50.20 - Other cervical disc displacement, unspecified cervical region

Assessment and Plan

Treatment Plans/Rationale

Assessment

- The patient's response to conservative care - Patient responded well to treatment today.

Prognosis

- Prognosis - Remains good.

Diagnostic Impressions

- Impression - Patient has completed the 20 visit series of non-surgical spinal decompression to address the disc injury at C5-6 and C6-7 causing severe left arm and forearm pain with numbness in the forearm and first two digits. She has improved greatly and has only mild pain in the left arm with the ability to perform all of her routine daily activities. She has been instructed to do home care exercises to strengthen her cervical spine muscles. It is expected that the disc remodeling and repair phases of healing will continue for the next 12-18 months. During this time, it is also expected that these healing processes can cause minor flare ups. She has been asked to return for additional treatment should a flare up lasting longer than three days occur.

Miscellaneous Notes

- Patient returned due to a flare up of symptoms today. She is instructed to return if symptoms persist.

Hansen M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Katarina Frankoski
Finalizing User

Received
JUN 08 2017
CCMSI-Reno

SIERRA NEUROSURGERY GROUP

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30 Years of Excellence

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Patient:	**Kimberly Kline**		
DOB:	Oct 07, 1979	**Address:**	305 Puma Dr
Sex:	F		Washoe Valley, NV 89704
MRN:	KA78754	**Phone:**	(775) 815-5790
Seen By:	Lali Sekhon MD	**Location:**	Sierra Neuro Pringle
Visit Date/Time:	Jul 05, 2016 12:00 PM	**Address:**	75 Pringle Way Suite 1007
Referred By:	Bryan C Hansen DC,		Reno, NV 89502-1475
		Phone:	(775) 657-8844
		Fax:	(775) 657-9881

Chief Complaint:

1. Neck pain and stiffness.2. Left arm numbness and pain.

History of Present Illness:

1. Neck pain and stiffness.2. Left arm numbness and pain.: Referring Physician: Jeffrey Muir, M.D.

Dear Jeff,

I had the pleasure of reviewing your patient, Kimberly Kline, a very nice 36-year-old woman for assessment of cervical radiculopathy.

Kimberly Kline is a very nice 36-year-old woman. She relates that she has had back and cervical issues in the past, mainly back, but these were quite manageable, but she was involved in an accident in her work in June 2015. There were actually 2 accidents, she was rear-ended. She was taken to the emergency room. Initially, she had neck pain and tightness in her neck. She was commenced on medication. She was commenced on physical therapy. She also had chiropractic. In January of this

numbness and aching in the arm. She had an epidural, this did not really help her. When I saw her today, she has neck pain and stiffness. She has a pressure feeling in the neck. She rates this as a 5/10. She has aching in the left arm again it is 5/10. She maps out numbness and aching in the forearm down to the thumb in the C6 distribution. Her right arm is okay. She feels she has plateaued. She has done extensive physical therapy. She has never had arm symptoms before these _____ injections.

Medical History:

Notes: Past Medical History:

1. Ankle sprain with surgery in 2013.
2. Cholecystectomy in 2010.

Social History: She is divorced. She is in the parking enforcement. She lives with her parents. She has 2 children, age 5 and 8. She does not smoke or consume alcohol.

Family History: Positive for arthritis in the family, cancer and diabetes in the mother.

Social History:

Smoking Status: Never smoker (4)

Allergies:

No Known Drug Allergies

Medications:

Prozac 40 mg capsule, 1 Select Frequency prescribed by Lali Sekhon on 07-05-2016

Review of Systems:

The patient completed a review of 16 symptoms and a pain diagram. This was reviewed at the time of initial consultation. Any pertinent positives have been included in the HPI, otherwise they were scanned into the medical record at that time. The patient's medications were reviewed at the time of the visit, also the patient's smoking status and BMI was reviewed with the patient. If the patient smoked or BMI was outside normal limits, the patient was encouraged to discuss with PCP treatment for this including options such as bariatric surgery.

Vitals and Body measurements:

Ht: 5'7"	Wt: 181.0 lbs	BMI: 28.3	Pulse: 59
RR: 16	BP: 117/71	Pain: 4	

Physical Examinations:

2) Well nourished and normally developed
3) Patient is oriented to time, place person. Cranial nerves II-XII were assessed.
4) No varicosities or edema
5) Normal gait and station
6) Coordination is normal in all 4 extremities. Tandem gait and Romberg's tested.
7) Muscle strength and tone were examined in both UE/LE
8) Sensation is was tested to pinprick and light touch in UE/LE
9) Deep tendon reflexes tested in UE/LE. Hoffman's and Babinski tested.
10) Mood and affect assessed
11) No cervical lymph nodes palpable
CERVICAL
12) Neck, shoulders and low back have normal range of motion with no scars. Palpated for tenderness.
13) Arms have normal range of motion with no scars
LUMBAR
14) Neck, hips and low back have normal range of motion and no scars. Palpated for tenderness.
15) Legs normal hip rotation and negative SLR and no scars
All the above systems and subsystems were examined and NORMAL except for findings described below:

She had a reduced range of motion of the cervical spine. She has numbness of the left forearm in the C6 distribution. On physical examination, she had 4/5 weakness in external rotators on the left, biceps and triceps on the left.

She had depressed reflexes in the left upper extremity.

Diagnostic Studies:

I independently reviewed and assessed the imaging. I also reviewed all imaging reports.

On her plain x-rays and MRI scan, she has loss of cervical lordosis. She has severe cord compression in the left greater than right at C5-6 and C6-7. She has a mobile C4-5 spondylolisthesis with moderate stenosis.

She had an MRI scan of the lumbar spine as well. This showed a desiccation of the L3-4, L4-5 and L5-S1 disk with mild lateral recess stenosis at L3-4 and L4-5.

Assessment:

Active:

Body mass index (BMI) 28.0-28.9, adult (ICD10:Z68.28)
Cervicalgia (ICD9:723.1, ICD10:M54.2)
Spinal stenosis, cervical region (ICD9:723.0, ICD10:M48.02)

Impression / Plan:

Impression:

1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord compression C5-6 and C6-7.
2. Mobile spondylolisthesis at C4-5.
3. Failed conservative therapy.
4. Minimal spondylosis, L3-4, L4-5 and L5-S1.

Kimberly has a cord compression and weakness. I think it is reasonable to offer her surgery.

She states that she never had these arm symptoms before these _____ accidents and although she may have had preexisting spondylosis, the accident has probably exacerbated her underlying stenosis.

I offered her C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

The procedure would entail anterior cervical diskectomy(ies) (with partial adjacent corpectomies) with fusion using PEEK cages, bone graft substitute and anterior plating with screws. I discussed the surgical procedure, goals alternatives, risks and potential complications in detail. Risks of a general anaesthetic include but are not limited to death, cardiorespiratory compromise, MI, DVT, PE and potential anaesthetic related problems to be discussed with anaesthesiology preoperatively. Risk of spinal cord or nerve root injury, swallowing and voice difficulty, loss of motion, recurrent laryngeal nerve injury-transient or permanent, esophageal injury, Horner's syndrome, CSF leak, infection, hemorrhage, major vessel injury, stroke, non-union hardware failure, swallowing problems, adjacent segment disease etc etc were all discussed in detail and understood by the patient. It was explained the risks of surgery included but was not limited to the preceding list. Discussed no absolute guarantee of success and possible need of further surgery. Discussed regenerating nerve root phenomenon and associated symptoms. I explained that if there is central cervical stenosis and canal compromise, there is a higher risk of cord injury than in a normal population from events such as MVA or falls, if a conservative path is elected. The precise risk is however, not quantifiable. A handout was provided. I used the bone model, imaging and handout literature to assist the patient with their decision making. I have answered all questions to the best of my ability. The use of any "off label" FDA products was discussed. All risks relating to this covered. I explained to the patient we may be using neurophysiological monitoring during the case (EMG/SSEP/MEP). We can put them in touch with our monitoring service, if desired for cost breakdowns etc. I recommended to the patient visit our web site www.sierraneurosurgery.com to further review conservative and surgical treatment options and www.spineuniverse.com for more information. The patient was provided with a copy of their dictation and encouraged to contact me with questions if they did not understand everything.

I explained that because of the degree of stenosis and canal compromise, there is a higher risk of cord injury than in a normal population from events such as MVA or falls, if a conservative path is elected. The precise risk is however, not quantifiable.

Plan: If she desire surgery, we will get a routine preoperative workup.

Sincerely,

Lali Sekhon, MD, PhD, FRACS, FACS, FAANS

Jeffrey Muir, M.D.

cc:
Bryan Hansen, DC
1664 N Virginia St
Reno, NV 89521
775-284-4902

Jennifer Leary, APN
645 N Arlington #600
Reno, NV 89503
775-322-3385

Scott Hall, MD
635 Sierra Rose Drive Suite A
Reno, NV 89501
775-322-2663

Orders:

Procedures & Treatments:

Comprehensive/High Comp (99245)
Current List of Medications (G8427)
Pain Assessment (G8730)
Calculated BMI above the upper parameter and a follow-up plan was documented in the medical

Associated Files:

Documents: Neck Injuries and Disorders (7/5/2016 1:05:05 PM)

Electronically signed by: Sekhon, Lali MD @ 09:42 AM on 7/6/2016

SIERRA NEUROSURGERY GROUP_NEURO | 75 PRINGLE WAY | RENO, NV 89502-1475

Kimberly M Kline

37yo F | 10/07/1979 | #147855

Encounter Summary
Date of Service: 04/03/2017)

Patient Demographics

Patient	Kline, Kimberly M (#147855)
Address	1617 Mountain Ln Reno, NV 89521
Phone Numbers	H: (775) 815-5790 M: (774) 815-5790
Referring Provider	

Encounter Notes

Encounter Date	04/03/2017
Chief Complaint	CC: 1. Neck Pain and Stiffness 2. Left arm numbness and pain
History of Present Illness	7.5.16 Dear Jeff, I had the pleasure of reviewing your patient, Kimberly Kline, a very nice 36-year-old woman for assessment of cervical radiculopathy. Kimberly Kline is a very nice 36-year-old woman. She relates that she has had back and cervical issues in the past, mainly back, but these were quite manageable, but she was involved in an accident in her work in June 2015. There were actually 2 accidents, she was rear-ended. She was taken to the emergency room. Initially, she had neck pain and tightness in her neck. She was commenced on medication. She was commenced on physical therapy. She also had chiropractic. In January of this year, she started developing severe left arm pain. The pain has somewhat settled but she still has numbness and aching in the arm. She had an epidural, this did not really help her. When I saw her today, she has neck pain and stiffness. She has a pressure feeling in the neck. She rates this as a 5/10. She has aching in the left arm again it is 5/10. She maps out numbness and aching in the forearm down to the thumb in the C6 distribution. Her right arm is okay. She feels she has plateaued. She has done extensive physical therapy. She has never had arm symptoms before these ____ injections. 4.3.17 Dr. Sekhon and I were able to review Kim Kline again today. She has continued with posterior neck pain and pressure. This pain continues to extend down the left arm following the left C6 distribution. Most of the symptoms are in the left arm and rated at times at a 9/10. The continues to limit her ability to sleep at night. The symptoms may be slightly improved but overall are very similar to the intensity she had last July.
Past Medical History	Reviewed Past Medical History
Past Surgical History	Reviewed Surgical History 1. Ankle sprain with surgery 2. Cholecystectomy
Medications	Reviewed Medications **PROzac 40 mg capsule** 04/03/17 entered Take 1 capsule(s) every day by oral route.
Allergies	

[illegible]	Reviewed Allergies NKDA
Social History	Reviewed Social History Smoking Status: Never smoker Advance directive: N
Family History	Reviewed Family History Father - Arthritis Mother - Family history of cancer (onset age: 65)
Review of Systems	**Additionally reports: The patient completed a review of 16 symptoms and a pain diagram. This was reviewed at the time of initial consultation. Any pertinent positives have been included in the HPI, otherwise they were scanned into the medical record at that time. The patient's medications were reviewed at the time of the visit, also the patient's smoking status and BMI was reviewed with the patient. If the patient smoked or BMI was outside normal limits, the patient was encouraged to discuss with PCP treatment for this including options such as bariatric surgery.**
Physical Exam	Patient is a 37-year-old female. 1) Vital signs review- BP/Pulse/temp/RR 2) Well nourished and normally developed 3) Patient is oriented to time, place person. Cranial nerves II-XII were assessed. 4) No varicosities or edema 5) Normal gait and station 6) Coordination is normal in all 4 extremities. Tandem gait and Romberg's tested. 7) Muscle strength and tone were examined in both UE/LE 8) Sensation is was tested to pinprick and light touch in UE/LE 9) Deep tendon reflexes tested in UE/LE. Hoffman's and Babinski tested. 10) Mood and affect assessed 11) No cervical lymph nodes palpable CERVICAL 12) Neck, shoulders and low back have normal range of motion with no scars. Palpated for tenderness. 13) Arms have normal range of motion with no scars LUMBAR 14) Neck, hips and low back have normal range of motion and no scars. Palpated for tenderness. 15) Legs normal hip rotation and negative SLR and no scars All the above systems and subsystems were examined and NORMAL except for findings described below: She had a reduced range of motion of the cervical spine. She has numbness of the left forearm in the C6 distribution. On physical examination, she had 4/5 weakness in external rotators on the left, biceps and triceps on the left. She had depressed reflexes in the left upper extremity.
Labs/Data/Imaging	N/A
Procedure Details	None recorded
Assessment and Plan	Imaging: No updated imaging MRI from RDC from January 2016 again reviewed: I independently reviewed and assessed the imaging. I also reviewed all imaging reports. On her plain x-rays and MRI scan, she has loss of cervical lordosis. She has severe cord compression in the left greater than right at C5-6 and C6-7. She has a mobile C4-5 spondylolisthesis with moderate stenosis. **1. Neck pain** M54.2: Cervicalgia **2. Cervical spondylosis** M47.812: Spondylosis without myelopathy or radiculopathy, cervical region **3. Spinal stenosis in cervical region**

M48.02: Spinal stenosis, cervical region
- MRI, CERVICAL SPINE, W/O CONTRAST
  Height (ft.): 5 ft 7 in | Weight (lbs): 178
- XR, CERVICAL SPINE
  Views (X-RAY, CERVICAL SPINE): AP, Lateral, Flexion & Extension

4. Body mass index 25-29 - overweight
Z68.29: Body mass index (BMI) 29.0-29.9, adult

Discussion Notes
Impression:
1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord compression C5-6 and C6-7.
2. Mobile spondylolisthesis at C4-5.
3. Failed conservative therapy.
4. Minimal spondylosis, L3-4, L4-5 and L5-S1.

Kimberly has a cord compression and weakness. I think it is reasonable to offer her surgery.
She states that she never had these arm symptoms before these ____ accidents and although she
may have had preexisting spondylosis, the accident has probably exacerbated her underlying stenosis.

She has an outdated MRI with persisting symptoms. Dr. Sekhon would like to request an updated MRI of the C-spine.

If she continues with stenosis on updated MRI and LUE radiculopathy Dr. Sekhon would offer her C4-5, C5-6 and C6-7 anterior cervical decompression and instrumented fusion.

The procedure would entail anterior cervical diskectomy(ies) (with partial adjacent corpectomies) with fusion using PEEK cages, bone graft substitute and anterior plating with screws. I discussed the
surgical procedure, goals alternatives, risks and potential complications in detail. Risks of a general
anaesthetic include but are not limited to death, cardiorespiratory compromise, MI, DVT, PE and
potential anaesthetic related problems to be discussed with anaesthesiology preoperatively. Risk of
spinal cord or nerve root injury, swallowing and voice difficulty, loss of motion, recurrent laryngeal nerve injury-transient or permanent, esophageal injury, Horner's syndrome, CSF leak, infection, hemorrhage, major vessel injury, stroke, non-union hardware failure, swallowing problems, adjacent segment disease etc etc were all discussed in detail and understood by the patient. It was explained the risks of surgery included but was not limited to the preceding list. Discussed no absolute guarantee of success and possible need of further surgery. Discussed regenerating nerve root phenomenon and associated symptoms. I explained that if there is central cervical stenosis and canal compromise, there is a higher risk of cord injury than in a normal population from events such as MVA or falls, if a conservative path is elected. The precise risk is however, not quantifiable. A handout was provided. I used the bone model, imaging and handout literature to assist the patient with their decision making. I have answered all questions to the best of my ability. The use of any "off label" FDA products was discussed. All risks relating to this covered. I explained to the patient we may be using neurophysiological monitoring during the case (EMG/SSEP/MEP). We can put them in touch with our monitoring service, if desired for cost breakdowns etc. I recommended to the patient visit our web site www.sierraneurosurgery.com to further review conservative and surgical treatment options and www.spineuniverse.com for more information. The patient was provided with a copy of their dictation and encouraged to contact me with questions if they did not understand everything.
I explained that because of the degree of stenosis and canal compromise, there is a higher risk of cord injury than in a normal population from events such as MVA or falls, if a conservative path is elected. The precise risk is however, not quantifiable.

Plan:
1. Repeat MRI and C-spine x-rays
2. Follow up with Dr. Sekhon in 2-4 weeks
3. Call with any other questions or concerns

Sincerely,

Curt Erickson, PA-C Lali Sekhon, MD, PhD, FRACS, FACS, FAANS

Return to Office
- Lali H Sekhon, MD for FOLLOW UP 30 at SIERRA NEURO PRINGLE_NEURO on 04/18/2017 at 12:30 PM

Curt Erickson, PA-C

Electronically Signed by: CURT ERICKSON, PAC, PA-C
04/03/2017 01:08 PM

15853E839641

Reno Diagnostic Centers

RDC EUREKA
590 Eureka Avenue
Reno, NV 89512
Phone: (775) 323-5083
Fax: (775) 333-2776

Patient Name: Kline, Kimberly
MRN: 407766
Date of Birth: 10-07-1979

Patient Phone: (775) 815-5790
Date of Exam: 04-21-2017
Exam: XR-Spine Cervical 4 or 5V AP, Lateral, Flexion, Extension [27985] - SPINE_C

Exam requested by:

Curt Erickson PAC
75 Pringle Way, Ste 1007
Reno NV 89502

Kline, Kimberly
305 Puma Drive
Washoe Valley NV 89704

CLINICAL INDICATION: M48.02 Spinal stenosis, cervical region.

TECHNIQUE: Four views of the cervical spine including flexion and extension.

COMPARISON: 7/5/2016.

FINDINGS:
There is normal alignment of the cervical spine in the neutral position. There is mild disc space narrowing at C6-7. There are facet degenerative changes at C7-T1. No abnormal motion on flexion. Upon extension there is development of 2 mm of retrolisthesis of C4 on 5. There is 1 mm of retrolisthesis of C6 on 7.

IMPRESSION:
1. Mild disc space narrowing and facet degenerative change of the lower cervical spine.
2. Development of retrolisthesis of 2 mm of retrolisthesis C4 on 5 and 1 mm retrolisthesis of C6 on 7 upon extension.

Thank you for referring your patient to RDC EUREKA
Electronically Signed by Kraemer, Eric, MD 04-21-2017 3:58 PM

Washoe

Received
APR 24 2017
COMST-Reno

Reno Diagnostic Centers

RDC EUREKA
590 Eureka Avenue
Reno, NV 89512
Phone: (775) 323-5083
Fax: (775) 333-2776

Patient Name: Kline, Kimberly
MRN: 407766
Date of Birth: 10-07-1979

Patient Phone: (775) 815-5790
Date of Exam: 04-21-2017
Exam: MR-Spine Cervical without contrast (16265) - SPINE_C

Exam requested by:

Curt Erickson PAC
75 Pringle Way, Ste 1007
Reno NV 89502

Kline, Kimberly
305 Puma Drive
Washoe Valley NV 89704

CLINICAL INDICATION: M48.02 Spinal stenosis, cervical region. Neck and left arm pain.

TECHNIQUE: Multiple acquisition parameters were performed to evaluate the cervical spine utilizing the Siemens 1.5 T MRI.

COMPARISON: Cervical spine plain radiographs 4/21/2017. Cervical spine MRI 1/13/2016.

FINDINGS:
There is straightening of the cervical spine in the imaged position. There is 1 mm of anterolisthesis of C4 on 5, new since the previous exam. There is mild disc space narrowing and mild endplate degenerative changes at C5-6. There is moderate disc space narrowing and mild endplate degenerative changes at C6-7. Findings are not significantly changed. No marrow signal abnormality. No cord signal abnormality.

At C2-3 and C3-4 there is no significant disc osteophyte complex, central canal or neural foraminal stenosis.

At C4-5 there is moderate posterior disc osteophyte complex with mild left facet degenerative changes. There is flattening of the ventral spinal cord. There is moderate central canal stenosis. No neural foraminal stenosis.

At C5-6 there is moderate posterior disc osteophyte complex with a left paracentral disc protrusion exerting mass effect upon the ventral spinal cord, left greater than right. There is moderate to severe central canal stenosis. No neural foraminal stenosis.

At C6-7 there is left paracentral disc osteophyte resulting in moderate central canal stenosis. No neural foraminal stenosis. Findings have slightly increased.

At C7-T1 there is mild posterior disc osteophyte complex without central canal or neural foraminal stenosis.

At T1-2 there is mild posterior disc osteophyte complex without central canal or neural foraminal stenosis.

IMPRESSION:
Moderate posterior disc osteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central canal stenosis as detailed above.

Thank you for referring your patient to RDC EUREKA

Electronically Signed by Kraemer, Eric, MD 04-21-2017 3:57 PM

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SIERRA NEUROSURGERY GROUP_NEURO | 75 PRINGLE WAY | RENO, NV 89502-1475

Kimberly M Kline

37yo F | 10/07/1979 | #147855

Encounter Summary
Date of Service: 04/25/2017)

Patient Demographics

Patient	Kline, Kimberly M (#147855)
Address	1617 Mountain Ln Reno, NV 89521
Phone Numbers	H: (775) 815-5790 M: (774) 815-5790
Referring Provider	

Encounter Notes

Encounter Date	04/25/2017
Chief Complaint	CC: 1. Neck Pain and Stiffness 2. Left arm numbness and pain
History of Present Illness	7.5.16 Dear Jeff, I had the pleasure of reviewing your patient, Kimberly Kline, a very nice 36-year-old woman for assessment of cervical radiculopathy. Kimberly Kline is a very nice 36-year-old woman. She relates that she has had back and cervical issues in the past, mainly back, but these were quite manageable, but she was involved in an accident in her work in June 2015. There were actually 2 accidents, she was rear-ended. She was taken to the emergency room. Initially, she had neck pain and tightness in her neck. She was commenced on medication. She was commenced on physical therapy. She also had chiropractic. In January of this year, she started developing severe left arm pain. The pain has somewhat settled but she still has numbness and aching in the arm. She had an epidural, this did not really help her. When I saw her today, she has neck pain and stiffness. She has a pressure feeling in the neck. She rates this as a 5/10. She has aching in the left arm again it is 5/10. She maps out numbness and aching in the forearm down to the thumb in the C6 distribution. Her right arm is okay. She feels she has plateaued. She has done extensive physical therapy. She has never had arm symptoms before these injections. 4.3.17 Dr. Sekhon and I were able to review Kim Kline again today. She has continued with posterior neck pain and pressure. This pain continues to extend down the left arm following the left C6 distribution. Most of the symptoms are in the left arm and rated at times at a 9/10. The continues to limit her ability to sleep at night. The symptoms may be slightly improved but overall are very similar to the intensity she had last July. 4.25.2017: REturns. Arm worse. Options discussed. Wants surgery.
Past Medical History	Reviewed Past Medical History
Past Surgical History	Reviewed Surgical History 1. Ankle sprain with surgery 2. Cholecystectomy
Medications	Reviewed Medications **PROzac 40 mg capsule** 04/03/17 entered

	Take 1 capsule(s) every day by oral route. **traMADol 50 mg tablet** 04/25/17 prescribed Take 1 tablet(s) EVERY 4-6 HOURS by oral route, prn pain.
Allergies	Reviewed Allergies NKDA
Social History	Reviewed Social History Smoking Status: Never smoker Advance directive: N
Family History	Reviewed Family History Father - Arthritis Mother - Family history of cancer (onset age: 65)
Review of Systems	**Additionally reports: The patient completed a review of 16 symptoms and a pain diagram. This was reviewed at the time of initial consultation. Any pertinent positives have been included in the HPI, otherwise they were scanned into the medical record at that time. The patient's medications were reviewed at the time of the visit, also the patient's smoking status and BMI was reviewed with the patient. If the patient smoked or BMI was outside normal limits, the patient was encouraged to discuss with PCP treatment for this including options such as bariatric surgery.**
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Labs/Data/Imaging	N/A
Procedure Details	None recorded
Assessment and Plan	Imaging: MRI from RDC from January 2016 again reviewed: I independently reviewed and assessed the imaging. I also reviewed all imaging reports. On her plain x-rays and MRI scan, she has loss of cervical lordosis. She has severe cord compression in the left greater than right at C5-6 and C6-7. She has a mobile C4-5 spondylolisthesis with moderate stenosis. 2017 imaging: C5/6 stenosis has progressed.