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

1	IN THE SOUREME COURT OF THE STATE OF NEVADA
2	-000-
3 4 5 6 7 8 9 10	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
12	MORGANDO,, ESQ., Sr. Appeals Officer; ) RAJINDER NIELSEN, ESQ., Appeals ) Officer; ATTORNEY GENERAL AARON ) FORD, ESQ.,
13	Respondents.
14	
15	Injured Worker Appellant's Appeal of the
16	Second Judicial District Court,
17	The Honorable Connie Steinheimer's Order
18	of the Appeals Officer's Decision of the Department of Administration
19	
20	APPELLANT'S APPENDIX
21	Volume VI
22	Pages 1251 - 1500
23	
24	HERB J. SANTOS, JR., ESQ.
25	Nv Bar No 4376 The Law Firm of Herb Santos, Jr.
26	225 S. Arlington Avenue, Suite C Reno, Nevada 89501
27	(775) 323-5200 herb@santoslawfirm.com
28	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

1

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

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II 0251-0365
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 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

TRANSMISSION VERIFICATION REPORT

82/22/2816 16:07

BROK3J489769

82/22 16:86 3823759 98:88:56 62 CK 5TANDARD ECM



February 22, 2016

Renown

Attn: Medical Records

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

Claimant:

S.S.N.:

Claim No.: 158535839641

0.O.B.

10/07/1979

Employer:

City of Reno

Dea: Medical Record: Department:

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

if there is a charge for the copies, plassa forward on invoice with the requested copies. If payment is required prior to shipment, please for 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 775-324-9850.

Sincerely

AA 1251

02/29/2016 09:29 HDWR0I \$44(177-4627)9 F.031/002

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Minutes 22, 2016

Attn: Medica, Records

Sent via fax to: 775-982-3759 205es 2 (Including cover)

Re: Calment Nomberly name Claim and Calment Ca

RECEIVED
FEB 9 8 2016
CCMSI - RENO

### Dear Modical Records Department

Bits on a 15 a CA form against by the interest worker all owers this office to about ricrios medical relations.

Please recovery cooled of this land of their call in posting bot in the LD/S/2016 and the COOLEGE to the address notice below. This individed all meaning provides for the wonder for the above references injuries worked.

If there is a country for the copies, procession for a more with the requested more. If payment is required under this ment one to leave the forming to me activation of the number record below.

If you have future: quantoms or with to allowed this creation flower contact mass: 776-324-9650.

Sincercly,

CORY IL

Yosenta Martinaz, Madezal Only Clehras Representative COMSI -- Reno, Newtos

空: F/b

the tree of the control of the contr

The second secon



Fabruary 22, 2016

Renown

Attr: Medica: Records

Sentivio fax to: 775-982-3759 Pages, 2 including coller

Claimant: Claim No.: Kimberly Kline

\$.S.N

15853E839641

10/07/1979

D.O.B.:

Employer

City of Reno

### Dear Medical Records Department:

Enclosed is a C-1 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 codies. If payment is required prior to shipment, please fax the invoke 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.

Yesenia Martinez, Medical Only Claims Representative

CCM51 - Reno, Nevada

cc: File

make any and a memory of the property of the property of the control of the contr

Cannon Cornran Management Services, inc. PO 8cm 20068 - Reno, NV 89515 866-603-8165 - 775-324-330. - Fax 775-324-9893 - www.comsicom TRANSMISSION VERIFICATION REPORT

IME 82/22/2016 : MAME FAX TEL 8ER M . BROK3J469769 22/22/2016 16:16

62/22 16-15 3566367 98:00-56 02 0K

February 22, 2016

Northern Nevada Medical

Attn: Medical Records

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

130 15339541

Claimant:

Claim No.: 8.5.N.

D,C,6.:

10/07/1979 City of Reno Employer:

Dear Medical Records Department:

Encloses & & C.4 form signed by the injured worker addring this fifthe to obtain oner mode of records. Please forward copies of any and all medital reporting between 15/1/2015 and U-20/2016 to the address noted below. It is not cost all treatment provided for any condition for the above information injurious with ter-

if there is a charge for the copies, plaase forward an involce with the requested copies. If payment is required prior to shipment, plause for 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



February 22, 2016

Nonhern Nevada Medicai

Attn: Medical Records

Sent via fax to: 775-396-0357 Pages: 2 (including cover)

Re Claimant: Kimberly Kline

Claim No.: 5.5.N.:

158536839641

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 modical 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 system.

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 discust this case further, please contact me at 275-324-9890.

Sincerely,

Yesenia Martinaz, Medical Only Claims Representative CCMSI - Reno, Nevada

cc Ale

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Osnnon Cachian Management Services, Inc. PO Box 20068 • Reno, NV 89515 886-601-6165 • 775-324-3301 • Fax: 775-324-9893 • www.comsicom

AA 1255

TRANSMISSION VERIFICATION REPORT

TIME B2/22/2015 :6 NAME FAX TEL SER.M BROK3J465765

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02/22 16:82 2644902 80:81:87 82 0K STANDARD



February 22, 2016

Leading Edge Chiropractic

Artn: Medical Records

Sent via fex to: 775-284-4902 Pages: I (including cover)

entitle and the

Claimant: Claim No.: 13453F639641

5.5.N. 0.0.B.: Employer:

10/07/1979 City of Rena

Dear Madical Records Department:

Enclosed is a C-4 form signed by the injured worker allowing this office to potain 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 quartiens or wish to discuss this case further, please contact me at 775-324-9890.



February 22, 2016

Leading Edge Chiropractic

Attn: Medical Records

Sent via fax to: 775-254-4902 Pages: 2 (including cover)

Claimant: Claim No.

Kimperly Kline 15853E839641

S S.N.

DOB:

Employer:

10/07/1979 City of Reno

Deer 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 at medical reporting prior to 6/25/2015 and any medical reporting after 6/25/2015 to the address noted below. This includes all reamient 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 involce to my attention at the number noted below.

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

Smcerely,

Yesonia Martinez, Medical Only Claims Representative

CCMSI – Reno, Nevada

cc File

Charles and the second of the

Cannon Cochran Management Services, Inc.
PO Box 20068 - Rend, NV 89515
86G-601-6165 - 775-324-3801 - 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:

KIMBERLY KLINE 305 PUMA DR WASHOE VALLEY, MV 89704 Hearing Number 5548/ JE Claim Number 158532439541

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

### BEFORE THE MEARING OFFICER

The Claimann's request for Hearing was filed on January 19, 2016 and a river in was scheduled for Pebruary 17, 2016. The Hearing was held of Pebruary 17, 2016 and 517 of the Novada Revised Statutes.

The L'aiman was present. The Employer was not present. The Insurer was tentescrived by Vegenia Martinez of COMSI, by telephone enniorance as:

### ISSUE

The Claiment 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.

### DECISION AND ORDER

RECEIVED

To e determination of the insurer is hereby REMANDED

CCMSI - RENC

On June 25, 2015, this Claimant sustained a compensable industrial injury The Claimant has treated conservatively under the claim and on October 28, 2015, Dr. Hall reported the industrial injury had read led maximum medica, improvement [MMI] without a retable impairment. Or November 6 2015, the insurer noticed the Claimant of its intention to class her claim without a PPD evaluation, the instant appeal. At many's hearing, the Claimant testified that her condition has significantly worsened and that she as over gon a to a entropressor for celled under new private insurance. Her chiroproctor pharmed for WRI water revealed disc degeneration with large olde production at the CD-D6 and C5 C7 levels. Having reviewed the submittee evidence and in consideration of the representations made at today's hearing the Hearing Officer finds a medical question regarding the Claimant's Mix. status as well as the disc degen; ration 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 e., medica, treatment, claim closure, PPD, etc.

In the Matter of the Contested Industrial Insurance Claim of Hearing Number: Page two

KIMBERLY KLINE 55487-JL

APPEAL RIGHTS

Pursuant to NRS 616C.345(1), should any party desire to appeal this final Decision and Frder 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.

January Hearing Officer

RECEIVED
FEB 28 2016
CCMSI - RENO

### CERTIFICATE OF MAILING

The undersigned, an employed of the State of Nevada, Department of Administration hearings Division does hereby ceruly that on the date shown below, a true and correct papy 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 biaced in the appropriate addresses 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 ARREYOUE PO BOX 1900 **RENO, NV 89505** 

CCMSI PO BOX 20068 RENO, NV 89515-0068

Dated this 25th day of Pebruary, 2015

Employee of the State of Nevada

RECEIVED FEB 2 9 2018 CCMSI - RENO 02/29/2016 1 15 17 PM -0500 FAXCOM

PAGE 1 OF 4 15853853964/

## FAX

### Medical Records Attached

TO:

Records Dept.

ORGANIZATION: COMSI

FAX NUMBER:

17753240453

DATE / TIME:

01:14.PM 02/29/2016

SUBJECT:

KIMBERLY KLINE(#12546853)

FROM:

The Valley Health System/NV

RETURN FAX: COMPANY:

(610) 962-8421 MRO Corporation

CONTACT EMAIL: roinelp@mrocotp.com

RECEIVED FEB 2 9 2016 CCMSI - RENO

The information transmitted is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material.

Any review, transmission, dissemination or other use of an taking of any action in reliance upon this information by persons or emities other than the intended recipient is prohibited.

If you have received this in error, please contact MRO at (888)252-4146, and destroy the material.

### NO RECORDS FOR DATE REQUESTED STATEMENT

I, the undersigned, being the duly suthonized modical 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

Records requested by

Date of request

THE RESIDENCE OF THE PROPERTY AND THE PROPERTY OF THE PROPERTY

Signature

Name.

Signed On.

NORTHERN NEVADA MEDICAL CENTER 2375 E PRATER WAY SPARKS NV 89434

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CCMSI - RENO

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PAGE S DF 4

CENTI

February 22, 2016

Northern Neveds Medical

Attn: Medical Records

Sent via fits to: 775-356-0357 Pages 2 (including sever)

te Claimant Craim No Kimberly Kilms 158538639641

5.5 N. 5.0.B Employer

-0/07/1979 City of Reno

Dear Medica: Records Department:

Enclosed is a C-4 form signed by the injured worker allowing this office to obtain prior med an records.
Please forward copies of any and all medical reporting between 10/1/2012 and 1/90/2016 to the address noted below. This buriedes all treatment grounded for any condition for the above referenced injured worker.

If there is a charge for the copies, please forward an avoice with the requested copies. If payment is required prior to propose of payment prepared on a standard of the number noted below.

11 you have further questions of wish to discuss this tase further please contact me at 775-124-9890

Sincerely,

Yasenia Martinez Medical Only Caling Representative COMS/ - Reno, Nevada

CC #10

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FEB 1 9 2016
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Cinsol Cooker Management Serving. Inc.
P(i) Edit 20080 • Ren. (NV \$9515
866 801-8165 c 775-324-330] a fair 775-324-8999 a www.czmsi.chm

62/24/2015 2 OBPH (GMT-05-00)

02/28/2018 2:01:00 AM - 3500 FAXCOM

PAGE 1 OF 1

MRO F.C 80x 61507 King of Prussia, PA 18408



Fax: (610) 962-8421 Phone: (888) 252-4146

Request Number: 12546853 Tracking 9: TVHSYMN4LE54S

Records Dept. CCMSI F.O. Box 20085 Reno, NV 89515

Track your request at www.ROILOQ.com. Enter your Tracking Fanc Request Number.

Date: 2/26/2016 Phone: 775-324-3301 Fee: 776-324-0453

Confirmation of Receipt of Madical Reserve Information Request

The Medical Facility below is in the process of spareting to: and relieving a dopy of the requestion bounds with be notified of any issues with your request. If there are no leaves, you will receive a pro-payment invoice. The records with be motival to you upon receils of your phyment.

Should you have any questions sone at 6-mail of Proportional or STAPOCAR to a Proper be used to query your factors number in the proper field of the runal STEAST OF UST STATEMENT FOR MEDICAL PARTY TO RESERVE THIS STANDARD

Patient Name: KIMBERLY KLINE Date of Birth:

Your Request Oate. Your Reference 15853E829641
Date Received at

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 2 6 2016 CCMSI - RENO



March 16, 2016

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

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

Dear Dr Hel:

Wis. Kline (relited with you for a cervical strain and reached White 8/20/2015) Due to continued come, she to liver to plat in the first or facility, at which time at MRI was on religious according to each of the MRI was on the MRI

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

- Is the diagnosed disc degeneration with large disc profrusion related to the industrie injuly E<sup>4</sup> 6/25/2015, or leib hop-industrial/pre-existing? Please explain.
- 2. Is Ms. Kline at MiMi 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 metter. I will be looking forwarding to your prompt reply

inia al Only Claims Replesenta y e

Co file, City of Reason control Kline

Enc. Reporting from Leading Edge Chiropractic and 1/13/2015 MR:

Cannon Cochran Management Services, Inc.
PO Box 20068 • Renc, NY 89515
866-601-6165 • 775-324-3301 • Fex: 775-324-9893 • www.come com

AA 1265



16503020042

+17753983687

15853E839641



### SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE Provider: Dr. Scott Hall, MD DOS: 10/07/1976 Visit: 03/16/2016 2:15PM Sex: F Chart: K\_Ki000001

### letter:

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

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

ions. While was injured in June of 2015 during a motor vehicle coordent with subsequent freedress for a connect timb. Her problement individed confervative care with medicallons and physical therapy. The patient reported pain contralitied in nor nock without significant rediation into the rains. (An neurologic symptoms were wentliked in her arms. The last visit with me was October 28, 2015 when she reported easentially no symptoms and minimal pain.

The medical records I received demonstrate a visit to a local chiropractor on Jenuary 13, 2016 with the acute onset of delivical pain, 7 days dureron, poin rolled 10/10 with rediation into the left aim and associated nativologic signs. An MRI done pisc on January 13, 2016 demonstrates findings of disc degeneration and protrosions at the C516 and C6-2 revets. A recommendation was made by the chiropractor to see to physical evaluation to Turbier regionship.

Questions from the administrator included my opinion about the disc degeneration and protoctors and their releasonship to the industrial injury. It is likely the patient had disc degeneration prior to the incustrial injury which may have been expectated by the industrial injury, however, there was no evidence of neurologic symptoms during transport to the moustnat known noted by myself of her physical theorypis. The patient esponded to conservative care with resolution. The collective records from the industrial injury support appropriate treatment and resolution of the devices strain. If not no objective evidence connecting the significant IARI indings from \$13716 and the industrial injury.

The modest records from the record stall to the chimphal for demail state the acute ones of symptoms in his neck and feet arm. Based on the most recent visit from the chimphalox if would soom these symptoms stand spontaneously without provided to it is uncertainful there is a relation to the industrial injury. Prior to the industrial injury in patient did seek upon manifoly an arthopodist and the noted dependentive charges in her undex spine. This suggests that the patient was fleving did ageneration prior to the industrial injury in panish her ocine.

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

(Page 1)

Pending o-signature

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MAR 1 8 2016

CCMSI - RENO

19 03/16/2016 2:24 PM

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+17753983682

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### SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE Provider: Dr. Scali Hall, MD DOB: 10/07/1979 Visit: 03/18/2016 2:16PM

Sex: F Chart: KLX1000001

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

Signed: Soofi Hall, MD

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CCMSI - REALE

(Page 2)

Pending a signature

AA 1267



### SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE

DOB: 10/07/1979

Sex: F

Provider: Or Scott Hall, MD

Visit: 03/16/2016 2:15PM

Chart: KUKI00000

### Chief Complaint:cervical lasue

### Medications & Aflergies:

Afference Oracy Wiczęles (NKDA)	Reaction NG
Accepoment	

Туре	Code	Description	
100-10-CM Consilion	513.42004	Sorbin of reaments of corvictal spine, initial encounter	 -
			 -

### lemen:

MBEPLY KLIJE was seen at Specialty-health for a medical evaluation on 03/16/2015 02 15Pag

the administrative written communication than the administration including medical records from a today of knot the administration of the administration o an MPI of her betweet spine with questions

hits. Kine was injured in June of 2015 during a major verticle accident with subsequent treatment for a colvical strain. Its: treatment induded conservative date with medications and physics: therapy. The datent reported dam centralized in her treck without significant radiation into her arms. No neurologic symptoms were identified in her aims. The last visit with me was October 28, 2015 when she reported essentially no symptoms and minimal paint

The medical records I received demonstrate a visit to a local oniropractor on January 13, 2016 with the abute criset of cervical pain, 7 days duration, pain raicd 10/10 with ractation into the left arm and associated Reutatogic signs. An MR. notes also on January 13, 2016 demonstrator, findings of disc degeneration and provisions at the C5-3 and C5-7 levels. A recommendation was made by the phyopiadiox to see to physicity evaluation for further treatment.

Quastions from the sombistrator included my opinion about the disc degeneration and protrysions and their relationship to the industrial injury. It is tikely the palient had disc degeneration oriot 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 har physical therapid. The patient responded to conservative care with resolution. The collective records from the incustrial injury support

(Page 1)

Eleigned by Dr. Scott Hell, MD on 03/16/2015 2:25PM

RECEIVED By SHMCO at 4:23 pm, Mar 17, 2016



### SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE DOB: 10/07/1979 Bex: F Provider: Dr. Scott Hall, MD Visit: 03/16/2016 2:15PM Chart: KUKI000001

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 obligaractor demonstrate the acuts onset of symptoms in her neck and left arm. Besec on the most (ecent visit from the chiropraphs, it would seem these symptoms started apontaneously 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 orthopediat and he noted degenerative changes in her lumbat spine. The suggests that the patient was having disc degeneration prior to the industrial injury in part of her spine

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

CM, ItaH stood bengils

(Page 2)

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



Me ch 4 2016

Kinoarly Line 305 Phina Dr. Wasnoe - aftey NV 89764

E. Claiment Claim No: Filmberly Kline -58535839641 6/25/2015

Injury Date: 5/25/2015 Employer: City of Reno

Date: N/a Klane

in compliance with the Meeting Office is became 1851155 and Mindle adverse in term one of east of the AST results and questioned with agreems good claim. After smooth and the dropp industry of the complementation plant. This became mindle dual all sevence has been popularly and the complementation of the became and the complementation of the complementation.

You are not being scheduled for a dispinity evaluation because Dr. Hall indicated the you do not have a result of your above-references stem.

If the demonstrate light for the contract of the light terrainstance of the contract of the second of the left of

If yo have any questions regarding the above matter pices: contact our office at 771 124 120 at 125

sc. File, City of Ranc

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### REQUEST FOR BEARING - CONTESTED CLAIM Pursuant to NAC 616C.274)

REALVIO

Department of Administration OF. Hearings Division 1050 E. William Street, Std. 400 Careon City, NY 88701 (775) 687-8440 Deprilment of Administration Hearings Division 2200 S. Rancue Drive Suite 175-Les Vegas, NV 89 00 (702, 486-2525 Employee Informition Employer Inforcation Joseffer 78 forfriedler. Third-Party Administrator Information Do Not Complete it Mail This Form Unless The Disague With the Insurer's Desentation. YOU MUST INCLUDE A COPY OF THE DETERM NATION LETTER OR A HEARING WILL NOT BE SCHEDULED PURSUANT TO NAS 616C.315 Brieffs expiall be past for this appeal The injured En playee Thus request for assuming is filled by or on behalf of The Employer and is daved rows . \_\_\_\_\_\_ day of \_\_\_ Signature of Injured Employer/Employer Injured Employee's Fauployer's Rep. (Advisor)

D-128 au (Inc



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

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05/09/2016 09:11

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May 2, 2016

### SENT VIA FACSIMILE: HARD COPY WILL NOT FOLLOW

Yesenie Julios 00MSI P.D. Box 200687 Rens, NV 89515

RE: Chairment: Kimberly Kilne Chaim No., 15853E83964!

DOI:

6-25-15

Dyar Mr. Narmnez

Picace of deviand less I have respond the Law Firm of Harb Sames, in the representation of the resistance in the improvement of the resistance with my producted oping which or content on Japa 25, 2015. Product Armed self-and the forest self-and and the self-and research self-and and the self-and research and the self-and research and the self-and research. in the light he pains contempondence, etc.

The signal of a situation constant is the modern provide the Athena parameters and a substitute for the signal constant in the situation of th mitter is greatly appreciated

Ушу иліу эсиль

Lancade Klore

Rimberly Kline

Recoved 1.27 83 2016

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05/02/2018 16:00

(FAX)775 \$23 5211

P.001/004



225 S. Arlington Ave, Suite C Ronc, Novade 89501 (775) 323-5200 Pax: (775) 323-5211

### **FAX COVER SHEET**

### FAX NUMBER TRANSMITTED TO:1-775-697-8441

Learings Office

From

Herb Santos, Jr. Client/Matter: Kamberly Kline/56373-3L

Date: May 2, 2016

Dr. Hansen report dated 1/13/16

COMMENTS.

NUMBER OF PAGES

Please be advised that Horb will be representing the Claimant for the above referenced hearing. Herb will participate by telephone at (7°5) 323-5200. Also anclosed is medical reporting that Horb 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

oc: Lisa Jones @ 324-0453

CCMSI - RENO

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\* NOT COUNTD'O COVER SIGET. IF YOU DO NOT PECEIVE ALL PAGES PLEASE TELEPHONE US DIMEDIATELY AT (775) 319-3100

05/03/2016 09:11

(FA00775 323 5211

P.002/004



May 2, 2016

SENT VIA PACSIMILE; HARD COPY WILL NOT FOLLOW

Yesenio Mertinez CCMSI P.O Box 200687 Rono, NV 89515

Chricant DOI:

Clair. No.

Kimberly Kline 158532839641

6-25-15

Dear Ms. Martinez:

Picese be advised that the appre-referenced Claimant has retained this office in apparection with the industrial injury else referenced above.

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

Thank you for your auticipated cooperation. Should you have any questions, please feel free to contex one at  $(776)\,323\cdot5200$ 

Very truly yours,

Herb Santos, Jr.

HJ8:ks

Received

MAY 03 2016

**CCNSHRENO** 

235 South Arlington Avesus, Spite C, Ikono, Nevado, 89581 Tel. (176) 373-5200 Fess (775) 323-5211 049-SANTOSLAW PIRM.com

(FAI)775 273 271 05/03/2016 09:11

### THE LAW FIRM OF HERB SANTOS IR

225 S. Arlington Avenue, Suite C Rene, Novada 89501 (775) 323-5200 Pax: (775) 323-5211

CHIRGRISATION IN REPASSED TOWNS INC.

To:

I hereby authorize you to pertrit Harb Santos, Ir., of the Law Firm of their Santos Ir. 212 South Arlington Avenus, Suite C. Pano, Nevede, 89501, or his duly authorized groups to inspect and obtain copies of all of my medical hospital and therapy records, reports, documents. prescriptions, papers and x-rays analos and and all renords per along it versitions, pre-temporal and ratiology together with copies of all politics for an of said stances, socident reports token by a police department of Highway Petrol, employment records which you have in your possession, control or custody I also authorize the relacto of my police report and any employment records I may have

You are baseby requested to discluse no information, orally or otherwise, to any insumant representative or other person, including a per physicians, without specific written authority from me to do so (pursuant to privileged and coaridential communications statutes). All prior authorizations are hereby canceled I hereby walve any privilege I leve to said information to my

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

Dated this 2 day of Man 2015.

Date of Birth: 10-07-79

Share KJino

Date of Acoldegt: 6-25-15

Received

P.004/004

MAY 03 2016

COMBLIGHT



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

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15853 E839641

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Thank runs

## STATE OF NEVADA DEPARTMENT OF ADMINISTRATION HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:

4

KIMBERLY KLINE 305 PUMA DR WASHOE VALLEY, NV 89704 Hearing Number: 36173-35-Claim Number: 186928859841

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

### BEFORE THE HEARING OFFICER

The C almost request the Hoaling was fliction April 5, 2016, and a Hearing was structured for May 3, 2016. The Hearing was both on May 3, 2016, in apportunite with Chapters 6.5 and 5.7 of the Newsda Revised Statutes.

The Claimant and her attorney, Herburt Sanies, Jr., were present by telephone conference call. The Employer was not crasent. The Insurer was represented by Lisa Jones of CCMS. Dy telephone conference call.

### ISSUE

The Claimant appeared the insurer's determination dated March 24, 2016. The established Hearing Officer is claim observe without a permanent partial disability IPPD award.

### DECISION AND GROEF

The determination of the Insurer is hereby AFFIRMED

On March 24, 2015, 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 last ter was instructed to provide Dr. Half with the MFI results and question him regarding the noco for further medical recatment, claim closure, PPD, etc. On March 16, 2016, Dr. Half responded and stated he found no a lattice evidence connecting the significant MRI industrial injury. As such the licening Officer firms the Insurer's determine on is proper.

APPEAL RIGHTS

Pursuant to WRS 615C 2450;, should any party desire it appeal this liner Decision and Order of the Hearing Officer, a request for appear must be filed with the Appears Officer within thirty (30) pays of the date of the decision by the Hearing Officer

IT IS 90 OEDERED this 6th day of May, 2016.

Jason Luis, Hearing Officer

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### 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 <u>DECISION AND ORDER</u> was deposited into the State of Nevada Interdepartmental mail system, OR with the State of Nevada mail system for mailing via United States Postal Sermice. 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

CCM91 PO BOX 20068 RENO, NV 89515-0068

Dated this 6th day of May, 2016.

Strong Single Employee of the State of Neveda

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HAY 0.9 2016
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#### Russell N. Anderson, DC 290 SE Court Street Prinaville, OR 97754 (541) 903-1444 (541) 362-4090-FAX

#### PERMANENT PARTIAL DISABILITY EVALUATION

Clarinum 15853F539645

Lisa Jones-Claims Representative

Date of Injury: 08\25\2015

Date of Evaluation: November 10th, 2017

Kimberly Köne presented to my Reno Office for a formal PPD evaluation on Faday, November 10<sup>17</sup>, 2017 at 8:80 AM. The insurance company approved the svaluation of her pervical spine

#### Treatment History

5\11\2015: Breti Men-Muir, MD: She is here for Billiower back pain. This is not work related 5he has been complaining of LEP for several months. It was exacerbated last months. It is \$\120 in severity. She takes dictofened, Zoloff, and ibuprofen. A history of degression. X-rays show L4-S dist DID. DX. discogenic back pain. Plant PT and voltaren.

6\25\2015. Richard Law, MD: Moderate oath in the upper lumbar spine, mid lumbar, and sover lumbar spine; radiates to the right thigh and left thigh. Sha had similar symptoms recently, had an MRI 1 month ago; nx of harriated disc at L3-4 and L4-5. She had had previous chronic LBP; intervertebral disc disease. Her meds include Zoloit. Exam show tendernass in the lumbar spine. Impression: acute lumbar radiculopathy, lumbar spine, and acute lumbar pain. Plant ice, limited activity, flexaril, nonce, pregnispone, follow in:

Plant ice, limited activity, flexeril, norco, premisons, follow up.

08/25/2015: This is a C-4-form that states "I was rearlended". The trainment was seen at St.

Mary's regional Medical Center BR. Her initial DX was acute furnoar sprain; MV2".

6/30/2015: Scott Hall, MD: She presents for her back after a [2"] IVVA or E [25] 15. She now reports, neet pain furnbar and thoracle pain. Assessment: nectrand back sprain, Plan.

chiropractic care, full duty work, recurs in 2 weeks.
7\29\2015: Scott Hall, MD: She continues with neck and back issues. Plan. FT, full duty, conservative treatment.

8\20\2012015; Scott Hall, MD; Her neck has improved and she describes only muscular tightness that is mild. She has no arm symptoms, PT has been neighbor. Plant complete her PT and monitor.

8\Z6\2015: Custom PT: She had a PT releval today: 12 more visits are recommended over the next 4 weeks.

9\23\2015: Scott Hall, MD: She reports improving NF; a 3:10. She is getting F7 20\28\\2015: Scott Hall, MD: Her neck has improved no current rignificant symptoms 資本包含 arm symptoms.

19 27 19

SCANNED

1464 2: 17 06:36p

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PAGE 2: Kim Kline continued

a\a\2016: MRI of the C-Spine: Impression. Disc degeneration with large protrusions at CS-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 myelomalacto.

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 "nigh 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. Plant cold pack to the neck, spinal decompression; 8-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.

2 15 2015. She states NP, numbricss, and weakness, same treatment.

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

02 (19) 2016: Decompression treatment and therapies

1\20\2016: She continues with chiropractic treatment

1\21\2016; Nothing new

J\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\2\16, ?\2\16, 2\5\16, 2\8\16. 2\10\16, ?\2\16, 2\16\16, 2\19\16\16, 2\19\16\16, 2\19\16, 2\16, 2\19\16, 2\16\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\19\16, 2\16

3\16\3016: Scott Hall, MO: 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 sportaneously 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 darmant had completely recovered from the industrial injury by the and of October, 2015.

4\78\2016: Bryan Hansen, DC: She presents with NP, weakness, and numbness. She is to do

7\\$\2036: Lali Sekhon, MO: Her CC is NF, stiffness, and left arm numbries 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 chiroporactic treatments. She had an apidural that really did not help. She rates her typ, HA and pressure feeling in the neck as \$\10\$ in severicy. The left arm symptoms are in a C6 distribution, her right arm is OK. She feels that she has plateaued. Assessment: cervicalgia, cervical some stenosis, C4-5 spondylolisthesis, failed conservative therapy, minimal spondylosis at C3-4 to E3-51. She has cord compression and weakness: Dr. Sokhon 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.

Receiver

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Page 3 Kim Kline continued

A\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 croub a 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 offerher 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 06 resulting in mass effect upon the ventral spinal cord and moderate to severe central anal stenosis.

C. Spine X-rays: Impression: mild disc narrowing and facet degenerative changes of the lower C-spine; development of retrolistnesss 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: Laft Sekhon, MD: She returns for review and all of her questions were answered She again requests surgery.

5\12\2017: Tall 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 ach ness in her neck; the left arm symptoms have improved. Follow in 4 weeks.

7\26\2017: Curt Erickson, PA-C (For Dr. Søkhan): 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\\$\2017: Curt Erickson, PA-C. Her symptoms are much improved, there is slight numbness in ther left hand, viery manageable. She has occasional neck pain. She believes the PT is nelping Cervical spine X-rays today show fusion from C4 to C7 with no evidence of hardware cumplications.

9\43\2027 Or Sekhon fills out a questionnaire from specialty Health. He says the dalment is stable and reached maximum medical improvement. She is released to full outy. 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 teceived fome chiropractic care. She tells me that this was mostly for lower back pain. She would get her neck (C-1916):

TRECETYES

MEN 2 2 1017

COMMIT Repo

No. 21-7 C 2/5

adjusted sometimes, but denies any significant prior neck pain, disability, or radiation upper Page 4 (Kimberly Kline cont.)

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

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

#### CURRENT SYMPTOMS

Currently, Ms. Kine has a chief complaint of frequent, daily headaches and limited mobility in her neck. She complaints 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 CS and/for 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

#### Cervica! Spine

the poetion reveals no cervical entaigns. She is in no distress. I absorve a surgical scar on the sinversor/left cervical region. It measures 7.2 CM.

Palpating the cervical spine soft tissue structures. I find the right scienius 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 gifth of the forearms, fillio 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 old appear to give her base effort on all RCM measurements.

Cervical Spine Active Ranges of Motion

Flex on. Calvarium 1 48 2 48 3 46

9:61/4

W 213 -

C ... Heno

## PAGE 5 (KIMBERLY ILLIUE)

T1 1. 8 2 4 3 5

Max ROM = 48-4= 44 degrees (1% WPi)
Extension. Calvarium 1 98 2 38 3. 38

T1: 1. 8 2 10 3.8

Max ROM = 38-8= 30 degrees (3% WPI)
Right Bending: Meao: 1. 38 2. 40 3. 44 4. 40

T1: 1 4 2 6 3 5

Max ROM = 44-6= 38 degrees (no impositment

Left Bending: Calvarium: 1, 38 2, 36 3, 36 T1: 1, 4 7 3, 4 Max ROM = 38-4=34 deglees (1% WPI)

Max ROM = 38-4= 34 deglees [1% Right Rotation 1 64 2 64 3 62 Max ROM = 64 degrees [1% V/Pr] Left Rotation 1 55 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+1+1>1 755 WPI from motion loss in the cervical spine.

tican efficit equal, +2 deep tendon reflexes at Right and Left biceps, bilachioredialis, and triceps

The disimant can demonstrate SNS strength, equal pilaterally at shoulder leibow, wrist, and lingers.

She has some decreased sensibility to light touch over the C6 derinatome on the left. This includes partial loss of 2 point distrimination over the paintail entiright and this finger 12 point sense at 9mm). This is grade 3 sensory loss, 25% sensory deficit of the C6 nervs root [Table 15 15]; we multiply this to the maximum upper extremity impairment for sensory loss at C6 (8% Table 15-17) and we got 2% left upper extremity impoirment 1% MPP

#### Impairment Calculation

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

As described above, this claiment has a cumulative total of 7% whole person imposment from motion loss in the cervical spins.

She has 1% WP! for sensory loss coming from the C6 nerve lost

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

Recel wa

95/21 7 547 5

# PAGE ( (KINDELLY KINE)

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. AlviA Guides, 5th Edition, page 3801.

#### 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 dialmant had underlying cervical spinel ssues that pre-date this work related car accident and injury. Namely, the MR and radiographic reports show cervical spine degenerative discs with large protrusions at C5-6 C5 7, effacement of the CSF and severe canal stenosis (MR) of 1/3/2016). It is not logical to believe that these findings are related to the car acadent that size 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 spline spondylosis, stendsls, and cord pressure at C4-

75% of this claimant's whole person impairment (cervical spine) is apportioned as non-

25% of her Impairment is industrial and related to the work injury that occurred on 6\25\2015 because.

- . The claiment had no documented cervical spine in tary or pain immediately after the accident (symptoms began 6\50\2015). After that the cervical strain could be described as slight.
- The findings of cervical spine spondylosis, stenasis, and disc bulges cannot be logically artributable to this car accident/work injury. These findings provided the indication for fusion surgery in the carvical 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 dialmant denies any prior upper extremity symptoms (radiculopality), 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

Nov 21 17 04:215

р.₿

PAGE 7 (KOMPERU KLINE)

56, 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 accurred on 6\25\2015.

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

Russell N. Anderson, DC

AA 1288

Nov 21 17, 04, 22p

Russell N. Anderson, DC 290 SE Court Street Prinaville, OR 97754 (541) 903-1444 (541) 262-4030-120

#### BILLING STATEMENT

November 215, 2017

Claimant: Kimberly Kline Claim #: 15853E839641

CCMSI-Lisa Jones-Claims Representative Date of Evaluation: November 10th, 2017

Service Performed: NV01000: Records review, PFD Exam and Report

5804

Service Performed at: 1699 5 Virginia Street

Suite 100 Reno, NV 89502

Please sand 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



December 5, 2017

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

Claimant Claim No. DO.L.

Employer:

Kimberly Kline 15853£839641 6/25/2015

City of Reno

Dear Ms. Kline:

We are in record of the fueself has expliced Permanent Ferral Disputity (PRD) regain. Peto to remain 10, F017, has broad, of your Petote and Petote Disputity (PRD) to also you have been prairies a gain anent carber research, clward of six 15%) describ on a write story basis for respondent of the cervical.

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

The provided with the stand developmentation to the rate of the state of tental of tental of the stands of the sta within seventy (70) days after the date on which the notice of this determination was malled

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

Claims Depresental va

CCMSI - Renc Nevada

File, City of Renc, Tirr 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

305 PUMA DR WASHOE VALLEY, NV 89704-9739 CITY OF RENU ATTN ANDRENA ARREYGUE PO BOX 1900

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.

JAN 1 - 2018

Time:

McDONALD CARANO

In the Matter of the Contested Industrial Insurance Claim of Hearing Number:
Page two

KIMBERLY KLINE 1801761-JL

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

Jeson Luis, Hooring Officer

**AA 1292** 

#### 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** 

Employee of the State of Nevada



April 4, 2018

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

Claim No.:

15853F839641

0.Q.L: Employer: 6/25/2015

Body part:

City of Reno 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 checking at least 40 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 conof your driver's license, birth certificate, or other official record that documents your exact age with you to the evaluation, or send a convito 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 interv. 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 crose 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.

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



Page 2 Re: Kimberty Kline April 4, 2018

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 Nevaca, 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.

Claus Repros

Chillie fono, Nevada

CC

City of Reno

Lisa Wiltshire-Alstead, Esq.

Herb Santos, Esq.

Dr. Jempsa

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

# REQUEST FOR HEARING - CONTESTED CLAIM

(Pursuant to NAC 616C.274)

REPLY TO

Signature of Injured Employee/Employer

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 89.02 (702) 486-2525

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

		Employer Information				
Employee s Name and Address		Employer's Name and Address				
KIMBERLY KLINE		CITY OF RENO				
305 Puma Dr WASHOE VALLEY, NV 8	8764	1 EAST FIRST STREET				
WASHOE VALLET, NV 8	9704	RENO, NV 89505				
Empleyee's Telephone Number	Classi No. 15853E83964	Employer's Telepione Number				
775-326-6637	3an 30tays ← 36125121 - 5	775-326-6637				
Insurer Information		Third-Party Administrator Information				
Table (Ayunt de sedicin		Third-Party Administrator's Nethboard Applicas				
as relisio conorre humber		Third-Party Administrator's Telephone Number				
Do Not Complete or Mail	This Form Unless Yo	u Disagree With the Insurer's Determination				
YOU MUST INCLUDE A BE SCHEDULED PURSU	COPY OF THE DETI	ERMINATION LETTER OR A HEARING WILL NO				
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	COPY OF THE DETI PANT TO NRS 616C.31 this appeal:	ERMINATION LETTER OR A HEARING WILL NO				

**AA 1296** 

# JAMES C. JEMPSA, DO

Reno, Nevada

Telephone: 775-786-9072

Fax:

775-787-6430

Lisa Jones CCMSI PO Box 20068 Reno, NY 89515

Telephone: 775-324-3301 Fax: 775-324-9893

### PERMANENT PARTIAL DISABILITY EVALUATION

RE

CLAIMANT:

Kimberly Kline

SSN:

CLAIM NO .:

15853E839641 06/25/2015

DOI: EMPLOYER: DATE OF EXAM:

City of Reno 05/08/2018 05/14/2018

DATE OF REPORT 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.

1 3 3 3 3

Page 1 of 12

AA 1297

Dear Lisa Jones:

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

#### PERS NAL 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 pair. It is described as being motionate degree of pair, in the upper lumbar and 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. Nec 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 Client. 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: I. Neck discomfort-moderate, diffuse, tadiation into the right shoulder, associated stiffness. 2. Lumbar and thoracte pain-diffuse, nonradiating, no red flags, no rumbness or weakness reported and legs. Physical Exam. Cervical examinable diffuse muscular tendentess 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 externes. Assessment. Sprain of neck. Plan: Chiropractic, full duty, return in two weeks.

On May 11, 2015 initial evaluation by Dr. Men-Mur. 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 numbriess or weakness. Physical Exam: Miscouloskeletat: Neck-normal inspection, mild diffuse muscular tenderness to palpation, grossiy normal strength and sensation. Assessment: Sprain of neck Plan: Physical therapy, Puliculty, 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 Illnoss. 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 Specially Health Clinic. History of Present Illness: Patient reports improvement in her neck without significant symptoms currently, no and symptoms reported. Patient has completed treatment. Physical Exami Muscuinskeietal: Neck exam-normal inspection, nontender to palpation, full motion with grossly normal strength. Assessment: Sprain of ligament of the cervical spins Plant 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 myelomalada.

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

On January 14, 2015 chiropractic treatment by Dr. Hansen.

On January 15, 2016 chiropractic treatment by Dr. Hansen

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

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

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

The World State

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, 2015 chiropractic treatment by Dr. Flansen

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. Hanson

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 forcam down to the thumb in the C6 distribution. Her right arm is okay. She feels she has placeaued. 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 forcarm in the C6 distribution. On physical examination, she has 4/5 weakness in external rotators in the left, bireps 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 C5-5 and C6-7. 2. Mobile spendylolisthesis at C4-5. 3. Failed conservative therapy 4. Minimal spondylosis, L3-4, L4-5 and L5-81. Klimberly 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 terrior, decompression and instrumented fusion.

On April 3, 2017 follow-up neurosurgical visit. Chief Complaint. 1. Neck pain and stiffness. 2 Left and numbriess and pain. History of Present Illness: She has continued with posterior neck pain and pressure. The pain continues to extend down the left aim following the left C-6 distribution. Most of his symptoms are in the left and 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 numbriess of the left form in the C6 distribution. On physical examination, she has 4/5 weakness in external intators on the left hiceps and triceps on the left. She has depressed reflexes in the upper extremity. Assessment and Plant 1. Neck pain 2 Cervical spondylosis 3. Spinal stenosis and cervical region Plant 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. Interession: In Mila disc space narrowing and facet degenerative change of the lower cervical spine. 2. Development of retrolisthesis of 2 mm of retrolisthesis C/ 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 poster or 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: I. Neck pain and stiffness. 2. Left arm numbness and pain. History of Present Illuess: 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 forcard and the C6 distribution. Physical examination, she has 4'5 weakness in externa' 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 one 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 weekness.

FUENCE

in external rotators on the left, brought biceps and triceps on the left. She has depressed reflexes in the upper extremity. Impression: 1. Corvical 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 derivical decompression and instrumented fusion.

On June 12, 2017 operative report by Dr. Sakhon, Preoperative Diagnosis, Cervical sterosis, Postoperative Diagnosis, Cervical sterosis, Title of the Procedure; 1, C4/5, C5/6, and C6/7 Anterior cervical decemps asson 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 interodissection, 5, Fluoroscopic guidance for placement of the screws.

On June 26, 2017 postop neurosurgical visit. Chief Complaint: I. 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 numbress in her ann and hand specifically have improved. She still has some achiness posteriorly of her neck. She has some mild dyaphasia 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 lablet 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 odoma 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: I. 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 corvical x-rays. 2. Call with any questions or concerns or changes in her cordition.

On July 24, 2017 x-rays of the cervical spine with floxion 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 liness Today, she presents to six weeks postoperative review. She continues to notice improvement to the left upper extremity symptoms. Left ann is overall much improved, but she has noticed some ongoing numoness in the left hand and forearm. Her posterior neck pain has mostly sented and her swallowing is not problematic. She occasionally takes about one pain tablet towards the end of the day, but off-erwise 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 5.75 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

MAY 1 & 2018 CAMPS - TOWN - TO

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 bijaterally. 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 states. 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 thurns.

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 mestal 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 oriving a car. She states severe difficulty with restfit sleep secondary to pain.

#### PART 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, 20, 5.

Pas. Surgical History Right ankle surgery 2013.

Medications Advil.

Liergies to Modicanons. No known drug allergies.

### PHYSICAL ENAMINATION:

On May 8, 2018 the claimant stood 67" tall and weighed 173 pounds. The claimant is right hand dominant.

This person's general appearance is that of a well-hydrated, well-neurished acult 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 orthodic device.

On visual inspection of the cervical spine there was normal development. There was a 7 cm surgical scar located over the left antenor inferior aspect of the neck. The scor was generally straight in appearance and normal in color. On palpation of the neck there was muscle sightness along the paravertebral musculature. On strongth testing, motor strength was 5/5 in all nuscle groups of the right and left upper extremities. On sensory testing there was intact sensation to light and sharp touch except for the left thorne which was 4.56 on monofilanien, testing. Deep tendon reflexes at the biceps and triceps were  $\pm 2/r4$  hilterelly. The right and left upper extremities have normal temporal we color and pulses. There was no evidence of strophy, upper arm and forcarm direcumferences were equal bilaterally.

Range of motion of the cervical spine:

San Areni

The claimant was informed not to perform any motions that were painful or that she was uncomfortable performing or that might cause her narm. 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.

Movemen	: Description	Rang	e		
Corvical	Calvazium angie	40	40	41	
Flexion	TI ROM	20	20	30	11000000
	Maximum cervical flexion angle	20	20	20	
	-10% or 5°	*Yes	No		
	Maximum cervical flexion angle	20			
	% impairment				
Movemen:	Description	Range	-		
Cervical	Calvariter, angle	20	20	20	-
Extension	TIROM	5	1 5	1 5	
	Cervical extension angle	! 15	13	15	
	-10% or 5	- Yes	: 10		
	Maximum cervical extension angle	1 15			
1	% Impairment	1 5		-11-	
Movement	Description	Rungo			
Certical	Calvarium angle	; 30	1 30	30	-14-20 000-
Left	TI ROM	,	10	10	
Lateral	Cervical loft lateral flexion angla	. 20	20	20	
Bending	+10% or 5°	*Yes	No		- Temperature
	Maximum cerucal left fateral	20			-
	flexion angle				
	% impairment	2			_
Movement	Description	Range			
Cervical	Calvarium angle	30	30	30	-
Right	TI ROM	10	10	:0	
ateral	Cervical tight lateral flexion angle	20	20	20	
Bending [	-10% or 5°	Yes :	No		
ŗ	Maximum cervical right lateral	20			
	flaxion angle % impairment	2 .			
	AN ASSISTANT OF THE STATE OF TH	۷ .			

Movement	Description	Range				
Cervical	Cervical left rotation angle	40	40	43	1	-
Left	+10% or 5°	*Yes	25			
Rotation	Maximum cervical left rotati	on 40				
	% Impairment	5				
Movement	Description	Range			-	-
Cervical	Cervical right rotation angle	40	40	4(		
Right	±10% cr 5°	* Y es	Ne			
Rotation	Maximum cervical right rotation angle	40				
	% impairment	1				

#### SHIMMARY 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 Cr-Sekhon.

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

## IMPAIRMENT EVALUATION ACCORDING TO THE GUIDES.

Impairment rating was done according to the Pifth Beitton. Sixth Printing AMA. Guides to the Evaluation of Permanent Impairment. The examination, measurements and impoirment 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 lated according to the calvical spine.

On page 380 right hand column. Range of motion method if: b. there is redical openly bilisters in 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 tange of motion of the impaired spinal region; (2) accompanying diagnosis (Table 15-7), and (3)

MAY 1 4 2015

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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 conthining ratings from all three components, using the combined values chart (p. 504).

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, Corvical Region Impairment from Abnormal Flexion or Extension of 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 15-15, Impairment Due to Abnormal Motion and Ankylos's of the Carvical 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 Duo to Abnormal Motion and Ankylosis of the Corvical Region: Rotation. Right rotation of 40° equals 2% whole person impairment. Left rotation of 40° equals 2% whole person impairment. Therefore, total impairment due in abnormal relation equals 4% whole person impairment.

Therefore 16% who e 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, muniplying 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%.

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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 INFAIRMENT: 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 the.

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:

Re:

Kimberly Kline 15853B839641

Claim No.: D.O.I.:

6/25/2015

Body Part:

Claimant:

Cervicai

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.

Gy of Reno, Herb Santos, Esq. Lisa Wiltshire Alstead, Esq.

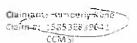
Enc. Dr Anderson PPD report

CANNON COCHRAN MANAGEMENT SERVICES, INC. - P.O. Box 20068 - Reno, NV 89515-0068 (775) 324-3301 Fax: (775) 324-0453 WWW.ccmai.com

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Russell R. Anderson, DC 290 SE Court Street Prineville, DR 97754 [541] 903-1444 (541] 362-4090-FAX

#### PERMANENT PARTIAL DISABILITY EVALUATION



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 13-4 and 14-5. 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 (2\*\*) MVA on 6\35\15 She no

6\30\2015: Scott Hall, MD: She presents for her track 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. Retired Ved arm symptoms.

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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\2015: The notes are about the same today.

01\19\2016: Decompression treatment and theraples.

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

1\21\2016: Nothing new.

1\25\2016: Same notes and treatment.

3\16\3016: Scott Half, 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\\$\2016: Lall 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 CK. She feels that she has plateaued. Assessment: cervicalgia, cervical spine stenosis, C4-5 spondylolisthesis, failed conservative therapy, minimal spondylosis at 13-4 to L5-51. 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.

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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 poster or 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-roys: 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: Lall 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: Lall 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-Ct. 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 Or. Sekhon): The X-rays show no instability. She has ongoing numeriess in the left hand and forearm, not as bad as before.

&\10\2017: Amanda Cowles, PT (Custom PT): She is having some trouble with ACLs. 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 pending 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)

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adjusted sometimes, but denies any significant prior neck pain, disability, or radiation upper Page 4 (Kimberly Kline cont)

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 reattach 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 C5 and\or ulnar nerve pattern.

Kim is having some difficulty with looking up to finse 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 spienius 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-feet.

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 inclinomaters. The claimant did appear to give her best effort on all ROM measurements.

Cervical Spine Active Ranges of Motion

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

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# 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 RGM = 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 raflexes at Right and Left biceps, brachiotadialis, 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 paimar 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.

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Nov 21 17, 04:21p p.7

# PAGE ( (KIMBERLY KLIME)

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 Guldes, 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 ciscs 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-

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.

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PAGE 7 (Kumberry 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 5\25\2015).

#### PERMANENT IMPAIRMENT SUMMARY

The claimant has 25% whole person impairment coming from the cervical spine. Of this, 5% 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

Received

NOV 2 2 2017

# 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: CLAI DOI:

CLAIM NO .:

EMPLOYER:

15853E839641 06/25/2015 City of Reno 05/08/2018

DATE OF EXAM: DATE OF REPORT: BODY PARTS:

of CS no

05/18/2018 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 claiment stated that she had no problems with her neck prior to her industrial injury of June 25, 2015. It have not received any medical records prior to the industrial injury of June 25, 2015. In accordance with NAC 516C.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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\* CONSI Read



May 24, 2018

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

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 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.

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 516C.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 85102 (702) 486-2525

Employee Information		Employer information				
Employer's Name and Address KiMBERLY KLINE 305 Puma Dr WASHOE VALLEY, NV 8	89704	Emptoyer's Name and Address CITY OF RENC 1 EAST FIRST STREET RENO, NV 89505				
Employee's Telephone Number	Clar No. 15853E83964	1 Employer a Telephone Number				
775-326-6637	Date of Injury 06/25/2015	775-526-6637				
Insurer Information	<u> </u>	Third Barry Administrator Information				
Insurer's Name and Address		Third-Party Administrator Information Third-Party Administrator's Name and Address				
o Not Complete or Mai	il This Form Unless Yo	u Disagree With the Insurer's Determination.				
E SCHEDULED PURS	A COPY OF THE DET! UANT TO NRS 616C 3:	ERMINATION LETTER OR A HEARING WILL NO				
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OU MUST INCLUDE A E SCHEDULED PURS riefly explain the basis for	A COPY OF THE DET! UANT TO NRS 616C 3. r this appeal	ERMINATION LETTER OR A HEARING WILL NO				

### 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

RE:

#### PERMANENT PARTIAL DISABILITY EVALUATION ADDENDUM

Kimberly Kline

CLAIMANT:

SSN:

SSN:
CLAIM NO. 15853E839641
DOI: 05/25/2015
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 apport comment 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 reports 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 impriment 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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## JAMES C. JEMPSA, DO

Reno, Nevada

Telephone:

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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 06/25/2015

DOI: EMPLOYER: DATE OF EXAM:

City of Reno 05/08/2018 05/14/2018

DATE OF REPORT: 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.

Page 1 of 12

Received

SCAMMIED

CONSI-Reto

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.

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MAY 1 4 2018

The claimant has not served in the military.

COMST-Reno

### 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 prodnisone.

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 Examt: 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.

SCANNED

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 tendemess 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 Examp Musculoskeletal: Neck exam-normal inspection, minimal muscle tenderness to palpation, full motion, normal strength and sensation in both arms. Assessment: Sprain of neck. Plant Physical therapy, Full duty, return in two weeks.

On October 28, 2015 follow-up visit at Specially 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 myelomalaoia.

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.

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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

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On July 5, 2016 neurosurgical evaluation. Chief Complaint: I. 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 sears. Palpation for tenderness. Anns have normal range of motion with no sears. 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

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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 amerior cervical decompression and instrumented fusion.

Oc 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 esteophyte 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 forcarm 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 spondylosishesis at C4-5. 3. Failed conservative therapy. 4. Minimal spondylosis, L3-4, L4-5 and L5-typersening symptoms and stemosis 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 carvical spine. She has numbness of the left form in the C6 distribution. On physical examination, she has 4/5 weakness

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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, Fluorescopic 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: American 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 pair, 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:

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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 shorting 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: I. 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 fat sensory function is concerned: She states no diff code was scoing, smelling, tasting, feeling sharp versus dull and feeling hot versus cold except for her left thumb.

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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 reals managing money/checkbook, taking medications, and using public transportation. She states mild difficulty with working around the house/housework, using the phone or writing ietters 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 FXAMINATION:

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 tighness along the paraverlebtal 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  $\pm 2/\pm 4$  bilaterally. The right and left upper extremities have normal temperature color and pulses. There was no evidence of anophy, 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.

Movemer	it Description	Ra	nge				~	
Ccrvical	Calvarium angle	4	0	40	)	40		
Flexion	TI ROM	2	0	20		20	1	
;	Maximum cervical flexion angle	2	0	20		20		•
Ť 1	+10% or 5°	*Y	es	No	1			-
}	Maximum cervical flexion angle	20	0					
line .	% Impairment	3						
Movement	Description	Ran	Op.	-				
Cervical	Calvarium angle	. 20		20	2	0		
Extension	TIROM	5		5		5		
	Cervical extension angle	15	44	15	1	-		
	+10% or 5"	*Ye		No	- 4	-		-
	Maximum cervical extension angle	15				-		
	% Impairment	5						
						-		
Movement	Description	Rang	C		-	***	-	-
Cervical	Calvarium angle	30		30	30			
Left	TI ROM	10		10	10		-,-	
Lateral	Cervical left lateral flexion angle	. 20	-	20	20			
Bending	+10% or 5°	*Yes	1	vo .				-
	Maximum cervical left lateral	20						***
	flexion angle	!						
	% Impairment	2						
Novement i	Description	Range		- 0-				
ervical	Calvarium angle	30		00	30	1		-
ight	T1 ROM	10	-	0 1	30 10	1-	-	-
ateral	Cervical right lateral flexion angle	20		0	20			
ending	+10% or 5°	*Yes	No		20	-		-
	Maximum cervical right lateral:	20	146	,			-	
	flexion angle	-0				1	Same	90 .

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Movement	Description	Range	е			
Corvical	Corvical left rotation angle	40	40	1 40	)	
Left	+10% or 5°	*Yes	No			- 1-
Rotation	Maximum cervical left rotation angle	40				
	% Impairment	2				
Movement	Description	Range		-	-	_
Cervical	Cervical right rotation angle	40	40	40		
Right	+10% or 5°	*Yes	No			
Rotation	Maximum cervical right fotation angle	40			The state of	

#### 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. Sekhop.

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 Princing 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 (Taple 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 Ankylesis of the Cervice 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, inultiplying 30% times 3% 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 one.

Sincerely,

James C. Jengea, DO

Board Certified American Board of Osteopathic Family Physicians, Member, American College of Osteopathic Family Physicians, DIR Designated Rating Physician, State of Nevada

Received



Jay E. Betz, MD Medical Director

Occupational Medicine Injury Care Briployer 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 Kimberiy 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. Men. Muir for low back pair related to a previous auto accident about 6 weeks prior to the 2nd motor vehicle accident on June 25, 2015. Ms. Kline was now compraining of neck, upper back and low back pain. After examination she was diagnosed with neck sprain. Chiropractic care was recommended.

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

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

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

in follow-up with Dr. Hali at Specialty Health Clinic on September 23, 2015. Ms. Kline again reported improving but persistent mild new 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 certical 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. Kille 13d essentially no symptoms on October 28, 2015 when she was discharged but was complaining of acute onset of neck pain of 3 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 one-operator 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 entropractic treatments from Dr. Hanser between landary 14th and April 28, 2016 without lasting benefit

Neurosurgical consultation was obtained from Dr. Sekhon on July 5, 1016. He indicated the patient had pre-existing spondylosis C4 through C7 with cord compression C5-6 and C6-7, mobile spondylolistnesis at C4-5 and lailed conservative therapy. He felt the accident exacerbated her underlying stemps. He offered anterior cervical decompression and fusion C4 through C7.

in neurosurgical follow-up on Apr. 3, 2017, repeat MRI and cervical e-rays were recommended

Repeat x-rays on April 21, 2017 choxied in Ididisc space narrowing and facet degenerative changes of the tower pervical spine with development of retrolisthesis of 2 millimeters C4 on 5 and 1 millimeters C5 on 7. MPT on the same day showed moderate posterior disclosteophyte complex at C4 through C6 resulting in mass effect upon the ventral spinal cord and moderate to severe central stenosis.

in following with the neurosurgeon or April 25, 2017, surgery was again recommended. He note: Ms. Kline had some weal ness and depressed reflexes in the left arm.

On lune 12, 2037 Or Beknon performed an annelity cervical decompression 04 throught Tiplicived by interbody fusion

In followup fir. Seknon feir the patient was improving and physical therapy was recommended. 👚 💥 🖽 🖫

X-rays on September 5, 2017 showed on hardware complications

On September 6, 2017-12 Weeks postor, the patient reported improvement. Example wes intermediately and provement of the patient reported improvement. Example were equal and normal bilaterally.

On September 11, 2017 Or. Sekhon le't Ms. Kline was MM, and she was released to full but?

A rating evaluation was then performed by Dr. Russell Anderson, on repractor on the LE 2015 Fe noted the patient still had headaches and imited mobility of her neck with numbness in the left wrist and hand affecting the C6 distribution. On examine found imited 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

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motion and 1% for sensory charges in the Combined total was 19% whole person impairment.

However, Dr. Anderson noted that under the DRE method the patient would be allowed a min mum a 25% whole person impairment and suggested that 25% be the appropriate a lower of the patient and suggested that 25% be the appropriate a lower of the patient and suggested that 25% be the appropriate a lower of the patient would be allowed a min mum as 25% whole person impairment and suggested that 25% be the appropriate a lower of the patient would be allowed a min mum as 25% whole person impairment and suggested that 25% be the appropriate a lower of the patient would be allowed a min mum as 25% whole person impairment and suggested that 25% be the appropriate a lower of the patient would be allowed a min mum as 25% whole person impairment and suggested that 25% be the appropriate a lower of the patient would be allowed as a min mum as 25% whole person impairment and suggested that 25% be the appropriate a lower of the patient would be allowed as 25% whole person impairment and suggested that 25% be the appropriate a lower of the patient would be allowed as 25% between the patient whole person impairment and suggested that 25% between the patient would be allowed as 25% between the patient whole person in the patient would be allowed as 25% between the patient whole person in the person whole person whole person whole person whole person whole person whole pers

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

A 2nd impairment evaluation was performed on May 8, 1018 by Dr. James Jembse, D.D. Henoter Ms. Kline st. II had a tight sore neck, shoulders and daily headaches with numberess in the left arm to the thumb. (In examination ne found normal strength in the upper extremities and symmetrical reflexes but decreased sensation over the laft thumb. Pange of motion measurements from significant Jusses in flexion and extension and moderate losses in lateral flexion and extension and moderate losses in lateral flexion and extension.

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.

#### DISCESSION/CONCLUSIONS:

Both Er Anderson and Er. 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% while person impairment utilizing Table 15 - T 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 Or Anderson versus Dr. Jempsa allowing 7% and 16% respectively.

As noted on page 390 of the Guides, "the physician should seek consistency when testing across motion. Tests with inconsistent results should be repeated. Results that remain inconsistent should be disnegarded." 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 supportive le, potentially under the influence of the individual. It is important to appreciate this and not confuse such observations with truly objective findings."

Clearly, Dr. lemps as 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 wall recognized that patients learn from prior rating experience. This can have a great effect when

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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 andwance 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 Edividual with both methods and award the higher rating."

The 2nd issue of concern is apport to ment which has a greater impact in this case. On Ancerson 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 opining on warthine 2016, in which he noted Ms. Kline's cervical symptoms were initially consistent with a sprain strain and that she necovered completely from the industrial injury with conservative treatments by the end of Cotober 2015. He went on to conclude there is no objective evidence to connect the patient's significant Violatindings 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 neve abute injury related pathologies on MiR.

If the occupational includent has significantly aggravated the patient's precisiting pathologies, the development of radicule on thy symptoms and findings would be expected in the first few days or weeks, not 3 months, after. Consequently it is likely that the potient shad cular symptoms were the result of a natural progression of her significant multilevel degenerative changes rather than the higher

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 multillere cervical disceptions 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 apportion need may be allowed if at least 80% of the total present impairment is due to a pre-existing or intervening interpretates or condition."

Consequently: Dr. Anderson's conclusion that 70% of the patient's impairment allowence should be apportioned to pre-existing pathologies is reasonable and supported by the Guides and MAC 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 he sitate 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



June 13, 2018

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

Re:

Claimant:

Kimberiy 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 pottom 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.

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.

In the Matter of the Co. sted Industrial Insurance Claim of Hearing Number: Page two

KIMBERLY KLINE 1803717/1803718-JL

# 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 8950 I

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

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

CCMSI PO BOX 20068 RENO, NV 89515-0068

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

Employee of McDonald Carano LLP

4822-6259-2879, v. 1

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### NEVADA DEPARTMENT OF ADMINISTRATION 20/9 APR BEFORE THE APPEALS OFFICER 2 In the Matter of the contested Industrial Claim No.: 15853E839641 Insurance Claim Hearing Nos.: 1803717-JL of 1803718-JL 1901522-JL KIMBERLY KLINE Appeal Nos.: 1900471-RKN 7 Claimant. 1902049-RKN 8 9 INSURER'S FIRST SUPPLEMENTAL DOCUMENTARY EVIDENCE 10 Index **Document Description Page** 11 9/20/18 Insurer Determination \_\_\_\_\_\_1 12 12/27/18 Hearing Officer Decision (Appealed)......2 13 14 **AFFIRMATION** 15 Pursuant to NRS 239B.030 16 The undersigned does hereby affirm that the preceding INSURER'S FIRST 17 SUPPLEMENTAL DOCUMENTARY EVIDENCE, filed in Nevada Department of 18 Administration Appeal Nos. 1900471-RKN & 1902049-RKN does not contain the social security 19 number of any person. 20 21 22 Attorneys for Employer 23 CITY OF RENO 24 Administered by: CCMSI 25



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  $\chi$ 

CANNON COCHRAN MANAGEMENT SERVICES, INC. - P.O. Box 20068 - Reno, NV 89515-0068

Representative - Reno, Nevada

CC:

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

RECEIVED

DEC 0 3 2018

CCMSI - Reno



# STATE OF NEVADA DEPARTMENT OF ADMINISTRATION **HEARINGS DIVISION**

In the matter of the Contested Industrial Insurance Claim of:

Hearing Number: 1901522-JL Claim Number:

15853e839641

KIMBERLY KLINE

CITY OF RENO POLICE DEPARTMENT

305 PUMA DR CARSON CITY, NV 89704-9739

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 Alstèad, 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**

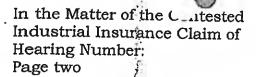
The determination of the Insurer is hereby AFFIRMED and REMANDED.

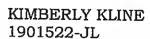
On September 20, 2018, the Insurer noticed the Claimant that in compliance with a denied Motion for Temporary Stay Pending Appeal, it was granting a PPD award of 27%. The Insurer offered the undisputed 6% in either installment or lump sum and the undisputed 21% in monthly instalments, the instant appeal. INRS 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.

**AA 1346** 

DFC 28 REC'D

002





### **APPEAL RIGHTS**

Pursuant to NR\$ 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

Pursuant to NRCP 5(b), I hereby certify that I am an employee of McDONALD CARANO LLP, and that on the 15<sup>th</sup> 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	Appeals Officer
☐ Email	Department of Administration
☐ FedEx	1050 East William St., Suite 450
Hand Delivered/Filing	Carson City, NV 89701
U.S. Mail	Herb Santos, Jr.
\overline Email	225 S. Arlington Ave., Ste. C
FedEx	Reno, NV 89501
Hand Delivered	
Facsimile	

Employee of McDonald Carano LLP

# NEVADA DEPARTMENT OF ADMINISTRATION BEFORE THE APPEALS OFFICER

In the Matter of the contested Industrial

Claim No.: 15853E839641

Insurance Claim

Hearing Nos.: 1803717-JL

of

1803718-JL 1901522-JL

KIMBERLY KLINE

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Appeal Nos.: 1900471-RKN

Claimant.

1902049-RKN

# INSURER'S SECOND SUPPLEMENTAL DOCUMENTARY EVIDENCE

Index	<b>Document Description</b>	<u>Page</u>
1/24/19	Insurer Determination	1

### **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.

Attorneys for Employer CITY OF RENO

Administered by: CCMSI

AA 1349

1143



January 24, 2019

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

Re:

Claim No.:

15853E839641

D.O.L.:

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,

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)

OR

REPLY TO:

Department of Administration

Hearings Division

1050 E. William Street, Ste. 400

Carson City, NV 89701

(775) 687-8440

Department of Administration

Hearings Division

2200 S. Rancho Drive, Suite 210

Las Vegas, NV 89102

(702) 486-2525

Employee's Name and Address  KIMBERLY KLINE 305 Purns Dr Washoe Valley, NV 89704  Employee's Telephone Number  Claim No. 15853E839641  775-326-6637  Date of Injury 06/25/2015  Employee's Name and Address  CITY OF RENO 1 EAST FIRST STREET RENO, NV 89505  Employer's Telephone Number  775-326-6637					
KIMBERLY KLINE 306 Purns Dr Washoe Valley, NV 89704  Employee's Telephone Number Claim No. 15853E839641  775-326-6637  CITY OF RENO 1 EAST FIRST STREET RENO, NV 89505  Employer's Telephone Number					
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Insurer Information Third-Party Administrator Insurer's Name and Address Third-Party Administrator's Name and Address	Information				
Insurer's Telephone Number Third-Party Administrator's Telephone Number					
DELEASE CHECK HERE IF YOUR REQUEST IS REGARDING A CLAIM FILED PURSUANT TO NRS 617.455 OR 617.457 OU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARING					
PLEASE CHECK HERE IF YOUR REQUEST IS REGARDIN A CLAIM FILED PURSUANT TO NRS 617.455 OR 617.457 OU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARINGE SCHEDULED PURSUANT TO NRS 616C.315.					
PLEASE CHECK HERE IF YOUR REQUEST IS REGARDIN A CLAIM FILED PURSUANT TO NRS 617.455 OR 617.457 YOU MUST INCLUDE A COPY OF THE DETERMINATION LETTER OR A HEARINGE SCHEDULED PURSUANT TO NRS 616C.315.					

### PERMANENT PARTIAL DISABILITY AWARD CALCULATION WORK SHEET

SS# .	mployee:	Kimbi	erly Kline	D. O. I	DOB: .: 6/25/2015	10/7/1979 Claim#	Sex:	Female
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D-9a (rev 12/16) AA 1352

# **CERTIFICATE OF SERVICE**

Pursuant to NRCP 5(b), I hereby certify that I am an employee of McDONALD CARANO LLP, and that on the 30<sup>th</sup> 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	Appeals Officer
Email	Department of Administration
FedEx	1050 East William St., Suite 450
Hand Delivered/Filing	Carson City, NV 89701
	Fax: 775.687.8421
U.S. Mail	Herb Santos, Jr.
☐ Email	225 S. Arlington Ave., Ste. C
FedEx	Reno, NV 89501
Hand Delivered	Fax: 775.323.5211
A Facsimile	

Employee of McDonald Carano LLP

4845-5127-6949, v. 1

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NEVADA	<b>DEPARTMENT</b>	<b>OF</b>	ADMINISTR	ATION!

# BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim

Claim No:

15853E839641

of

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Hearing No:

1801761-JL

KIMBERLY KLINE,

Claimant.

Appeal No:

1802418-RKN

# **INSURER'S THIRD SUPPLEMENTAL DOCUMENTARY EVIDENCE**

<u>Index</u>	<b>Document Description</b>	Page
5/14/18	James Jempsa, DO (PPD Evaluation)	1
5/18/18	Insurer's Correspondence w/ Enclosures	14
5/18/18	James Jempsa, DO (PPD Evaluation Addendum)	22
5/24/18	Insurer's Correspondence w/ Enclosures	24

### **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.

24 Attorneys for Employer

CITY OF RENO

Administered by: CCMSI

ENTERED INTO



15252E2391641

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

#### **FACSIMILE TRANSMITTAL**

To:	Lisa Jours
	- MS
From:	James C Jenpse Du
á	13 43
Fax: _	324-9873
	5/14/2018
	Pages (including cover):
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The information contained in this facsimile is privileged and confidential protected from disclosure. If the reader of this facsimile is not the intended recipient, you are hereby notified that any reading, dissemination, copying or other use of this facsimile is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately by telephone at (775) 786-9072. Thank you.

Received

KANNED

MAY 1 4 2018

CCMST-Reno

# 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: EMPLOYER:

06/25/2015 City of Reno

DATE OF EXAM:

05/08/2018 05/14/2018

DATE OF REPORT: 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.

Page 1 of 12

Received
MAY 1 4 2018

SCANIGED

<sub>002</sub> AA 1356

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.

Received

MAY 1 4 2018

The claimant has not served in the military.

# REVIEW OF MEDICAL RECORDS:

CCWSI-Reno

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.

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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 Specially 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.

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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 19, 2016 chiropractic treatment by Dr. Hansen
On February 24, 2016 chiropractic treatment by Dr. Hansen

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On April 28, 2016 chiropractic treatment by Dr. Hanson

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

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

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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 forcarm 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

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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 cdema 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:



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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.

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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:

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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			
Ccrvical	Calvarium angle	40	40	40	
Flexion	T1 ROM	20	20	20	
	Maximum cervical flexion angle	20	20	20	
	±10% or 5°	*Yes	No	<u>-</u> -	 
	Maximum cervical flexion angle	20		·	
	% Impairment	3			 

Movement		Range					
Cervical	Calvarium angle	20	20	20			
Extension	T1 ROM	5	5	5	0.60	1	
	Cervical extension angle	15	15	15	<del> </del>		_
	±10% or 5"	*Yes	No				
	Maximum cervical extension angle	15					
	% Impairment	5					

Movement	Description	Rnnge					
Cervical	Calvarium angle	30	30	30	1	Τ	T-
Left	T1 ROM	10	10	10		<del> </del>	<del>                                     </del>
Lateral	Cervical left lateral flexion angle	20	20	20			+
Bending	±10% or 5°	*Yes	No				
	Maximum cervical left lateral flexion angle	20					
	% Impairment	2	<del> </del>		-		

Movement	Description	Range			
Cervical	Calvarium angle	30	30	30	
Right	T1 ROM	10	10	10	
Lateral	Cervical right lateral flexion angle	20	20	20	
Bending	+10% or 5°	*Yes	No		<u> </u>
	Maximum cervical right lateral flexion angle	20			Tax on to an all
- (1	% Impairment	2	_		Peraner

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	Description	Range				<del></del> .	
Ccrvical	Cervical left rotation angle	40	40	40	T		_
Left	±10% or 5°	*Yes	No			1	_
Rotation	Maximum cervical left rotation angle	40					
	% Impairment	2			1	<u> </u>	<u></u>

Movement		Range	·			<del></del>	
Cervical	Cervical right rotation angle	40	40	40		T	T
	±10% or 5°	*Yes	No			1	<del> </del>
Rotation	Maximum cervical right rotation	40	ĺ		31.0	1	
	angle		1		1		
L	% 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) received

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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 Abaormal 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 Duc 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%.

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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.

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May 15, 2018

Dr. James Jempsa Fax # 775-787-6430

RE: Claimant: Re:

Kimberly Kline 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.

Claims Representative

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

Enc. Dr. Anderson PPD report

5

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 E: 15853E839641

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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 L4-5 disc DiD. 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 (2<sup>nd</sup>) 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 Half, 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 @geted.veci arm symptoms.

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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

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

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 LS-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.

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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 falled 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. 5ekhon 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)

NOV 2 2 2017

adjusted sometimes, but denies any significant prior neck pain, disability, or radiation upper Page 4 (Kimberly Kline cont)

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 reattach 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

Received.

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

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# 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% WP!)

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.

l can elicit equal, +2 deep tendon reflexes at Right and Left biceps, brachloradialis, 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.

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NOV 2 2 2017

# PREE ( (KINDERLY 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 cialmant 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-

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.

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# PAGE 7 (KIMBERLY 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 5\25\2015).

# PERMANENT IMPAIRMENT SUMMARY

The claimant has 25% whole person impairment coming from the cervical spine. Of this , 5%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

Received.

NOV 2 2 2017

15853E8391W1

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

#### **FACSIMILE TRANSMITTAL**

To:	Lise Jones	
	Lunes C Sergeson 1820	
25	324-9893	
Date:		_
Total Pag	es (including cover):	%
	Kline Addendeen	

The information contained in this facsimile is privileged and confidential protected from disclosure. If the reader of this facsimile is not the intended recipient, you are hereby notified that any reading, dissemination, copying or other use of this facsimile is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately by telephone at (775) 786-9072. Thank you.

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COMST Reno

<sub>022</sub> AA 1376

# 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 06/25/2015

DOI: EMPLOYER: DATE OF EXAM:

City of Reno 05/08/2018

DATE OF REPORT:

05/18/2018

BODY PARTS: 03/16/2018

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.

Deviceday &

UAY TO TT

CONST Reno



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,

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 897	′04				
Employee's Telephone Number	Claim No. 15853E839641				
775-326-6637	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 f	or this appeal:		
This request for hearing is	filed by, or on behalf of:	The Injured Employee The Employer	
and is dated this	day of		
Signature of Injured Emplo	oyee/Employer	Injured Employee's/Employer's Rep. (Adv D-12a	

<sub>025</sub>AA 1379

# JAMES C. JEMPSA, DO

Reno, Nevada

Telephone: 775-786-9072

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Lisa Jones **CCMST** PO Box 20068 Reno, NV 89515

Telephone: 775-324-3301 Fax: 775-324-9893

# PERMANENT PARTIAL DISABILITY EVALUATION ADDENDUM

RE:

CLAIMANT:

Kimberly Kline

SSN:

DOI:

CLAIM NO .:

15853E839641 06/25/2015 City of Reno

EMPLOYER: DATE OF EXAM:

05/08/2018 05/18/2018

DATE OF REPORT: **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

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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COMST RAMO

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Fax: 775-324-9893

# PERMANENT PARTIAL DISABILITY EVALUATION

RE:

**CLAJMANT:** 

Kimberly Kline

SSN:

CLAIM NO.:

15853E839641

DOI:

06/25/2015

EMPLOYER: DATE OF EXAM:

City of Reno 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.

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Received

MAY 1 4 2018

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**AA 1381** 

127

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.

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The claimant has not served in the military.

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# REVIEW OF MEDICAL RECORDS:

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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.

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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 Specially 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 myelomelecia.

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.

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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. Hausen.

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. Hanson

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MAY 1 4 2018

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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 roduce 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

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compression C5-6 and C6-7. 2. Mobile spondylolisthesis at C4-5. 3. Failed conservative therapy. 4. Minimal spondylosis, L3-4, L4-5 and L5-81. 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

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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: I. 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 cdema 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:

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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.

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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:

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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						
Ccrvical	Calvarium angle	40	40	40		7	_	
Flexion	T1 ROM	20	20	20			-	
	Maximum cervical flexion angle	20	20	20		<del></del>	-	
	±10% or 5°	*Yes	No			l		
	Maximum cervical flexion angle	20		L			- 3	
	% Impairment	3	(18)					

Movement		Range					
Cervical	Calvarium angle	20	20	20	T		
Extension	T1 ROM	5	5	5	†	W.	
	Cervical extension angle	15	15	15			<del></del>
}	±10% or 5°	*Yes	No		<u> </u>		
}	Maximum cervical extension angle	15					
<u> </u>	% Impairment	5					

Movement	Description	Range					
Cervical	Calvarium angle	30	30	30	=	1	_
Left	TI ROM	10	10	10	1,4		+
Lateral Bending	Cervical left lateral flexion angle	20	20	20			<del>                                     </del>
	+10% or 5°	*Yes	No	<u> </u>		<u></u>	
	Maximum cervical left lateral flexion angle	20					
	% Impairment	2					

Movement	Description	Range					
Cervical	Calvarium angle	30	30	30	1	1	
Right	T1 ROM	10	10	10		<del> </del>	
Lateral Bending	Cervical right lateral flexion angle	20	20	20		17.	+-
Dending	+10% or 5°	*Yes	No				
	Maximum cervical right lateral flexion angle	20	Desired				
	% Impairment	2	+Receive				

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#### Kimberly Kline Page 10

Movement	Description	Range		-	
Ccrvical	Cervical left rotation angle	40	40	40	1
Left	±10% or 5°	*Yes	No		
Rotation	Maximum cervical left rotation angle	40			
	% Impairment	2			_

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

#### SHMMARY 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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#### Kimberly Kline Page 11

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%.

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Kimberly Kline Page 12

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.

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Pursuant to NRCP 5(b), I hereby certify that I am an employee of McDONALD CARANO LLP, and that on the Tof 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

Employee of McDonald Carano LLP

4815-5510-6662, v. 1

### NEVADA DEPARTMENT OF ADMINISTRATION

### BEFORE THE APPEALS OFFICER AND A 1

In the Matter of the Contested Industrial Insurance Claim

of

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Claim No:

15853E839641

Hearing No: 1801761-JL

KIMBERLY KLINE,

Claimant.

Appeal No:

1802418-RKN

# INSURER'S FOURTH SUPPLEMENTAL DOCUMENTARY EVIDENCE

<u>Index</u>	Document Description	<b>Page</b>
6/4/18	Jay E. Betz, M.D. (PPD/Chart Review)	1

#### **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



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

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#### 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.

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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.

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

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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.

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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.

Received COMSIRENCE

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

Received CCMS/Reno

1	CER	RTIFICATE OF SERVICE
2	Pursuant to NRCP 5(b), I	hereby certify that I am an employee of McDONALD
3	CARANO LLP, and that on the 8th	of June 2018, I served the within INSURER'S FOURTH
4	SUPPLEMENTAL DOCUMENT	ARY EVIDENCE upon the following parties at the
5	addresses and service as identified:	
6	⊠ U.S. Mail □ Email	Appeals Officer
7	FedEx	Department of Administration 1050 East William St., Suite 450
8	Hand Delivered/Filing	Carson City, NV 89701
9		Herb Santos, Jr. 225 S. Arlington Ave., Ste. C
10	☐ FedEx	Reno, NV 89501
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4816-3768-7399, v. 1

# NEVADA DEPARTMENT OF ADMINISTRATION BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim

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Claim No:

15853E839641

Hearing No:

1801761-JL

KIMBERLY KLINE,

Claimant.

Appeal No:

1802418-RKN

#### INSURER'S FIFTH SUPPLEMENTAL DOCUMENTARY EVIDENCE

<u>Index</u>	<b>Document Description</b>	<u>Page</u>
6/25/15 - 6/15/18	Copy of Medical File Provided to Jay E. Betz, M.D. for Records Review	1

# 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

Date

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	I'S AND CHIROPRACTOR'S  COGRESS REPORT
	CATION OF DISABILITY
Patient's Name	Oct   Date of Injury
Employer:	Name of MCO (If applicable)
Patient's Job Description/Occu	FRANCE
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No Pushing	No Climbing  No Reaching Above Shoulders: CMSI - RENC
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	D-39 (Rev. 7/99
	American Legisher, Inc.

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 déployment. intermittant radiation into 8 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.

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KLINE, KIMBERLY M

M001221557

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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. pifferential 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** 

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KLINE, KIMBERLY M

M001221557

V00008267251

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.

FÖ]]ow-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)

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KLINE, KIMBERLY M

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V00008267251

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: /

of see.

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

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KLINE, KIMBERLY M

M001221557

V00008267251



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	ВМІ	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

[Page 1]

E-signed by Dr. Scott Hali, MD on 08/30/2015 11:32AM

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By SHMCO at 1:24 pm, Jun 30, 2015

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Electronically
CV19-01683
2019-09-18 11:28:40 AM
Jacqueline Bryant
Clerk of the Court
Transaction # 7490553



#### SPECIALTY HEALTH CLINIC

Patient: KIMBERLY KLINE

DoB: 10/07/1979

Sex: F

Provider: Dr. Scott Hall, MD

Visit: 06/30/2015 11:15AM

Chart: KLK1000001

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 tendemess 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:

Туре	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

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Work status: Full duty Return visit: 2,week(s) CCMSI - RENO

Additional health information: Previous records reviewed as summarized above

Treatment plan: Conservative treatment

Туре	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

[Page 2]

E-signed by Dr. Scott Hall, MD on 08/30/2015 11:32AM



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

Insurer:

Insurance #:

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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

[Page 3]

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

PCEASE IT	
EMPLOYEE'S CLAIM PROVIDE	ALL INFORMATION REQUESTED.
First Name  M.I. Last Name  E M.I. Last Name	Sex Claim Number (Insurer's Use Only)
Home Address A	ge Height Weight Social Security Number
City State Zig	Telephone
Mailing Address	e 'Zip , Primary Language Spoken
LISAME	
INSURER THIRD-PARTY ADMINIST	RATOR Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred Rack Inc. 5052/2010/00/00
Employer's Name/Company Name City Of Rong	Telephone 324-242(1
Office Mail Address (Number and Street)	marcia Dans
Date of Injury (if applicable) Hours Injury (if applicable) Date Employer Noti	fied Last Day of Work After Injury Supervisor to Whom Injury Reported
10/25/15 am 33 Om 10/25/15	or Occupational Disease Tim Hendricks
Address or Location of Accident (if applicable)	
What were you doing at the time of the accident? (if applicable)	
How did this injury or occupational disease occur? (Be spedificand answer in o	letall. Use additional sheet if necessary)
I was rear endid	,,,
If you believe that you have an occupational disease, when did you first have k relationship to your employment?	nowledge of the disability and its Wilnesses to the Accident (if applicable)
	abhirante)
Algum of Injury of Commoditional Places	d(a) of Production of the state of
Nature of Injury or Occupational Disease  Car Oprod Ont	nt(s) of Body Injured on Affected
I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND TH	AT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S
INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (RRS 6184 TO 6160, INCLUSIVE SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINI INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER INSTITUTION OF ORGANIZATION TO RELEASE TO EACH OTHER PERSON, ANY HOSPITAL TO THIS INJURY OR OISEASE, EXCEPT INFORMATION RELATIVE TO DUGGOSIS. TRICONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTI	ON CHAPTER ST. OF MRS.I. THEREST AUTHORIZE ART PHYSICIAN, CHROPPACTOR, STRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY SER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE
PERTIMENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TRI CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOST	EATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR NY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL
Date 6/25/15 Place	Employee's Signature Tump with the
THIS REPORT MUST BE COMPLETED AND MAIL Place	1878年中国的大学的大学的大学的大学的大学的大学的大学的大学的大学的大学的大学的大学的大学的
Saint Mamp regunal Medic	Denter ER
Date UNS 15 Diagnosis and Description of Injury or Occupational Disease  OCHE LUMBAY STAYN	is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident?
Hour à	No 🖸 Yes (if yes, please explain)
Treatment:	Have you advised the palient to remain off work live days or more?
Made, rest, Te, Per W2 23 mg	☐ Yes Indicate dates: from
M Pau Cladia	Allo If no is the laised and and an about at C 641 day & -
X-Ray Findings: L-SANe: L45 DDD 11 March alu	Windilled duty, specify any limitations/restrictions: NO bounding,
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred?	carrying or 118thing > 10/bs und 1
Is additional medical care by a physician indicated? (A Yes O No	- cleared by un
Do you know of any previous injury or disease contributing to this condition or oc	cupational disease?
Date	
	Ify that the employer's copy of form was mailed to the employer on:
Address 12 (1) (1) (1)	INSURER'S USE ONLY
State Zip Provider's Tax I.D. Number Tele	phone
Meno NU FASTS	203185
Doctor's Signature Degr	MD D
ORIG	PA PACE 2 EMPLOYED PACE 4 EMPLOYED
RECEIVED	PA PAGE 3 - EMPLOYER PAGE 4 - EMPLOYEE Form C-4 (rev 10/07)
By SHMCO at 1:51 pm, Jul 01, 2015	
Lay Silinov activi pili, Julivi, 2013	<b>→</b> []

<sub>009</sub>AA 1411

Wed 01 Jul 2015 11:01:26 AM POT

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Reno Orthopaedic Clinic

555 North Arlington Ave Reno, NV 89503

(775) 786-3040

July 1, 2015 Page 1 Office Visit

KIMBERLY KLINE

Female DOS: 10/07/1979 AGE:35 Years Old

Home: (775) 815-5790

INSURANCE: CDS-WCSD- PHCN/ Saint Mary's

network

**PATIENT ID: 176038** 

05/11/2015 - Office Visit: Initial Office Visit

Provider: Brett Men-Mulr

Location of Care: Reno Orthopaedic Clinic

Primary Care Physician: Leary, Jennifer M. Chief Complaint: bliateral 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:

#### Family History (Responses from Intake form)

Patient Indicates a family history of:

Mother (blol.) - Family History of Anaesthetic Complications Father (blol.) - Family History of Arthritis

#### Social History/PQRS Review

Never smoker

Received

Pain assessment on a scale of 0 to 10 based on VRNS: 7

JUL Q 1 2015

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

CCMSkReno

#### 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,

Page 3 of 7

Reno Orthopaedic Clinic 555 North Arlington Ave Reno, NV 89503

(775) 786-3040

July 1, 2015 Page 2 Office Visit

KIMBERLY KLINE

Female DOB: 10/07/1979 AGE:35 Years Old

Home: (775) 815-5790

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 paln.

Genitourinary: indicates no symptoms of: urinary urgency, urinary frequency, incontinence, blood in

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 Tiblelis 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

**Bebinski** Negative

Achilles 0

Patellar 0

Cionus 0

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JUL 0-1 2015

**CCMSLReno** 

Wed 01 Jul 2015 11:01:26 AM PDT

Page 4 of 7

Reno Orthopaedic Clinic

555 North Arlington Ave Reno, NV 89503 (775) 786-3040

July 1, 2015 Page 3 Office Visit

**KIMBERLY KLINE** 

Female DOB: 10/07/1979 AGE:35 Years Old

Home: (775) 815-5790 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 Paln: 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

\$1 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 Hallucia Longus 5

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Wed 01 Jul 2015 11:01:26 AM PDT

Page 5 of 7

Reno Orthopaedic Clinic

555 North Arlington Âve Reno, NV 89503 (775) 786-3040

July 1,2015 Page 4 Office Visit

KIMBERLY KLINE

Female DOB: 10/07/1979 AGE:35 Years Old

Home: (7.75) 815-5790

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

**Antaigic Gelt No** Fabor Test Negative

Trendelenburg No

Received

JUL 0.1 2015

**CCMSt-Reno** 

Wed 01 Jul 2015 11:01:26 AM PDT

Page 6 of 7

Reno Orthopaedic Clinic

555 North Arlington Ave Reno, NV 89503

(775) 786-3040

July 1, 2015 Page 5 Office Visit

KIMBERLY KLINE

Female DOB: 10/07/1979 AGE:35 Years Old

Home: (775) 815-5790 INSURANCE: GDS-WGSD- 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.

#### <u>Impression</u>

- Discogenic back pain.
- 2. Disc degeneration, L4-L5.

#### Plan

5 r. . .

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 delive 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

Entered by:

Nichole Brooks

Received

JUL 0-1 2015

**CCMSI-Reno** 

O14 AA 1416

Wed 01 Jul 2015 11:01:26 AM PDT

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Reno Orthopaedic Clinic

555 North Arlington Ave Reno, NV 89503

(775) 786-3040

July 1, 2015 Page 6 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** 

Authorized by: Brett Men-Muir

Electronically signed by: Nichole Brooks on 05/11/2015

Method used: Electronically to

Walgreens N Virginia\* (retali)

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

JUL 0 1 2015

**CANSHReno** 



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

[Page 1]

E-signed by Dr. Scott Hall, MD on 07/14/2015 11:08AM

RECEIVED

By SHMCO at 2:46 pm, Jul 14, 2015



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:**

Туре	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

Туре	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

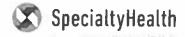
It is the injured worker's responsibility to inform the employer of current work status.

CURRENT RESTRICTIONS: Full duty without restrictions

CONDITION STABLE? NO CONDITION RATABLE: NO

[Page 2]

E-signed by Dr. Scott Hall, MD on 07/14/2015 11:08AM



Patient: KIMBERLY KLINE

Provider: Dr. Scott Hall, MD

DoB: 10/07/1979

Visit: 07/14/2015 10:45AM

Sex: F

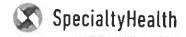
Chart: KLKI000001

RETURN VISIT: 2 weeks SIGNED: Scott Hall, MD

12703 08-20-15 12:28pm

# TREATMENT ENCOUNTER NOTE

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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	ВМІ	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:

Туре	Code	Description
ICD-9-CM Condition	847.0	SPRAIN OF NECK

[Page 1]

E-signed by Dr. Scott Hall, MD on 08/20/2015 10:25AM

RECEIVED

By SHMCO at 1:47 pm, Aug 20, 2015



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.

Тур	e	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

NO. 0747) P. 21





# UPDATED PLAN OF CARE For outpatient rehabilitation

PATIENT NAME: Kimberly Kline

OOB: 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: 08/03/16** START OF CARE DATE: 08/05/15 TOTAL VISITS: 6 of 8 approved

DATE OF REEVALUATION: 08/26/15 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 atill comes and goes depending on her activity level. She atill complains of pain and pressure across the low back. She has no pain going down the legs. She occasionally has trouble steeping at night because she is unable to get comfortable. She has been able to look around better while driving, but still has lightness at end range of cervical rotation.

#### Patient Problems/Status:

1. Patient is becoming more aware of utilizing proper posture throughout the day.

Improving lumber AROM: Flexion was fingers-to-toes with a "catch" at 80° when going into decion, extension 35° with mild pain and side bending was fingers to knee joint the without pain.

Improving corvical AROM: Flexion 55' (was 60'), extension 55' (was 60'), right rotation 78' with tightness at and range (was 66'),

left rotation 76° with tightness at range (was 70°), the right aide bending 36° and left side bending 35°.
Palpation: There was tenderness and tightness noted in the suboccipitals and bilaterel upper trapezius. There was tenderness noted in the lumber paraspinels and gluteals. Pelvio asymmetry was noted with a posterior rotation of the left innominate. Bilateral hip weakness (4+/5). Bilateral knee and ankle strength was 5/5. Bilateral upper extremity attempt was 5/5. Back index score improved to 38% (score was 52% at Initial evaluation).

Neck index score remained about the same at 26%.

Were previous coals met? Palient met short-term goals and made good progress toward the long-term goals.

<u>Unitated alon of meatment:</u> 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 readucation for spinal stabilization exercises, and home exercise program development.

#### Long-term goals: (4-6 weeks)

Decrease Back Index score to < 25% by discharge.

Decrease Neck Index score to ≤16% by discharge

Patient will be able to forward bond during ADLs without back pain.

Patient will be able to drive the work vehicle throughout the day without increased pain. 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/wack for 6 weeks;

I have reviewed this plan of care and recertify a contlinuing need for services and the petient is under my care. The above updated plan of care is herein established and will be reviewed every 30 days.

Referring Physician's signature:

T: radmt.com/GV/MV

Therapist signature.

DSPARKS LOCATION • 1450 E. Prater Way, Suite 103 • Sparks, NV 89424 • T: 775.331.1199 • F: 775.331.1160 DNORTHWEST RENO 1610 Robb Drive, Ste. D5 • Reno, NV 89523 • T: 776.746.9222 • F: 775.746.9224 ASOUTH RENO - 11331 South Virginia, Suite 3 - Reno, NV 89511 - T: 775,853,9966 - F: 775,853,9969

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#### TREATMENT ENCOUNTER NOTE

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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	вмі	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:

Туре	Code	Description
ICD-9-CM Condition	847.0	SPRAIN OF NECK

[Page 1]

E-signed by Dr. Scott Hall, MD on 09/23/2015 9:00AM

RECEIVED

By SHMCO at 3:06 pm, Sep 23, 2015



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

Туре	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

[Page 2]

E-signed by Dr. Scott Hall, MD on 09/23/2015 9:00AM



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



## <u>UPDATED PLAN OF CARE</u> For outpatient rehabilitation

PATIENT: Kimberly Kline

DOR: 10/07/79

REFERRING PHYSICIAN: Scott Hall, M.D.

THERAPIST: Mark Bruesewitz, P.T.

DIAGNOSES: 1. Lumbosacral strain/sprain with pain and decreased ROM.

LUINCIE HEALIN UL

2 Cervical strain/sprain with pain.

DATE OF ONSET: 08/03/16

START OF CARE DATE: 08/05/15

TOTAL VISITS: 12

DATE OF REEVALUATION: 09/29/15 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, dightness and speams 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 ilmit 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

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 50° 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.

Palpation: There was tenderness and lightness noted in the right suboccipitals, C5-C7 paraspinals, right scalenes, right upper trapezius, and right levalor scapula. Patient had no tenderness around the low back

Right shoulder AROM was within normal limits. Right upper extremity strength was 5/5. Right shoulder impingement test was negative.

Back index score was 32% (score was 52% at initial evaluation).

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Neck Index score remained at 28%.

OCT 12 2015

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SPARKS LOCATION - 1450 E. Preter Way, Suite 103 - Sparks, NV-69434 - T; 776,531.1199 - F; 775.331.1160

O NORTHWEST RENO • 1810 Robb Drive, Suite D5 • Reno, NV 89523 • T: 775.746,9222 • F: 776.746.9224

SOUTH RENO • 734 South Mandows Plwy., Suite 101 • Rena, NV 89521 • T: 775.853.9966 • F: 775.853.9969

No. 1667 P. 2

8=4:30. 2015 8:24AM

**AA 1429** 

人

Page 2 Kimberly Kline 09/29/15

Were previous goals met? Patient has made good progress in her lumbar pain and symptoms, but made minimal progress in her nack symptoms because of flare-up of symptoms about 1-1/2 weeks ago. Patient la still limited with cervical rotation to the right during ADLs and work activities.

Undated plan of treatment: Modelities as needed for pain control, neck AROM and stretching exercises. manual therapy lechniques to decrease pain and improve mobility of the neck and low back, progressive tharapeutic exercise and therepeutic 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.
- 8. Patient will be independent with home exercise program by discharge.

Goals discussed with patient? Yes,

Rehabilitation potential la: 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.

Date: 9/29/15
Date:

T: rsdmt.com/GV/MV

RECEIVED OCT 12 2015 CCMSI - RENO

- D SPARKS LOCATION 1450 E. Preter Way, Buile 103 Sparks, NV 89434 T: 775,331,1199 F: 775,331.1180
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# TREATMENT ENCOUNTER NOTE

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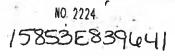
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No. 1995 P. 4/10

10-05-15 01 31pm

# TREATMENT ENCOUNTER NOTE

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Patient: KIMBERLY KLINE

DoB: 10/07/1979

Sex: F

Provider: Dr. Scott Hall, MD

Visit: 10/06/2015 4:00PM

Chart: KLK1000001

# \*\*\*RETURN TO WORK:

RETURN TO WORK FOR: KIMBERLY KLINE DATE OF APPOINTMENT: 10/08/2015 04:00PM

BODY PART: LUMBAR FOLLOW UP EMPLOYER: CITY OF RENO

Date of injury:6-26-15

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

RECEIVED

OCT 07 2015

CCMSI - RENO

No. 2040 P. 3 10-07-15 11:02am

# TREATMENT ENCOUNTER NOTE

Accoun	t#: 0026102075	Ço	- Pay:		OR	Co - tr	neurance:	_
Name:	Kline, Kimberly	Inju	ury#: 0	101	Ox:	8472	Sprains and strains of lumb	a
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		Tx Time O	ut: 10	-00	Tot	al Time Ba	sed Time: <u>(60</u>	
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1004	OT Re Eval		C001	Theraputic Activities	<del>  -</del>	H006	Coutom WHO State	┼
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12837 10-14-15 11:04am

# TREATMENT ENCOUNTER NOTE

Account #: 6028102075  Co - Pey: OR Co - Insurance:   Name: Kine. Kinebarky   Injury #: 601   Dx: 6472 Spraw and strains of lumba   Psyor Code: A0028   Psyor Name: CCMSI   Financial Class: WCOMPP   Appointment Detail   Of the Tax Time Out   O	Patier	nt Information							
Payor Code: ADDZE Payor Name: COMSI  Appointment Detail  Ducipine: PT  Tx Time In: 9 PD  Tx Time Out: 10 1 to 115  SVibis Prior to Today: 12 or 34  Total Time Based Time: 70  Date: 10 1 to 11 to 115  SVibis Prior to Today: 12 or 34  Total Treatment Time: 70  IST Code Description ADDI PT Bush ADDI PT Bush ADDI PT Bush ADDI PT Bush ADDI OT Bus	Accoun	nf #: 0028102075		Co - Pay: _		OR	Co-Ir	isurance;	_
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No. 2251 P. 2

Oct. 15. 2015 9:05AM

No. 2919 P. 10/10 AUZZ1 10-21-16 01:00pm

# TREATMENT ENCOUNTER NOTE

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A004	OT Re Eval			Cont	Theraputic Activities		H006	Custom WHO Statio	
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No. 2812 P. 2 10-26-15 05:03pm

# TREATMENT ENCOUNTER NOTE

Patient	Information				_			
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Name; _	Kline, Kimberly	in	jury #: _00	01	Dx;	833.5XX	Elprain of ligaments of lum	ba
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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:

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

[Page 1]

E-signed by Dr. Scott Hall, MD on 10/28/2015 3.14PM

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By SHMCO at 1:36 pm, Oct 29, 2015



Patient: KIMBERLY KLINE

Provider: Dr. Scott Hall, MD

DoB: 10/07/1979

Visit: 10/28/2015 2:15PM

Sex: F

**Chart:** KLKI000001

## Plan:

Work status: Full duty, MMI

Туре	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 01/18/2016 Mon 14:09

Reno Diagnostic Center 333-2761

Reno Diagnostic CenterID: #1119839 Page 1 of 1



625 Sierra Rose Drive Reno, NV 89511 Phone: (775) 323-5083

Fax: (775) 333-2776

853E83944

Exam requested by: Bryan Hansen DC 10635 Professional Circle Ste B Reno NV 89521

Diagnostic

MR-Spine Cervical without contrast [16265] - SPINE C

Patient: Kline, Kimberly Date of Birth: 10-07-1979 Phone: (775) 815-5790 MRN: 407766 Acc: 5111686 Date of Exam: 01-13-2016

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 tevels. 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 leftsided 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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Printed: 01-18-2016 2:08 PM

Kline, Kimberty (Exam: 01-13-2016 2:10 PM)

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Leading Edge Chiropracits
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Kimberly Kline 305 Puma Dr Washoe Valley, NV 89704

	Patient	179019 - Kline, Kimberly - COVL
	Date of Birth	10/7/1979
	Patient Gender	Female
100	Social Security	2795
1	Mental Status	Divorced
1 200	Decupation:	
100	Ulness:	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

Received

Musculoskeletat

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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 St 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.

Received

# Treatment Plans/Rationale

### **Prognosis**

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Prognosis - guarded.

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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

#### Sch

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Schedule of care - As outlined in previous repo	art.	

Hansen M.S., D.C., Bryan C.
Provider of Regard and Treating Provider

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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**

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Narrative Encounter - Decompression

Kline, Kimberly

Thursday, January 14, 2016 11:06 AM

· The patient presents with neck pain.

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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

# <u>Treatment</u>

### **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.

Received

### Treatment Plans/Rationale

# **Prognosis**

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Prognosis - guarded.

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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...

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Provider of Record and Treating Provider

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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** 

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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,

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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**

MS0.20 - Other cervical disc displacement, unspecified cervical region

### Assessment and Plan

## **Treatment**

#### **Physical Modelities**

- 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.

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LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

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## Treatment Plans/Rationale

The patient's response to conservative care - Patient responded well to treatment today.

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**Assessment** 

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Narrative	Encounter -	Decompress	ion
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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 NPS
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

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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** 

Received

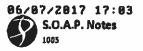
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Narrative Encounter - Decompression

Kline, Kimberly

Monday, January 18, 2016 10:16 AM

. The patient presents with neck pain.

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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 2-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.

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LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

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Treatment Plans/Rationale
Assessment

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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.

Hanson M.S., D.C., Bryan C. Provider of Record and Treating Provider

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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

Received

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15853E83964

Narrative Encounter - Decompression

Kline, Kimberly

Tuesday, January 19, 2016 3:41 PM

. The patient presents with neck pain.

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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 Modelities**

- · 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.

Received

LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

Treatment Plans/Rationale

JUN 08 2017

Assessment

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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
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confirms said impression with two large left paracentral disc protrusions at C5-6 and C6-7 causing severe left NPS
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.

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Provider of Arcord and Treating Provider

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Narrative Encounter - Decompression

Fineliting User

Kline, Kimberly

Wednesday, January 20, 2016 10:24 AM

# Subjective

# **Chief Complaint**

• Neck pain. (Pain Scale 7 of 10.)

### **History of Present Illness**

Received

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6/7/2017 2:33:27 PM

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Narrative Encounter - Decompression

Kline, Kimberly

Wednesday, January 20, 2016 10:24 AM

The patient presents with neck pain.

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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.
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- Electrical stimulation applied to: the muscles of the posterior neck.
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Received

### Treatment Plans/Rationale

### **Assessment**

JUN 08 2017

The patient's response to conservative care - Patient responded well to treatment today.

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6/7/2017 2:33:27 PM

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Leading Edge Chiropractic

Narretive 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 NPS
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.

Hans	on M.S., D.C.	., Bryan C.
Provider a	f Record and Ti	eating Provider

Jerllyn Cox Finalizing User

Narrative Encounter - Decompression

Kline, Klmberly

Thursday, January 21, 2016 2:37 PM

# Subjective

# **Chief Complaint**

Neck pain. (Pain Scale 6 of 10.)

## **History of Present Illness**

Received

JUN 08 2017

CCMSI-Reno

Narrative Encounter - Decompression

Kline, Klimberly

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-Gray 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.

Received

JUN 08 2017

# Treatment Plans/Rationale **Assessment**

The patient's response to conservative care - Patient responded well to treatment today.

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6/7/2017 2:33:27 PM

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Leading Edge Chiropractic

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.

Hanson M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jertlyn 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**

Received
JUN 08 2017
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6/7/2017 2:33:27 PM

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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**

## Musculoskeletai

- 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.

Received

LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

JUN 08 2017

# **Treatment Plans/Rationale**

Assessment

The patient's response to conservative care - Patient responded well to treatment today.

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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 Tracting Provider

Jetlyn Cox Finalizing Uter

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** 

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JUN 08 2017

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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 60ibs with a 20 to 25 degree scoop.
- Electrical stimulation applied to: the muscles of the posterior neck.

Received

 LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck. Treatment Plans/Rationale

JUN 08 2017

#### Assessment

CCMSI-Reno

The patient's response to conservative care - Patient responded well to treatment today.

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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 NPS
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.

Manson M.S., D.C., Bryan C. Provider of Record and Treating Provider

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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**

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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.

# **Obiective**

## Examination

#### Musculoskeletai

- 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

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Narretive 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., Gryan C. Provider of Record and Treating Provider	Received
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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, tendemess, and trigger point is moderate bilaterally and cervical paraspinals spasm, tendemess, and trigger point is moderate.

#### **Dx Codes**

Received

MS0.20 - Other cervical disc displacement, unspecified cervical region

## **Assessment and Plan**

JUN 08 2017

## <u>Treatment</u>

## Physical Modelities

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- · 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.

6/7/2017 2:33:27 PM

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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.

Hanson M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerllyn 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**

Received

JUN 08 2017

CCMSI-Reno



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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.

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## Treatment Plans/Rationale

**Assessment** 

JUN 08 2017

The patient's response to conservative care - Patient responded well to treatment today.
 Prognosis

CCMSI-Reno

6/7/2017 2:33:27 PM

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Leading Edge Chiropractic

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.

Hanson M.S., D.C., Bryan C.

Provider of Record and Treating Provider

Jerliyn Cox Finalizing User

Narrative Encounter - Decompression

Kline, Kimberly

Tuesday, February 02, 2016 10:16 AM

# Subjective

## **Chief Complaint**

Received

Neck pain. (Pain Scale 4 of 10.)

## **History of Present illness**

JUN 08 2017

· The patient presents with neck pain.

CCMSI-Reno

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

6/7/2017 2:33:27 PM

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96/87/2017 17:03 S.O.A.P. Notes From: 7753607665 Pro Spinal

Leading Edge Chiropractic

158535839641

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.
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Hansen M.S., D.C., Bryan C.

Provider of Record and Treating Provider

JUN 08 2017

CCMSI—Reno

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Narrative Encounter - Decompression

Kline, Kimberly

Friday, February 05, 2016 11:49 AM

## Subjective

## **Chief Complaint**

6/7/2017 2:33:27 PM

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06/07/2017 17:03

S.O.A.P. Notes

From: 7753607665 Pro Spinal

Leading Edge Chiropractic

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.

Received

LightCure Class-4 deep tissue laser therapy applied to: the muscles of the posterior neck.

JUN 08 2017

Treatment Plans/Rationale Assessment

CCMSI-Reno

6/7/2017 2:33:27 PM

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Leading Edge Chiropractic

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.

Hanson M.S., D.C., Bryan C.
Provider of Record and Treating Provider

Jerthyn Cox Finalizing Utar

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**

Received

JUN 08 2017

CCMSI-Reno

6/7/2017 2:33:27 PM

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Leading Edge Chiropractic

Narrative Encounter - Decompression

Monday, February 08, 2016 4:37 PM

Kline, Kimberly

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

#### Musculoskalatal

- · 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

Received

JUN 08 2017

The patient's response to conservative care - Patient responded well to treatment today.

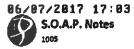
Prognosis

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Leading Edge Chiropractic

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

Jerliyn Cox Finalizing Urer

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 Reserved severe. The severity of the patient's symptoms interferes daily with work, sleeping, routine daily activities and household activities.

JUN 08 2017

Duration: Current symptoms started approximately 7 days ago.

CCMSI-Reno

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

6/7/2017 2:33:27 PM

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06/07/2017 17:03 S.O.A.P. Notes

From: 7753607665 Pro Spinal

Leading Edge Chiropractic

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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**

M\$0.20 - 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

٠	Schedule	of	care	- As	stated	in	initial	report	
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Hansen M.S., D.C., Bryan C. Provider of Record and Treating Provide

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JUN 08 2017

CCMSI-Reno

Narrative Encounter - Decompression

Friday, February 12, 2016 11:41 AM

Kline, Kimberly

Subjective

**Chief Complaint** 

6/7/2017 2:33:27 PM

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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 Modelities

- 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. Received

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.

JUN 08 2017

Treatment Plans/Rationale

**Assessment** 

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Narrative Encounter -	Decompression
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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

> Jerllyn Cox Finalking 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** 

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6/7/2017 2:33:27 PM

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Leading Edge Chiropractic

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 numbress.

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.

Received

JUN 08 2017

CCMSI-Reno

#### Treatment Plans/Rationale

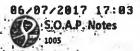
## **Assessment**

The patient's response to conservative care - Patient responded well to treatment today.
 Prognosis

6/7/2017 2:33:27 PM

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Leading Edge Chiropractic

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

Jerliyn Coa Finalking Uter

Narretive 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.

Received

Objective

JUN 08 2017

6/7/2017 2:33:27 PM

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Leading Edge Chiropractic

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.

Hensen M.S., D.C., Bryan C. Provider of Record and Treating Provider	Received
	JUN 08 2017
Jerilyn Cox Finalieing User	CCMSI-Reno
Narrative Encounter - Decompression	Kline, Kimberly
Wednesday, February 24, 2016 2:04 PM	

6/7/2017 2:33:27 PM

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Leading Edge Chiropractic

Kline, Kimberly

Narrativa Encounter - Decompression

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

Received

## Assessment and Plan

## **Treatment**

#### **Physical Modalities**

JUN 08 2017

CCMSI-Reno

- 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.

6/7/2017 2:33:27 PM

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Leading Edge Chiropractic

Narrative Encounter - Decompression

Wednesday, February 24, 2016 2:04 PM

Kline, Kimberly

## **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

> Jetlyn 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**

Received

JUN 08 2017

CCMSI-Reno

6/7/2017 2:33:27 PM

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Patient: KIMBERLY KLINE

DOB: 10/07/1979

Sex: F

Provider: Dr. Scott Hall, MD

Visit: 03/16/2016 2:15PM

**Chart:** KLK1000001

### letter:

KIMBERLY KLINE was seen at SpeciallyHealth 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 laft 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

[Page 1]

Pending e-algnature

RECEIVED

MAR 1 8 2016

**CCMSI - RENO** 

AA 1479

077



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

RECEIVED MAR 1 8 2016

CCMSI - RENO

[Page 2]

Pending e-signature

**AA 1480** 

078



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:

Туре	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.

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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

[Page 1]

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

RECEIVED
By SHMCO at 4:23 pm, Mar 17, 2016

\_AA 1481



Patient: KIMBERLY KLINE DOB: 10/07/1979 Sex: F

Provider: Dr. Scott Hall, MD Visit: 03/16/2016 2:15PM Chart: KLKI000001

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



15853 E83964

Leading Edge Chiropractic

Narrative Encounter - Exam - Final

Wednesday, March 16, 2016 5:12 PM

Kline, Kimberly

The patient presents with neck pain.

Associated symptoms: The patient reports associated symptoms of weakness and numbress.

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.

## **Obiective**

## **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.) Fajersztajń's well leg raising test
  for lumbar intervertebral disc hemiation 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.)

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Leading Edge Chiropractic.

Nairative Encounter - Exam - Final

Wednesday, March 16, 2016 5:12 PM

Kline, Kimberly

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.

Hansan M.S., D.C., Bryan C. Provider of Record and Treating Provider

Jerllyn Cox

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**

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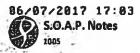
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Page 40 of 42



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Leading Edge Chiropractic

Narrative Encounter - Decompression -21

Thursday, April 28, 2016 10:56 AM

Kline, Kimberly

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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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.)

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Leading Edge Chiropractic

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 retur	ned due to a flare up of symptoms today. She is instructed to return if symptoms persist.
Hansen N	4.5., D.C., Bryan C.
Provider of Rec	cold and Treating Provides
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Kata	rina Frankoski
_	tradition of

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05/11/2017 07:38



J Dawn Waters, MD
Joseph R. Walker, MD
Oante F. Vacca, MO
Lall Schloen, MD, PhD
Daven Khosla, MO
Jay K. Morgan, MD
David C. Lepha, MD
Hilari L. Fleming, MD, PhD
Christopher P. Demers, MD
Inhis S. Davis, MO
Michael S. Edwards, MD

\$ 775.329.2080, BBB,323.2080

(FAX)775 657 9881

P.011/018

Reno, Nevada 8951)

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Jennifer Minard, APRN

Jannifer Keller, APRN

dreg Graves, PA-C

Curt Erickson, PA-C

☐ 275.323.8216

Ashile Teixelra-Smith, FNP-C

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: Fax:

(775) 657-8844

(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

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By SHMCO at 2:52 pm, May 12, 2017

Encounter Note Page #1 - Kline, Kimberly (Oct 07, 1979)

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-

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:

MAY 1 1 2000

Encounter Note Page #2 - Kline, Kimberly (Oct 07, 1979)

CUSTANO

### 05/11/2017 07:38

(FAX)775 657 9881

- 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 galt 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 Bablinski 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 tendemess.
- 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)

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MAY II

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Encounter Note Page #3 - Kline, Kimberly (Oct 07, 1979)

#### Impression / Plan:

Impression:

- 1. Cervical spondylosis, C4-5, C5-6 and C6-7 with cord compression C5-8 and C6-7.
- 2. Mobile spondylolisthesis at C4-5.
- 3. Falled 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, Homer'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.

Encounter Note Page # 4 - Kline, Kimberly (Oct 07, 1979)

MAY 1-1 20:

- PERSON

05/11/2017 07:39

(FAX)775 657 9881

P.015/018

Plan: If she desire surgery, we will get a routine preoperative workup.

Sincerely,

Lali Sekhon, MD, PhD, FRACS, FACS, FAANS

Jeffrey Mulr, 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

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### Orders:

Procedures & Treatments:

Comprehensive/High Comp (99245) Current List of Medications (G8427)

Pain Assessment (G8730)

Received

MAY YY SOL

CKMI RENO

Calculated BMI above the upper parameter and a follow-up plan was documented in the medical

Encounter Note Page # 5 - Kline, Kimberly (Oct 07, 1979)

P.016/018

Associated Files:

AND RELEASE TO SECOND

Documents: Neck Injuries and Disorders (7/5/2016 1:05:05 PM)

Electronically aigned by: Sekhon, Lali MD @ 09:42 AM on 7/6/2016

. . . . . .

Encounter Note Page #6 - Kline, Kimberly (Oct 07, 1979)



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)

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Patient Demographics

******	racient petnographics
Patient	Kline, Kimberly M (#147855)
	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	H
History of Present Iliness	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	ed toda en Petro tandampanio pero Espaino ant Petro
ast Medical listory	Reviewed Past Medical History	ved.
ast Surgical listory	Reviewed Surgical History  1. Ankle sprain with surgery  2. Cholecystectomy	8 201
ledications	Reviewed Medications	1980
	PROzac 40 mg capsule 04/03/17 entered Take 1 capsule(s) every day by oral route.	

SIERRA NEUROS URGERY GROUP\_NEURO

Kline, Kimberly M (ID: 147855), DOB: 10/07/1979

<sub>091</sub> AA 1493

## athena

## 4/3/2017 4:13:20 PM

inc. year	Reviewed Allergies	
4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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 paipable 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 5LR 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	paraminante nominario de montra mandra de mandra de la companha de la companha de la companha de la companha d	
Procedure Details		
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	eived
	1. Neck pain M54.2: Cervicalgia	0 8 2017
	Cervical spondylosis     M47.812: Spondylosis without myelopathy or radiculopathy, cervical region	Mano
	3. Spinal stenosis in cervical region	
DA NEIDOCHDOCOV COOL		

SIERRA NEUROSURGERY GROUP\_NEURO

Kline, Kimberly M (ID: 147855), DOB: 10/07/1979

#### 4/3/2017 4:13:20 PM

M48.02: Spinal stenosis, cervical region MRI, CERVICAL SPINE, W/O CONTRAST

Height (ft.): 5 ft 7 in Weight (lbs): 178

XR, CERVICAL SPINE

Mews (X-RAY, CERVICAL SPINE): AP, Lateral, Flexion & Extension

4. Body mass index 25-29 - overweight Z68.29: Body mass index (8MI) 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. Falled conservative therapy.
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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 LIJE 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(les) (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 making. I have answered all questions to the best or 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 the case (EMG/SSEP/MEP). 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.

Repeat MRI and C-spine x-rays
 Follow up with Dr. Sekhon in 2-4 weeks

3. Call with any other questions or concerns

Received

CCM81-Reno

SIERRA NEUROSURGERY GROUP\_NEURO

Kline, Kimberly M (ID: 147855), DOB: 10/07/1979

4/3/2017 4:13:20 PM \_

Sincerely,

Curt Erickson, PA-C Lali Sekhon, MD, PhD, FRACS, FACS, FAANS

Return to Office

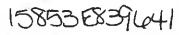
 Lali H Sekhon, MD for FOLLOW UP 30 at SIERRA NEURO PRINGLE\_NEURO on 04/18/2017 at 12:30 PM

Electronically Signed by: CURT ERICKSON, PAC, PA-C 04/03/2017 01:08 PM

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CCMSI-Rego



Reno Diagnostic CenterID: #1316397 Page 1 of 1



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 C8-7. There are facet degenerative changes at C7-T1. No abnormal motion on flexion. Upon extension there is development of 2 mm of retrolistnesis of C4 on 5. There is 1 mm of retrolistnesis of C6 on 7.

#### IMPRESSION:

1. Mild disc space narrowing and facet degenerative change of the lower cervical spine.

 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

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Kline, Kimberly (Exem: 04-21-2017:1:40 PM)

Page 1 of 1



## 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

Same.

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 spiral 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

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Washoe

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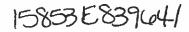
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Kline, Kimberly (Exam. 04-21-2017 2:00 PM)

Page 1 of 1



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)

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Patient Demographics

*******************	
Patient	Kline, Kimberly M (#147855)
	1617 Mountain Ln Reno, NV 89521
	H; (775) 815-5790 M: (774) 815-5790
Referring Provider	

Encounter Date	04/25/2017	
Chief Complaint	CC: 1. Neck Pain and Stiffness 2. Left arm numbness and pain	
History of Present iliness	7.5.16 Dear Jeff, I had the pleasure of reviewing your patient, Kimberly Kline, woman for assessment of cervical radiculopathy. Kimberly Kline is a woman. She relates that she has had back and cervical is: back, but these were quite manageable, but she was involv work in June 2015. There were actually 2 accidents, she wat taken to the emergency room, initially, she had neck pain and She was commenced on medication. She was commenced on also had chiropractic. In January of this year, she started arm pain. The pain has somewhat settled but she still has rethe arm. She had an epidural, this did not really help her. She has neck pain and stiffness. She has a pressure feeling this as a 5/10. She has aching in the left arm again it numbness and aching in the forearm down to the thumb in right arm is okay. She feels she has plateaued. She has detherapy. She has never had arm symptoms before these line 4.3.17 Dr. Sekhon and I were able to review Kim Kline again today. I posterior neck pain and pressure. This pain continues to extend times at a 9/10. The continues to limit her ability symptoms may be slightly improved but overall are very she had last July.  4.25.2017: REturns. Arm worse. Options discussed. Wants surgery.	very nice 36-year-old sues in the past, mainly ed in an accident in her is rear-ended. She was at tightness in her neck, in physical therapy. She developing severe left numbness and aching in When I saw her today, in the neck. She rates is 5/10. She maps out the C6 distribution. Her one extensive physical ections.  She has continued with tend down the left arm and to slean at right. The
ast Medical listory	Reviewed Past Medical History	Received
est Surgical Istory	Reviewed Surgical History  1. Ankle sprain with surgery  2. Cholecystectomy	APR 2 5 201
ledications	Reviewed Medications	- COIST-Ren
	PROzac 40 mg capsule 0.	4/03/17 entered

SIERRA NEUROSURGERY GROUP\_NEURO

Kline, Kimberly M (ID: 147855), DOB: 10/07/1979

## athena

## 4/25/2017 2:33:21 PM

i	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, pm 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.	
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 galt and station 6) Coordination is normal in all 4 extremities. Tandem galt 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 ILIMBAR 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	
abs/Data/Imaging	N/A	
rocedure Details	None recorded APD 9 R :	
Issessment 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.	

SIERRA NEUROSURGERY GROUP\_NEURO

Kline, Kimberly M (ID: 147855), DOB: 10/07/1979