IN THE COURT OF APPEALS OF THE STATE OF NEVADA

VENETIAN CASINO RESORT, LLC; AND LAS VEGAS SANDS, LLC,

Petitioners,

vs.

THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK; AND THE HONORABLE KATHLEEN E. DELANEY, DISTRICT JUDGE,

Respondents,

and

JOYCE SEKERA, AN INDIVIDUAL,

Real Party in Interest.

No. 83600-COA

REAL PARTY IN INTEREST'S APPENDIX, VOLUME 11 (Nos. 2025–2144)

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INDEX TO REAL PARTY IN INTEREST'S APPENDIX

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EXHIBIT 44

2025

CLAGGETT & SYKES LAW FIRM

4101 Meadows Lane #100 | Las Vegas, NV 89107
Tel. 702.655.2346 | Fax 702.655.3763 | claggettlaw.com

January 8, 2020

VIA FACSIMILE

Pain Institute of Nevada
702-878-9096

***Updated Records Request:
09/17/18 - Present***

Re: **Medical and Billing Records Request**
Client Name: Joyce Sekera
Date of Loss: 11/4/2016
DOB: 03/22/1956

To Whom It May Concern,

I understand that our client, Joyce Sekera, treated at your facility in relation to the above-referenced date of loss. Please send us copies of all medical and billing records, including:

- **ALL PAST RECORDS** (even if unrelated to condition as alleged within the current claim) and all medical records which are in the control or possession of this witness
- **ALL CLINICAL DOCUMENTATIONS:** all notes (handwritten or otherwise), prescriptions, surgical reports, all sign-in sheets, dictated reports, chart notes, insurance forms, progress notes, patient questionnaires, blood tests, laboratory findings, all test results, appointment records, discharge reports, admission reports, and nurses' notes
- **ALL DIAGNOSTICS:** X-ray reports, X-ray films, MRI reports, MRI films, and CT-scans (if possible, please put films on CD-ROM or DVD. Please contact our office before you put them on CD-ROM or DVD)
- **ALL BILLING RECORDS**: invoices and statements (**please include CPT coding & ICD-10)**

Please also provide all correspondence with any and all insurance companies or providers regarding the treatment of our client including, but not limited to, all requests for treatments, referrals, referral forms, authorizations, and denials.

Enclosed please find a copy of a medical authorization signed by our client. **PLEASE BE SURE TO COMPLETE AND SIGN THE DECLARATION FOR CUSTODIAN OF RECORDS (NOTARY NOT NEEDED) ON THE THIRD PAGE OF THIS REQUEST**.

Claggett & Sykes Law Firm will reimburse any reasonable copying charges you may incur. Please include a statement of copying fees. Please feel free to contact me if you have any questions.

Sincerely,
CLAGGETT & SYKES LAW FIRM

/s/ Paola Jimenez

PAOLA JIMENEZ

DECLARATION FOR MEDICAL RECORDS AND MEDICAL BILLING RECORDS

STATE OF Nevada)
) ss:
COUNTY OF Clark)

COMES NOW Michelle Fazio, who after first being duly sworn, deposes and says:

1. That Declarant is the Custodian of Medical Records and of Medical Billing Records for **Pain Institute of Nevada.**

2. That **Pain Institute of Nevada** is licensed to do business in the State of Nevada;

3. That on the 09 day of January, 2020, Declarant was served a Medical Records and Medical Billing Records Request in connection with the above-entitled cause, calling for the production of Medical Records and Medical Billing Records pertaining to: **JOYCE SEKERA.**

4. That Declarant has examined the original of both those Medical Records and Medical Billing Records and has made or has caused to be made a true and exact copy of them, and that the reproduction of them attached hereto is true and complete.

5. That the original of both those Medical Records and Medical Billing Records were made at or near the time of the act, event, condition, opinion, diagnosis recited therein by or from information transmitted by a person with knowledge, in the course of a regularly conducted activity of Declarant or **Pain Institute of Nevada;**

6. That the services provided were reasonable and necessary and the amounts charged for the services were reasonable and necessary at the time and place that the services were provided.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: 09 day of January, 2020.

DECLARANT

SEK

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and 45 CFR 164.508

To: Pain Institute of Nevada (Medical Care Provider)

Date(s) of Treatment Requested: 09/17/18 - Present

I, Joyce SeKera, do hereby authorize the above-named entity to disclose and deliver to the office of CLAGGETT & SYKES, or a representative of the office, protected health information as follows:

Information to Be Disclosed:

Any and all document relating to my physical and mental condition, any and all documents relating to treatment which I have received or am currently receiving. Such documents include, but are not limited to, any and all x-rays, radiographic studies, films, or reports, lab studies and reports, all other diagnostic studies and reports, treatment notes, handwritten notes, chart notes, nurses' notes, doctors' orders, prescription records, written records, billing statements and records, chart covers and backs, all records, and any other document of information which is or may be considered a part of my medical file, and which may be considered related to the undersigned prior, current, and/or future physical condition, treatment, and/or hospitalization.

The following items must be initialed to be included in the use and/or disclosure:

JS HIV/AIDS Related Information and/or Records
JS Mental Health Information and/or Records
JS Genetic Testing Information and/or Records
JS Drug/Alcohol Diagnosis, Treatment or Referral Information
Describe: _____

Purpose or Use of Authorization:

The documents and information referred to herein shall be used for the purposes of settling and/or litigating a disputed injury claim, with regard to any injury or incident which occurred on or about 11-4-2016 The documents and/or information to be disclosed pursuant to this Authorization "ARE NOT" limited to the documents related to the subject injury or incident. This Authorization allows for the production of documentation and information relating to "ALL DATES."

Revocation:

This Authorization shall expire on 10/10/21, unless otherwise revoked. I understand that if I desire to revoke this Authorization, prior to the above-referenced date, I must do so in writing, and deliver such writing to the entity listed above. I understand that such revocation will be effective, except to the extent that (a) the covered entity has taken action reliance thereon; or (b) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, by 45 CFR 164.508, or other applicable statutes.

I understand that the release of personal health information through this Authorization will not effect my treatment, payment, enrollment or eligibility for benefits.

I further understand that the above-referenced entity may not disclose my information, as requested herein, without my signature on this Authorization, and that my signing or refusing to sign this Authorization will not affect my ability to receive treatment, payment, or health care operations from the above-referenced entity.

THIS AUTHORIZATION IS A CONTINUING AUTHORIZATION WHICH PERMITS MY ATTORNEY AND THEIR STAFF TO OBTAIN UPDATED RECORDS BEYOND THE DATE OF THIS AUTHORIZATION.

A photostatic copy of this Authorization shall be considered as effective and valid as the original.

DATED this 10 day of 10, 2019.

Joyce Sekera
Print Name

Client's Signature

3-22-56
Date of Birth

091-48-8430
Social Security Number

Run Date: 1/09/20

Patient Procedures Ledger

WALTER M KIDWELL MD, 7065 W ANN ROAD #130-548, LAS VEGAS, NV 89130-4990
(702)878-8252

Acct Num: 31614.00

JOYCE P SEKERA
7840 NESTING PINE PL

LAS VEGAS, NV 89143

SSN: ***-**-430 **DOB:** 3/22/1956 **Sex:** F
Pat Type: 8/LIEN
Empl/Sch:
Home Ph: 702 467-5457 **Work Ph:** 000 000-0000
Cell Ph: 702 467-5457
Email:

Ins: 4941 GALLIHER ESQ, KEIT **Pol #:** 31614-PINV **Group:**

Date	Patient	Procedure	Description	Amount	DailyTot	Balance
		---------	Open Claims ---------			
9/17/18	JOYCE	99214/EST. PT OFFICE 4		450.00	450.00	450.00
6/10/19	JOYCE	99214/EST. PT OFFICE 4		450.00	450.00	900.00
6/20/19	JOYCE	6463550/FACET NERVE DESTRUCTION		4200.00	4200.00	5100.00
6/20/19	JOYCE	99152/CONSCIOUS SEDATION 15 MINS			4200.00	5100.00
7/10/19	JOYCE	99214/EST. PT OFFICE 4		450.00	450.00	5550.00
10/16/19	JOYCE	99214/EST. PT OFFICE 4		450.00	450.00	6000.00
10/16/19	JOYCE	99070/DME		210.00	660.00	6210.00
11/13/19	JOYCE	99214/EST. PT OFFICE 4		450.00	450.00	6660.00
12/11/19	JOYCE	99214/EST. PT OFFICE 4		450.00	450.00	7110.00

SEKERA001190

2030

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8252
Fax 702-878-9096

OFFICE VISIT

Date of Service: September 17, 2018

Patient Name: **Joyce P Sekera**
Patient DOB: 3/22/1956

PAIN COMPLAINTS
Low back pain

Joyce returns for follow up today.
The patient is s/p radiofrequency rhizotomy bilateral L4-5 L5-S1
Sustained improvement: 70% reduction in usual pain from Dec 2017 to May - June 2018
Symptoms are returning. VAS are 8-9 and she went into the hospital for severe pain. Her pain is bilateral low back into bilateral buttocks nad posterior thigh. She reports it is the same pain as pre-RFA. She thought it was supposed to cure her pain so felt it didn't work. I explained that we need to repeat it at 6 months up to 2 years many time. She didn't realize this or forgot. Function is declining. She is ready to repeat RFA, now understanding it's a repeat procedure.

I have reviewed Dr. Smith's notes and will request Centennial Hills Hospital records. I will CC my note to Dr. Smith.

INTERIM HISTORY
Hospitalizations or ER visits: 08/29/18 Patient went to the ER because she has severe low back pain. Pt. Was diagnosed and treated for Sciatic pain.
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Unable to work due to pain
Therapy: Pt is not currently receiving physical or chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular fissuring. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

PROCEDURES
03/09/2017
FJI B L5S1
Post injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/08/2017
MBB B L5S1
Post Injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief and pain eventually returned

11/30/2017
RFA B L5S1
Sustained: ROM has improve significantly, 70-80% resolution of usual pain until May-June of 2018

MEDICAL HISTORY
Diabetes type 2
Sciatica

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 1 tablet qd

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes rarely. The patient does not drink. The patient denies recreational drug use.

SYSTEMS REVIEW
Constitutional Symptoms: Nightsweats
Visual: Negative
ENT: Negative
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Geniturinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: See HPI
Hematologic: Negative
Integumentary: Negative
Psychological: Negative

VITAL SIGNS
Height: 60.00 Inches
Weight: 204.00 Pounds
Blood Press: 130/70 mmHg
Pulse: 54 BPM
Respirations: 16 RPM
Pain: 08

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: Mod discomfort
Transition: Slight limited
Ambulation: Patient can ambulate without assistance.
Gait: Gait is antalgic

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Alignment: Spine is straight and in normal alignment.
Tenderness: Moderate tenderness noted bilateral lower SIJ lumbar spine.
Spasm: Moderate spasm is noted in the paravertebral musculature.
Facet Tenderness: Facet joint tenderness is noted.
Spinous Tenderness: Spinous processes are non-tender.
ROM: Range of motion is decreased due to pain.
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.
Pelvic Rock: Negative for SIJ pain bilaterally
Yeoman: Negative bilaterally
Patrick's (FABER): Negative bilaterally

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented.
Mood/Affect: The patient is anxious.
Thought Processes: Thought processes are intact.
Memory: Memory is intact.

Concentration: Concentration is intact.
Suicidal Ideation: The patient denies suicidal ideation.

DIAGNOSIS
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS
M54.5 LOW BACK PAIN
M51.27 LUMBOSACRAL DISCOPATHY
M62.838 MUSCLE SPASM

COUNSELING
Radiofrequency Rhizotomy
The patient received extensive counseling regarding radiofrequency rhizotomy (RFR). The procedure to be performed was explained in detail using skeletal and anatomic model. The patient understands that RFR is a neurodestructive procedure intended to cauterize nerves for pain relief. It is expected that the nerves will re-generate in 6-24 months and repeat RFR would be needed if the pain returns. The type of sedation to be used was explained as well. All questions were answered.

Informed Consent: The procedure(s) was reviewed with the patient in detail using a skeletal model. All questions were answered. The risk were reviewed and include but are not limited to increase in pain, bleeding, infection, discitis, damage to nerves, spinal cord, structures of the neck and back, spinal headache, reaction to medication, loss of airway, pneumothorax, seizure, stroke, paralysis and death. No guarantees were made regarding outcome. The risks of injection of corticosteroids include but are not limited to thinning of bones, fractures, avascular necrosis of the hips, cataracts, weakening of structures such as ligaments, fat necrosis, dimpling of skin, adrenal suppression. Common side effects include water retention, flushing, insomnia, increased pulse and blood pressure. Diabetics will have increased blood sugars for about a week after injection. The patient has the option for sedation for the procedure. I advised the patient that conscious sedation may be utilized to provide a "twilight" effect. The patient will be arousable and able to respond throughout the procedure. This will not be a deep sedation. The patient may or may not have recall of the procedure. The risk of sedation includes loss of airway, aspiration, reaction to medication and damage to nerves.

PRESCRIPTIONS
Medication Management: I have reviewed the patient's medications with the patient including the potential risks and side effects.

Re-Start GABAPENTIN 300MG , Qty: 60, Refills: 0, sig: TAKE 1-2 QHS for NERVE PAIN for RFA pain flare

PLAN
** Adding gabapentin at night
** Recommend to take Naprosyn that Dr. Smith prescribed
** RADIOFREQUENCY RHIZOTOMY (64635) BILATERAL L5-S1
** RETURN: 4 weeks for re-evaluation with kdt
** RECORDS FROM: Centennial Hills Hospital

Katherine D Travnicek MD

Copy to: William Smith MD

Electronically signed by KATHERINE TRAVNICEK Date: 9/17/2018 Time: 9:59:18

PAIN INSTITUTE OF NEVADA
7435 W. Azure Dr. Ste 190
Las Vegas, NV 89130
Phone: 702-878-8252
Fax: 702-878-9096

Medical Records Review and Report
DATE: March 11, 2019
RE: Joyce Sekera
DOB: 03/22/1956
DOI: 11/04/2016

To Whom this May Concern:

I was asked to evaluate the medical records and bills for the care of Ms. Joyce Sekera, who is a 62-year-old female and was involved in a slip and fall on November 4th, 2016. I am currently a full-time practicing physician in private practice and board certified in Physiatry (Physical Medicine and Rehabilitation) and Pain Management. I have also provided my CV separately.

MEDICAL RECORDS & BILLING RECORDS REVIEWED
1. Centennial Hills Hospital Medical Center
2. Desert Chiropractic and Rehabilitation
3. Southern Nevada Medical Group
4. Radar Medical Group
5. Desert Institute of Spine Care
6. Western Regional Center for Brain and Spine Surgery
7. Desert Radiology
8. Steinberg Diagnostic Medical Imaging Centers
9. Las Vegas Radiology
10. Pain Institute of Nevada
11. PayLater Pharmacy

ACCIDENT HISTORY
Ms. Sekera suffered a slip and fall at work at the Venetian. She went to Centennial Hills Emergency Room that same day and reported severe low back pain and left elbow pain. She was then seen 4 days later and developed headaches, neck pain and left shoulder pain also.

PRIOR INJURIES
None reported

CLINICAL TIME LINE

11/4/2016	SLIP AND FALL
11/4/2016	ED physician evaluation at Centennial Hills Hospital Medical Center CC: Low back pain and left elbow pain, VAS 9 Exam: Left elbow tenderness Diagnosis: Back strain, left elbow pain Plan: Discharged home with ibuprofen 600 mg TID, Norco 5-325 mg TID x five days
11/8/2016	Initial consultation at Desert Chiropractic and Rehabilitation Headache - VAS 8 - with blurred vision, balance problem, memory problem, difficulty sleep, soreness and achiness Cervicalgia - VAS 7 - with numbness and tingling down bilateral arms to fingers Low back pain – VAS 7- radiating to bilateral upper legs, numbness and tingling down bilateral thighs to just below knees Left shoulder – VAS 6, Left elbow – VAS 8, Thoracic spine pain – VAS 4 Plan: Chiropractic care
11/21/2016	Office visit at Southern Nevada Medical Group with Michelle Hyla, DO

CC: Headache, trouble sleeping, anxiety, pain at cervical, thoracic and lumbar spine, abdominal, bilateral shoulders, left shoulder joint, bilateral upper arm, left elbow, left forearm, bilateral hip, left hip joint, bilateral thigh, bilateral knee, bilateral knee joint, bilateral lower leg and bilateral calf regions
Most severe pain at cervical and thoracic spine and left shoulder
Pain radiated to bilateral upper and lower extremities
Exam: Tenderness at abdomen, cervical, thoracolumbar spine, bilateral shoulder, bilateral arm, left elbow, left forearm, bilateral hip, thigh, knee, leg and calf with hypertonicity and decreased range of motion at cervical and thoracolumbar spine, left shoulder, bilateral knee, left hip, bruises at left elbow, abnormal gait with asymmetric posture
Concussion symptoms – Nausea, headache, dizziness, tinnitus, trouble remembering, balance problems, drowsiness, sensitivity to noise and light, feeling slowed down, feeling in a fog, difficulty concentrating, difficulty remembering, trouble falling asleep, more emotional than usual, irritability, sadness, nervousness, trouble finding words
Plan: Medications prescribed (cyclobenzaprine, flurbiprofen, amitriptyline, gabapentin, lidocaine), recommended conservative rehabilitation for 6-12 weeks, might need massage therapy, orthopedic evaluation and pain management consultation, pending x-ray and MRI

12/1/2016 Neurologic evaluation at Radar Medical Group with Russell Shah, MD
CC: Agitation, irritation, forgetful, personality changes, insomnia, ringing in the ear and dizziness and pain in head, neck shoulder mid and low back
Headache – At forehead and top of the head with blurred vision, light sensitivity and occipital pain
Neck pain with limited range of motion
Left shoulder pain with left hand weakness and numbness at bilateral palms
Upper and low back pain
Tightness and abnormal feeling at thighs
Exam: Tenderness at cervical paraspinal with tightness and spasm, tenderness at bilateral trapezius muscle, mild at anterior left shoulder area, between shoulder blades, thoracic paraspinal, mild/moderated at lumbar paraspinal, mild at lumbar sacral spinous process, tightness and/or spasm at lumbar paraspinal muscles, limited range of motion at cervical spine with pain on flexion and extension, limited range of motion at lumbar spine with pain on extension, abnormal left shoulder range of motion on reaching back and arm raising to 80
Diagnoses: Post-traumatic brain syndrome, cervical strain/headache, migraines secondary to post-traumatic brain syndrome and cervical strain/headache, lumbar strain, secondary insomnia due to post-traumatic brain syndrome, cervical strain/headache and lumbar strain
Plan: Prescribed medications (Flexeril and ibuprofen), labs, obtain LV radiology X-ray results and ER results, spine restrictions given, planned for upper neurodiagnostic studies if numbness persist, recommend EEG and NB

12/5/2016 Follow-up at Southern Nevada with Michelle Hyla, DO
CC: Improved left shoulder pain with some weakness
Left elbow pain better
Left hip symptoms improved, walking much better
Knee complaints remained unchanged
More pain at cervical and lumbar spine, left shoulder and headache
VAS 6-9
Exam: Unchanged – nausea, sensitivity to noise and light, cervical spine, thoracic spine, lumbar spine, bilateral shoulder, left forearm, bilateral knee left thigh, leg and calf, improved – bilateral arms, left elbow, bilateral hips and right thigh, aggravated – headache, dizziness, trouble remembering, drowsiness, balance problem, feeling slowed down, difficulty concentrating and remembering, trouble sleep, emotion than usual, irritability, sadness, nervousness, trouble finding words, right leg and calf, resolved – tinnitus

Plan: Follow-up with neurology, MRI pending, continue therapy

12/9/2016 Re-evaluation after 14 chiropractic sessions at 3x weekly
CC: Headache, cervicalgia, low back pain, pain at left shoulder, left elbow, thoracic spine, left hip
Headache – VAS 7 with nausea and dizziness
Cervicalgia – VAS 7 - stiffness, numbness, tingling down bilateral arms to fingers
Low back pain – VAS 8 with radiation to bilateral upper legs, numbness, tingling at bilateral thighs to toes
Left shoulder pain – VAS 6 with stiffness
Left elbow pain – VAS 2
Thoracic spine pain – VAS 7
Left hip pain – VAS 2
Improved overall, however not yet returned to pre-accident status

12/12/2016 EEG report by Russell Shah, MD.
Impression – This was an unremarkable EEG study, single lead EKG was normal, no evidence of a metabolic encephalopathy, no triphasic waves, no focal slowing or worrisome findings demonstrated, no cortical irritability is demonstrated, no evidence of an early cortical dementia.

12/19/2016 Follow-up at Southern Nevada with Michelle Hyla, DO
CC: Headache, cervical spine, lumbar spine and left shoulder pain
Radiating pain to bilateral upper and lower extremities, VAS 7-8
Exam: Resolved – tinnitus, abdomen tenderness and left elbow bruises, cervical spine, thoracic spine, lumbar spine, bilateral shoulders, arms, right hip, bilateral thighs, knees legs and calf and left forearm, unchanged – nausea, balance problem, sensitivity to noise and light, feeling slowed, difficulty concentrating and remembering, improved – left elbow, aggravated – headache, dizziness, trouble remembering, drowsiness, trouble falling asleep, more emotional than usual, irritability, sadness, nervousness, trouble finding words, left hip.
Plan: Follow-up with Dr. Shah, pending MRI of cervical and lumbar spines, continue therapy

12/20/2016 Neurologic follow-up at Radar Medical Group with Russell Shah, MD
CC: Headache, mid back low back pain and memory loss
Neck pain with numbness at bilateral hands
Ringing sensation of the ears was better
Exam: Tenderness at cervical paraspinal muscles, limited range of motion at cervical spine, lumbar spine due to pain.
Plan: Prescribed medications(Aricept and Topamax), ordered EMG/NCV of upper extremity, continue therapy, planned to consider cervical and lumbar MRI if symptoms persist.

1/9/2017 Consultation with Dr. Katherine Travnicek MD at Pain Institute of Nevada
CC: Neck, low back and bilateral knee pain
Neck pain radiates to bilateral shoulders, numbness, tingling at bilateral hands, VAS 4-9
Low back pain without radiating to legs VAS 4-9
Knee pain with some swelling that comes and goes
Exam: Cervical and lumbar range of motion was full with pain in flexion
Plan: Prescribed medication (Naproxen and Robaxin), suspected facet and disc mediated neck and low back pain, continue therapy.

1/10/2017 Neurologic follow-up at Radar Medical Group with Russell Shah, MD
CC: Intense headache, nausea, forgetful, agitated, irritated, dizziness
Neck, upper and low back pain
Continued thigh tightness and abnormal feeling
Bilateral palmar numbness and repositioning of the hands

Exam: Mild distresses, tenderness at cervical paraspinal muscles, spinal process, trapezius muscles with tightness and/or muscle spasm of cervical paraspinal, tenderness at left shoulder, positive Phalen's sign at left wrist, tenderness between shoulder blades, thoracic paraspinal with tightness, tenderness at lumbar paraspinal, lumbar sacral spinous process with tightness at lumbar paraspinal, limited range of motion at cervical spine with pain on lateral flexion and extension, positive axial compression, limited lumbar spine range of motion, abnormal range of motion at left shoulder
Plan: Prescribed medications (Topiramate/Aricept) & neuropsychology evaluation

1/16/2017 Follow-up at Southern Nevada with Michelle Hyla, DO
CC: Cervical, lumbar and left shoulder pain
Pain radiated to bilateral upper and lower extremities, VAS 7-8
Exam: Resolved – nausea, tinnitus, noise sensitivity, left elbow bruises, left elbow and forearm, improved – headache, balance problem, right shoulder and arm and right thigh, aggravated – dizziness, unchanged – trouble remembering, drowsiness, light sensitivity, feeling slowed, difficulty concentrating, remembering, trouble falling asleep, emotional than usual, irritability, sadness, nervousness, cervical spine, thoracic spine and lumbar spine, left shoulder left arm, bilateral hip, knee, leg calf and left thigh
Plan: Follow-up with neurology, continue therapy

1/30/2017 Follow up with Travnicek MD
CC: Neck, low back, bilateral knee and shoulders pain
Neck pain was constant and with stiffness, VAS 4-7
Low back pain was constant and achy
Plan: Prescribed medication (Robaxin, gabapentin), continue Naprosyn & therapy

1/30/2017 Discharge summary at Southern Nevada with Michelle Hyla, DO
CC: Residual pain at cervical, lumbar, bilateral shoulders, bilateral hips, residual headache and concussion, pain radiating down bilateral upper and lower extremities
VAS 7, overall unchanged progress
Exam: Resolved - nausea, tinnitus, left elbow bruises, left elbow and forearm, abdomen, thoracic spine, bilateral arm, bilateral thigh, knee, leg and calf
Unchanged – headache, dizziness, trouble remembering, drowsiness, balance problem, noise sensitivity, light sensitivity, feeling slowed, difficulty concentrating, remembering, trouble falling asleep, emotional than usual, irritability, sadness, nervousness, trouble finding word, cervical spine and lumbar spine, bilateral shoulder, bilateral hip with decreased range of motion at cervical spine and thoracolumbar spine
Plan: Referred to Dr. Kidwell and Shah & discharged from care

2/7/2017 Neurology follow-up at Radar Medical Group with Russell Shah, MD
CC: Memory problem
Improved headache, neck and low back pain
Less emotional and feeling better, dizziness and nausea significantly better
Bilateral hand numbness more on left, positive flick test and repositioning noted
Exam: Mild distresses, tenderness at cervical paraspinal muscles, bilateral trapezius muscles with tightness and/or muscle spasm of cervical paraspinal, positive Tinel's sign on left, positive Phalen's sign at bilateral wrist, tenderness upper thoracic paraspinal with tightness and/or muscle spasm of thoracic paraspinal muscles, tenderness at lumbar paraspinal with tightness at lumbar paraspinal, limited range of motion at cervical spine with pain on lateral flexion and extension, positive axial compression, limited lumbar spine range of motion, abnormal range of motion at left shoulder.
Plan: Prescribed medication (Aricept), continue Robaxin and ibuprofen, neuropsychology evaluation, obtain MRI results, may need hand surgeon, re-evaluate in 2 weeks.

2/20/2017 Follow up with Dr. Travnicek MD
CC: Pain at top of bilateral shoulders, VAS 5, & Low back pain, VAS 2-7
Exam: Tenderness at bilateral lower lumbar spine and bilateral L5-S1 facet joint, spasm at paravertebral muscles, decreased lumbar spine range of motion due to pain.
Plan: Administered trigger point injection at bilateral trapezius muscles and levator scapula, recommended lower lumbar L5-S1 facet joint injection, to obtain labs performed in January 2017.

3/15/2017 Follow up with Dr. Travnicek MD
CC: Neck and low back pain.
Status post L5-S1 facet joint injection with 100% pain relief for 6 hours only and then returned with worse low back pain, VAS 8
Neck pain with bilateral shoulder muscle pain, no relief with trigger point injection
Exam: Slight limited transition and antalgic gait, tenderness at bilateral L5-S1 facet joint more on left, paravertebral muscle spasm, decreased range of motion with pain
Plan: Prescribed medication (Celebrex), recommended bilateral L5-S1 facet medial branch block

4/11/2017 Neurology follow-up at Radar Medical Group with Russell Shah, MD
CC: Low back pain
Stiffness and ache in shoulder blades and legs
Less neck pain and less numbness in hands
Better in her memory, less forgetful and much less emotional
Recovering form cough and cold illness after injection, pain shot with Kidwell delayed
Exam: Mild distressed, mild lumbar paraspinal muscle tenderness with tightness and/or spasm, limited lumbar spine range of motion on extension.
Plan: Reinitiate Aricept once recovered from illness, follow-up with pain management, to hold any procedures, continue wrist splints, perform neuro-diagnostics of lower extremity

5/1/2017 Final report – Desert Chiropractic and Rehabilitation after 36 more treatments
CC: Headache, cervicalgia, low back pain, pain at left shoulder and thoracic spine.
Headache – VAS 5 with frequency of approximately two days a week.
Cervicalgia – with stiffness, numbness and tingling at bilateral hands and fingers, mild neck pain
Low back pain – VAS 6 with radiation to bilateral legs to feet and decreased numbness and tingling down the thighs to toes
Left shoulder pain – VAS 5
Thoracic spine pain – VAS 6
She has had total of 50 chiropractic treatments

5/2/2017 Neurologic follow-up at Radar Medical Group with Russell Shah, MD
CC: Improved mood, emotions and low back pain with gabapentin
Improved neck pain
Still forgetfulness
Pain at bilateral gastrocnemius, buttocks and lower back
Exam: Mild distressed on lumbar range of motion examination, tenderness at lumbar paraspinal muscles and lumbar sacral spinous process with tightness and/or spasm of lumbar paraspinal muscle, limited lumbar range of motion on extension.
Plan: Hold reinitiating of Aricept, follow-up with pain management, explained Neuro-diagnostics lower extremity result, continue wrist splints, may need surgeon evaluation if carpal tunnel syndrome continued

5/11/2017 Follow up with Dr. Travnicek MD
CC: Improving lower back pain with mild pinching feeling at lower back, VAS 3
Status post L5-S1 medial branch block with 100% relief immediately after the procedure and sustained 60% reduction in pain.
Plan: Recommended radiofrequency ablation at bilateral L5-S1 when pain returns, follow up in 3 weeks.

6/1/2017 Follow up with Dr. Travnicek MD
CC: Low back pain, VAS 3-5
Exam: Tenderness at bilateral L5-S1 facet joint with spasm at paravertebral muscles
Plan: Refilled Celebrex, recommend radiofrequency ablation at bilateral L5-S1 facet joints

6/26/2017 Follow up with Dr. Travnicek MD
CC: Low back pain, VAS 5
Plan: Recommended radiofrequency ablation at bilateral L5-S1 facet joints

7/10/2017 Follow up with Dr. Travnicek MD
CC: Low back pain, VAS 0-5
Declined radiofrequency ablation as her pain was not severe enough

7/10/2017 Neurologic follow-up at Radar Medical Group with Russell Shah, MD
CC: Constant low back pain on Celebrex
Diabetes, on Metformin
Neck pain with bilateral hand numbness and tingling more on right side and limited neck range of motion
Blurred vision, eye pain and headache
Pain radiating down legs intermittently
Some forgetfulness
Exam: Tenderness at cervical, thoracic and lumbar paraspinal muscles, tightness at thoracic and lumbar paraspinal, limited cervical range of motion, positive axial compression, limited lumbar range of motion on extension
Plan: Need to restart Aricept, continue wrist splints, perform neuro-diagnostic in 4 months if carpal tunnel symptoms persist

10/5/2017 Progress note at Desert Institute of Spine Care with Andrew Cash, MD
CC: Neck pain, VAS 6-7 and low back pain, VAS 5-7
Numbness and tingling, weakness and pain in upper and lower extremities.
Exam: tenderness at lumbar facet, painful extension, concordant facet loading, tenderness and pain at bilateral lumbar paraspinal muscles
Plan: Referred to pain medicine, ordered x-ray of neck and lower spine, give lumbar restrictions including no repetitive bending, twisting, stooping, crawling, climbing, squatting or lifting more than 10 pounds frequently or 20 pounds occasionally, follow-up in 4 weeks

10/23/2017 Follow up with Dr. Travnicek MD
CC: Low back pain without radiating to legs, VAS 5
Wanted to proceed with radio frequency ablation
Exam: Tenderness at bilateral L5-S1 lumbar facet joint, spasm at paravertebral muscles, full range of motion with pain
Plan: Prescribed medication (Gabapentin, Celebrex), recommend L5-S1 radiofrequency ablation, follow-up in three weeks

10/23/2017 Neurologic follow-up at Radar Medical Group with Russell Shah, MD
CC: Low back pain, to see pain management, Dr. Kidwell, seen by Dr. Andrew Cash, not taking Celebrex
Pain at left-sided neck, upper back, behind shoulder with tingling mainly with limited neck range of motion
Still forgetfulness and problem with recall/remembering, improved partially
Improvement with Aricept
Plan: Restart Aricept, may need further imaging for post-traumatic brain syndrome, re-evaluate in 4 months, consider neurodiagnostic studies in 6 months and hand surgeon evaluation if symptoms persist

12/7/2017 Follow up with Dr. Travnicek MD
CC: Improving low back pain, VAS 0-3

Status post radio frequency rhizotomy at bilateral L5-S1 with 100% reduction of usual pain post-procedurally and sustained 80% improvement
Plan: Planned to repeat L5-S1 radio frequency ablation when pain return in around 1 years' time, follow-up in 3 weeks

1/11/2018 Follow up with Dr. Travnicek MD
CC: Mild low back pain without lower extremity symptoms, VAS 2-3
70% improvement from radiofrequency rhizotomy
Plan: Follow-up as needed

2/22/2018 Office visit at Western Regional Center for Brain and Spine Surgery - William Smith, MD
CC: Severe low back pain
Moderate cervical spine discomfort
Mild transient improvement with chiropractic therapy, seen by pain management, received several epidural steroid injections without any significant relief
Diagnoses: Lumbar spondylosis with myelopathy, cervical spondylosis with myelopathy, other secondary scoliosis; lumbar region, back pain; sacroiliac
Exam: Walking with mildly wide-based gait with an unusual posture and knee somewhat flexed, spasm at bilateral paraspinal muscles of posterior cervical triangles more on right than left, pain on axial loading during Spurling's test and radiating pain to bilateral shoulders, areflexic at upper extremities, reduced flexion and extension of lower back, positive bilateral finger Fortin test more on left, positive Gaenslen's and Faber sign, areflexic except for left patella, pain on deep flexion & extension
Plan: Ordered x-ray of cervical spine, lumbar spine, lumbosacral spine, entire spine and CT scan of lumbar spine

8/29/2018 ED physician evaluation at Centennial Hills Hospital Medical Center
CC: Left-sided low back pain radiating to buttock since 8/28/2018 - VAS 10
Symptoms similar to previous sciatica episode
Exam: Slow steady gait, decreased back range of motion by pain
Diagnosis: Left-sided sciatica
Plan: Prescribed medications (Valium, Norco, dexamethasone, Naprosyn, Medrol, Flexeril), follow-up with primary care physician or Dr. Damaj in 1-2 days, discharged home

9/10/2018 Follow-up at Western Regional Center for Brain and Spine Surgery - William Smith, MD
CC: Low back pain
She reported multiple injections including rhizotomy without significant relief
Exam: Consistent with bilateral sacroiliac joint dysfunction with bilateral finger Fortin Maneuvers
He noted review of cervical MRI, Lumbar MRI, CT lumbar spine, flexion/extension images
Plan: He noted she has a very complicated issue as CT indicative of L5-S1 region being main pain generator. He recommended 3 foot standing X-rays to document sagittal alignment and pelvic incidence to assure spinal pelvic parameters are normal. Pain management referral for bilateral SI joint injections for diagnostic and therapeutic purposes, & recommended Naprosyn, to avoid opioids, & smoking cessation.

9/17/2018 Follow up with Dr. Travnicek MD
CC: Returning of bilateral low back pain radiating to bilateral buttocks & posterior thigh VAS 8-9
Status post L4-5 and L5-S1 radio frequency rhizotomy and sustained 70% reduction of pain from December 2017 to May-June 2018
Exam: Moderately discomfortable, slight limited transition and antalgic gait, tenderness at bilateral lower sacroiliac joint and facet joint, spasm at lumbar paravertebral muscles, decreased lumbar range of motion due to pain
Plan: Restarted gabapentin, to repeat bilateral L5-S1 radio frequency ablation at 6 months up to 2 years, follow-up in 4 weeks

02/07/2019 Follow-up at Western Regional Center for Brain and Spine Surgery - William Smith, MD
CC: Low back pain s/p rhizotomy with brief relief of pain
Noted Dr. Smith did not have Pain Institute of Nevada's notes
CT scan lumbar spine reviewed & there is rotary subluxation at L5-S1 of ~10 degrees
Diagnosis: L5-S1 level and bilateral SI joint dysfunction
Plan: Bilateral SI joint injections

IMAGING done at Desert Radiology
X-ray of lumbar spine, three views done on 8/22/2018
Mild multilevel spurring but more moderately at L2-3
Very mild sclerosis left SI joint

X-ray of cervical spine, five views done on 7/31/2018
Cervical spine straightening
Multilevel mild spondylosis
Mild degenerative changes at the mid and lower C-spine, as described

X-ray scoliosis study on 7/31/2018
No significant scoliosis
Mild degenerative changes of the thoracic and lumbar spine

X-ray of lumbar spine, four views done on 7/31/2018
Osteopenia and degenerative changes as described
No evidence of laxity or instability

CT scan of lumbosacral spine without contrast done on 7/31/2018
Mild spinal canal narrowing at L2-3, L3-4 and L4-5
Bilateral lateral recess narrowing at L4-5

IMAGING done at Steinberg Diagnostic Medical Imaging Centers
MRI of the brain done on 12/16/2016
Brain normal for age

MRI angiogram of the brain done on 12/16/2016
No significant abnormality identified on magnetic resonance angiogram of the brain

MRI of lumbar spine done on 12/21/2016
Multilevel lumbar degenerative disc disease with disc bulges extending from L1-2 through L5-S1. Annular fissuring at L4-5. No canal stenosis or neural foraminal narrowing at any level. There is note made of facet and ligamentum flavum hypertrophy at multiple levels.

MRI of cervical spine without contrast done on 12/21/2016
Mild multilevel degeneration. Mild neuroforaminal stenosis at C5-6. No spinal canal stenosis throughout. Mild dextro-curvature. Straightening of the cervical lordosis which may be seen with muscle spasm.

IMAGING done at Las Vegas Radiology
X-ray of left hip, two views performed on 11/30/2016
Mild arthropathy of each hip.
If symptoms persist, additional imaging of the hip should be considered.

X-ray of sacroiliac joint, two views performed on 11/30/2016
Mild arthropathy of each sacroiliac joint. If symptoms persist additional imaging should be considered.

X-ray of thoracic spine, two views performed on 11/14/2016
No evidence of acute skeletal pathology to the thoracic spine

X-ray of left shoulder, two views performed on 11/14/2016
No evidence of acute skeletal pathology to the left shoulder.
There are mild degenerative changes at the acromioclavicular articulation.

X-ray of cervical spine performed on 11/14/2016
No evidence of acute fracture. No significant spondylolisthesis. On the neutral, lateral projection, there is reversal of the normal lordotic curvature, could be due to spasm.

IMAGING done at Centennial Hills Hospital Medical Center.
X-ray of lumbosacral spine, three views performed on 11/04/2016
Degenerative disc disease most conspicuously at L2-3 where there is endplate osteophyte formation and some endplate sclerosis. There is slight increased density at the disk space of uncertain etiology possibly related to some calcification. Further assessment with CT or MRI scan can be obtained as clinically warranted.

X-ray of left elbow, four views performed on 11/04/2016
No evidence of acute fracture or dislocation.

PROCEDURE TIME LINE

3/9/2017	Bilateral L5-S1 facet joint injection by Dr. Travnicek MD Post VAS 100% reduction of usual pain
5/8/2017	Bilateral L5-S1 facet joint medial branch block by Dr. Travnicek MD Post VAS 100% reduction of usual pain
11/30/2017	Bilateral L5-S1 facet joint radiofrequency rhizotomy by Dr. Travnicek MD

SURGERY TIME LINE
None

Billing

1. Centennial Hills billing total is $5,662.00.
2. Desert Chiropractic and Rehabilitation total billing is $10,756.00.
3. Southern Nevada Medical Group total billing is $1,975.00.
4. Las Vegas Pharmacy total billing is $1,090.93.
5. Valley View Surgery Center total billing is $20,278.34.
6. Steinberg Diagnostic Medical Imaging total billing is $1,400.00.
7. Desert Institute of Spine Care total billing is $1,750.00.
8. Western Regional Center for Brain and Spine total billing is $1,150.00.
9. Las Vegas Radiology total billing is $3,548.00.
10. Radar Medical Group total billing is $17,088.50.
11. Walter Kidwell, MD total billing is $16,000.00.
12. Desert Radiology total billing is $78.00.
13. PayLater Pharmacy total billing is $282.33.

IMPRESSION: Causally related and based on the 11/4/16 slip and fall:

1. Low back facet mediated pain, bilateral
2. Left elbow contusion/pain, improved
3. Left shoulder strain, improved
4. Thoracic spine pain, improved
5. Cervicalgia/neck pain, improved
6. Concussion/headache with improved memory on Aricept
7. Sacroiliac joint dysfunction and pain, bilateral

COMMENTARY AND MEDICAL DECISION MAKING:

I am evaluating the medical records of Joyce Sekera (DOB 03/22/56) and I was asked to author a report regarding causation of injuries, comment on the usual and customary billing, and on her future care. All records sent to me are reviewed for the purpose of a medical decision based upon the events of the current pain complaints. The opinions of this report are within a reasonable degree of medical probability and are based upon my review and examination of the evidence in the medical records provided to me.

All of my opinions have been rendered with a reasonable degree of medical probability, but if there is relevant information that I have not yet had the opportunity to review, then my opinions may change.

My opinions in regards to Ms. Sekera are based upon my clinical experience as an active treating Physiatrist who specializes and is boarded in Physiatry and Pain Medicine. I am currently practicing full time in private practice. Based upon my review of the records available to me, I would make the following opinions to a degree of medical probability based on events and medical evidence:

1. The Centennial Hills Hospital Medical Center emergency room visit was reasonable, necessary and related to the fall on 11-4-2016. The medical bills are usual and customary for the Las Vegas area.

2. The chiropractic care (Desert Chiropractic and Rehabilitation) provided was reasonable and necessary. The care by Dr. Michelle Hyla, DO was also reasonable and necessary. The medical bills are usual and customary for the Las Vegas area.

3. The neurological care provided by Dr. Russell Shah at Radar Medical Group, including testing, was reasonable and necessary. The medical bills are usual and customary for the Las Vegas area.

4. The MRIs, CTs, and X-rays done at Desert Radiology and Steinberg Diagnostic Medical Imaging Centers and Las Vegas Radiology were reasonable and necessary. The medical bills are usual and customary for the Las Vegas area.

5. The consultation and follow up visits provided by Dr. William Smith MD at Western Regional Center for Brain and Spine Surgery were reasonable and necessary. The medical bills are usual and customary for the Las Vegas area.

6. The consultation and provided by Dr. Andrew Cash MD at Desert Institute of Spine Care was reasonable and necessary. The medical bills are usual and customary for the Las Vegas area.

7. The consultation, follow up visits and injections done by me at The Pain Institute of Nevada were reasonable and necessary. Our medical bills are usual and customary for the Las Vegas area.

8. Low back pain – She will need repeat lumbar facet joint radiofrequency rhizotomy when her pain returns. This can range 6 months up to 2 years and most patients pain returns around 12 months so 1 per year. This will need to include office visits before and after each procedure.

9. Dr. Smith did recommend bilateral sacroiliac joint injections for diagnostic and therapeutic purposes also which she will need a onetime injection. If she also has an SI joint pain generator, I would recommend repeat SI joint injections, RFA and/or SI joint fusion depending on outcomes to the procedures.

10. Further neurological care to include Aricept and follow-up visits with a neurologist.

Katherine D. Travnicek M.D.
Physical Medicine and Rehabilitation
Pain Medicine

Electronically signed by KATHERINE TRAVNICEK Date: 3/11/2019 Time: 9:24:08

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8252
Fax 702-878-9096

OFFICE VISIT

Date of Service: June 10, 2019

Patient Name: **Joyce P Sekera**
Patient DOB: 3/22/1956

PAIN COMPLAINTS
Neck
Left shoulder
Low back

Joyce returns for follow up today.

Neck and left shoulder pains - these are mild and come and go and not as bothersome as her low back pain
Activities that aggravate the pain: Walking, standing, sitting, house chores
Activities that relieve the pain: Stretch, heat pad, laying on pillows
Description of the pain: Sharp and shooting
Least pain throughout day (0-10): 1/10
Most pain throughout day (0-10): 5/10

Bilateral low back pain is constant and does not radiate down her legs. She will have pain into her buttock and posterior thighs but not past the knees. She denies leg weakness and bladder/bowel dysfunction.
Activities that aggravate the pain: Walking, house chores and getting of her bed
Activities that relieve the pain: Stretching, heat pad, putting pressure
Description of the pain: Sharp and shooting
Least pain throughout day (0-10): 3/10
Most pain throughout day (0-10): 6/10
She had done well with RFA and pain returned. She had forgotten it was a repeat procedure if pain returned. She wants to avoid spine surgery per Dr. Smith's recommendations. I recommend repeat RFA.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: **Yes.** Patient rolled out her bed and hurt her right knee, denies injury to neck or low back.
Work Status: Unemployed
Therapy: Pt is not currently receiving physical or chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular fissuring. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

XRAYS cervical spine with Flex/Ext : Report dated 7/31/2018
Cervical spine straightening with mild degenerative disc disease at C5, there is 6 to a lesser degree. C4-C5. Multilevel mild spondylosis. Flexion and extension views demonstrate no ligamentous laxity or instability.

AP and lateral thoracic and lumbar spine with right and left lateral bending: Report dated 7/31/2018
Mild endplate osteophytosis of the mid thoracic and lumbar spine. Equal excursion of right and left lateral bending. No significant scoliosis measured on chronic exam.

X-ray lumbar spine with flexion and extension: Report dated 7/31/2018
Mild degenerative disc disease at L1-L2 mL, 2–3 with multilevel mild spondylosis, most evident at L4-S1. Vascular calcifications noted with slight levoconvex curvature. No evidence of subluxation with flexion extension views.

CT lumbar spine: Without contrast: Report dated 7/31/2018
Mild levoscoliosis of the lumbar spine with anterior osteophyte formation at L1-L3. Moderate facet hypertrophy is seen at right L4-S1 levels and mild facet hypertrophy seen within the remainder of the lumbar spine.
Disc bulges causing mild spinal canal narrowing at L2-L3, L3-L4, and L4-L5 with bilateral lateral recess narrowing at L4-L5.

X-rays lumbar spine: Report dated 8/22/2018
Spurring seen mildly throughout lumbar spine, or focal involving L2-L3. Mild sclerosing of left SI joint.

PROCEDURES
03/09/2017
FJI B L5S1
Post injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/08/2017
MBB B L5S1
Post Injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief and pain eventually returned

11/30/2017
RFA B L5S1
Sustained: ROM has improve significantly, 80% resolution of usual pain. Tender ache with right side more than left.

MEDICAL HISTORY
Diabetes type 2, HbA1C 6.5 %
Memory impairment from mild TBI
Low back pain

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 500mg qd

NV & CA PMP REVIEWED 6/5/17-6/5/19 NO MEDS FOUND

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes rarely. The patient does not drink. The patient denies recreational drug use.

SYSTEMS REVIEW
Constitutional Symptoms: Negative
Visual: Negative
ENT: Headaches
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Geniturinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: See HPI
Hematologic: Negative
Integumentary: Negative
Psychological: Negative

VITAL SIGNS
Height: 66.00 Inches
Weight: 200.00 Pounds
Blood Press: 140/76 mmHg
Pulse: 64 BPM
BMI: 32.3
Pain: 05

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: Mod discomfort
Transition: Difficult
Ambulation: Patient can ambulate without assistance.
Gait: Gait is antalgic

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Alignment: lordosis increased
Tenderness: Moderate tenderness noted bilateral lower lumbar spine, bilateral SIJ and gluteals
Trigger Points: None noted.
Spasm: Moderate spasm is noted in the paravertebral musculature.
Facet Tenderness: Facet joint tenderness is noted.
Spinous Tenderness: Spinous processes are non-tender.
ROM: Full ROM with pain on extension only today
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.
Pelvic Rock: Negative for SIJ pain bilaterally
Patrick's (FABER): Mildly positive bilaterally
Yeoman: Negative bilaterally

Motor/Strength Testing:
Hip flexion (L2-L3): L 5/5, R 5/5
Hip abduction (L4-S1): L 5/5, R 5/5
Knee extension (L3-L4): L 5/5, R 5/5
Knee flexion (L5-S1): L 5/5, R 5/5
Ankle inversion (L4): L 5/5, R 5/5
Ankle eversion (S1): L 5/5, R 5/5
Ankle dorsiflexion (L4, L5): L 5/5, R 5/5
Ankle plantarflexion (S1): L 5/5, R 5/5
EHL(L5): L 5/5, R 5/5

Sensory:
L1: Normal bilaterally
L2: Normal bilaterally
L3: Normal bilaterally
L4: Normal bilaterally
L5: Normal bilaterally
S1: Normal bilaterally

Reflexes:
Knee (L4): Left 2+, right 2+
Ankle (S1): Left 2+, right 2+
No Clonus bilaterally

LOWER EXTREMITIES -- hip exam
Appearance: No masses, lesions, swelling, edema, discoloration.
Palpation: No Tenderness, trigger points, or spasm.
Range of Motion: Full range of motion in bilateral hips and no pain on hip exam

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented.
Mood/Affect: The patient is anxious.
Thought Processes: Thought processes are intact.
Memory: Memory is intact.
Concentration: Concentration is intact.
Suicidal Ideation: The patient denies suicidal ideation.

DIAGNOSIS
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS
M53.3 SACROILIAC JOINT PAIN / COCCYX PAIN
M46.1 SACROILIITIS
M51.27 LUMBOSACRAL DISCOPATHY

COUNSELING
Radiofrequency Rhizotomy
The patient received extensive counseling regarding radiofrequency rhizotomy (RFR). The procedure to be performed was explained in detail using skeletal and anatomic model. The patient understands that RFR is a neurodestructive procedure intended to cauterize nerves for pain relief. It is expected that the nerves will re-generate in 6-24 months and repeat RFR would be needed if the pain returns. The type of sedation to be used was explained as well. All questions were answered.

Informed Consent: The procedure(s) was reviewed with the patient in detail using a skeletal model. All questions were answered. The risk were reviewed and include but are not limited to increase in pain, bleeding, infection, discitis, damage to nerves, spinal cord, structures of the neck and back, spinal headache, reaction to medication, loss of airway, pneumothorax, seizure, stroke, paralysis and

death. No guarantees were made regarding outcome. The risks of injection of corticosteroids include but are not limited to thinning of bones, fractures, avascular necrosis of the hips, cataracts, weakening of structures such as ligaments, fat necrosis, dimpling of skin, adrenal suppression. Common side effects include water retention, flushing, insomnia, increased pulse and blood pressure. Diabetics will have increased blood sugars for about a week after injection. The patient has the option for sedation for the procedure. I advised the patient that conscious sedation may be utilized to provide a "twilight" effect. The patient will be arousable and able to respond throughout the procedure. This will not be a deep sedation. The patient may or may not have recall of the procedure. The risk of sedation includes loss of airway, aspiration, reaction to medication and damage to nerves.

PRESCRIPTIONS
None

PLAN
** RADIOFREQUENCY RHIZOTOMY (64635) BILATERAL L5-S1
** RETURN: 2 weeks after injection with kdt

Katherine D Travnicek MD

Copy to: William Smith MD Referring Provider Primary care provider

Electronically signed by KATHERINE TRAVNICEK Date: 6/10/2019 Time: 13:53:09

PAIN INSTITUTE OF NEVADA
7435 W. Azure Dr. Ste 190
Las Vegas, NV 89130
Phone: 702-878-8252
Fax: 702-878-9096

Supplemental Report

Patient: **Joyce Sekera**
DOB: 3/22/1956
Date of Report: June 18, 2019

To Whom this May Concern:

I was asked to provide a future cost of care for Ms. Joyce Sekera, who is a 63-year-old female and was involved in a slip and fall on November 4th, 2016. I forgot to add the formal numbers in my last report with life expectancy. Based on National Vitals Statistics Reports, Mrs Sekera is expected to live another 23 years.

FUTURE COSTS:

1. Low back facet mediated pain, bilateral

She will need repeat lumbar facet joint RFA when her pain returns. This can range 6 months up to 2 years and most patients pain returns around 12 months so 1 per year. This will need to include office visits before and after each procedure.

Interventional pain medicine visits are $450 / visit for 2 yearly visits makes $900.00 / year. For 23 years total the cost is $20,700.00.

Bilateral one level lumbar RFA (L5-S1) – PINV professional fees are $6,000.00 and the VVSC facility fee is $5,600.00 for a total of $ 11,600.00. The total cost for one repeat yearly for the next 23 years is $266,800.00.

2. Sacroiliac joint dysfunction and pain, bilateral

Dr. William Smith MD did recommend bilateral sacroiliac joint injections for diagnostic and therapeutic purposes. I will allow a one time injection. If the SI joint is a significant pain generator, I would recommend repeat SI joint injections, RFA and/or SI joint fusion depending on outcomes to the procedures.

Bilateral SIJ Injection costs – PINV professional fees are $4,000.00 and the VVSC facility fee is $6,400.00. The total cost for one injection is $10,400.00.

Katherine D. Travnicek M.D.
Physical Medicine and Rehabilitation
Pain Medicine

Electronically signed by KATHERINE TRAVNICEK Date: 6/18/2019 Time: 15:21:25

PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: **Joyce P Sekera**
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: June 20, 2019

DIAGNOSIS
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: The patient has had successful prior radiofrquency nerve ablation. The nerves have regenerated and the pain has returned. Repeat RFA is indicated.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED FACET JOINT RADIOFREQUENCY RHIZOTOMY BILATERAL L5-S1 WITH CONSCIOUS SEDATION
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, insulated radiofrequency needle(s) were inserted percutaneously and directed to the lateral base of the superior articulating process corresponding to the location of each nerve to be lesioned. Needle position was verified in multiple fluoroscopic views. Each nerve was stimulated at 2 hz (motor) to verify needle proximity to the medial branch to be lesioned. Next, each nerve was stimulated at 2 hz 2 volts rule out major motor stimulation. Prior to lesioning, each nerve was anesthetized. Each nerve was then lesioned. After lesioning, each site was injected. All injected medications were preservative free. Injection was made slowly after negative aspiration for blood. The needles were cleared of injectate and removed. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.

SEDATION (medications titrated to effect): Fentanyl Midazolam
NEEDLE: 18g RF insulated Venom
LESION: 80 dgrees C for 90 seconds
INJECTATE (each site): Lidocaine (pf) 2% final concentration and separately Bupivicaine (pf) 0.5% final concentration were injected for a total of 1ml each site (0.5ml of each local anesthetic).

POST-PROCEDURE PAIN: Complete resolution of low back pain.

Copy to: William Smith MD Referring Provider Primary care provider

Electronically signed by KATHERINE TRAVNICEK Date: 6/20/2019 Time: 9:05:48

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8252
Fax 702-878-9096

OFFICE VISIT

Date of Service: July 10, 2019

Patient Name: **Joyce P Sekera**
Patient DOB: 3/22/1956

PAIN COMPLAINTS
Neck
Low back

Mrs Sekera returns for follow up. She saw Dr. Smith yesterday and his notes say she got no relief from the RFA. She tells me this must be an error as she feels about 70% relief in her low back pain. Her memory isn't too good she tells me so can't remember exactly what he told her but that she would need surgery at some point. She has mild pain now, improved range of motion, has less AM pain, and walks longer / farther now.
Activities that aggravate the pain: Sitting and walking for prolonged periods
Activities that relieve the pain: Stretch and exercise
Description of the pain: Ache
Least pain throughout day (0-10): 3/10
Most pain throughout day (0-10): 3/10

Neck stiffness comes/goes and isn't too bothersome. She denies arm symptoms.
Activities that aggravate the pain: Turning to the left
Activities that relieve the pain: Heat
Description of the pain: Dull
Least pain throughout day (0-10): 0/10, no pain.
Most pain throughout day (0-10): 3/10

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Unemployed
Therapy: Pt is not currently receiving physical or chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular fissuring. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

XRAYS cervical spine with Flex/Ext : Report dated 7/31/2018
Cervical spine straightening with mild degenerative disc disease at C5, there is 6 to a lesser degree. C4-C5. Multilevel mild spondylosis. Flexion and extension views demonstrate no ligamentous laxity or instability.

AP and lateral thoracic and lumbar spine with right and left lateral bending: Report dated 7/31/2018
Mild endplate osteophytosis of the mid thoracic and lumbar spine. Equal excursion of right and left lateral bending. No significant scoliosis measured on chronic exam.

X-ray lumbar spine with flexion and extension: Report dated 7/31/2018
Mild degenerative disc disease at L1-L2 mL, 2–3 with multilevel mild spondylosis, most evident at L4-S1. Vascular calcifications noted with slight levoconvex curvature. No evidence of subluxation with flexion extension views.

CT lumbar spine: Without contrast: Report dated 7/31/2018
Mild levoscoliosis of the lumbar spine with anterior osteophyte formation at L1-L3. Moderate facet hypertrophy is seen at right L4-S1 levels and mild facet hypertrophy seen within the remainder of the lumbar spine.
Disc bulges causing mild spinal canal narrowing at L2-L3, L3-L4, and L4-L5 with bilateral lateral recess narrowing at L4-L5.

X-rays lumbar spine: Report dated 8/22/2018
Spurring seen mildly throughout lumbar spine, or focal involving L2-L3. Mild sclerosing of left SI joint.

PROCEDURES
03/09/2017
FJI B L5S1
Post injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/08/2017
MBB B L5S1
Post Injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief and pain eventually returned

11/30/2017
RFA B L5S1
Sustained: ROM has improve significantly, 80% resolution of usual pain. Tender ache with right side more than left.

06/20/2019
RFA B L5S1
Sustained: 70% reduction of usual pain with improved ROM again

MEDICAL HISTORY
Diabetes type 2, HbA1C 6.5
Memory impairment from mild TBI
Low back pain

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 500mg qd

NV & CA PMP REVIEWED 6/5/17-6/5/19 NO MEDS FOUND

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes rarely. The patient does not drink. The patient denies recreational drug use.

SYSTEMS REVIEW
Constitutional Symptoms: Negative
Visual: Negative
ENT: Negative
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Geniturinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Negative

VITAL SIGNS
Height: 66.00 Inches
Weight: 205.00 Pounds
Blood Press: 134/78 mmHg
Pulse: 82 BPM
BMI: 33.1
Pain: 03

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: Mild discomfort
Transition: Slight limited
Ambulation: Patient can ambulate without assistance.
Gait: Gait is normal

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Tenderness: Mild tenderness noted bilateral lower lumbar spine
Trigger Points: None noted.
Spasm: Mild spasm is noted in the paravertebral musculature.
Facet Tenderness: Facet joint tenderness is noted.
Spinous Tenderness: Spinous processes are non-tender.
ROM: Full ROM with mild pain on extension only
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented x3. No sign of impairment.
Mood / Affect: Mood is normal. Full affect.
Thought Process: Intact.
Memory: Intact.
Concentration: Intact.
Suicidal Ideation: None.

DIAGNOSIS
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS
M51.27 LUMBOSACRAL DISCOPATHY
M62.838 MUSCLE SPASM

PRESCRIPTIONS
None

PLAN
** RETURN: As needed when her pain returns

Katherine D Travnicek MD

Copy to: William Smith MD

Electronically signed by KATHERINE TRAVNICEK Date: 7/10/2019 Time: 11:20:13

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8252
Fax 702-878-9096

OFFICE VISIT

Date of Service: October 16, 2019

Patient Name: **Joyce P Sekera**
Patient DOB: 3/22/1956

PAIN COMPLAINT
Low back

Joyce returns for follow up today.
The patient is s/p radiofrequency rhizotomy bilateral L5-S1 in June 2019
Sustained improvement: She feels she had significant pain relief but it returned and she can't remember when exactly.
Low back pain is a constant dull ache and involves whole low back with some posterior thigh pain. She denies numbness, tingling or weakness.
Activities that aggravate the pain: Sitting, standing, walking
Activities that relieve the pain: Apply pressure while sitting down
Description of the pain: Dull, ache, stiffness
Least pain throughout day (0-10): 2/10
Most pain throughout day (0-10): 6/10
Helpful treatments: Ice and heat, laying down
Non-helpful treatments: N/A
She can't bend over and pick up grandkids and can't do certain activities with them (sports).
Dr. Smith is on some sabbatical and won't be returning for some time ? It's unclear if he'll return to practice. She was transferred to Dr. Garber who recommended a SCS trial. She read the risks and would like to hold off. He ordered a bunch of new imaging which I don't have so will request.

She is seeing her PCP for diabetes and she hasn't seen Dr. Shah lately. Her memory is still impaired and I recommend seeing him again.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Retired
Therapy: Pt is not currently receiving physical or chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular fissuring. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

XRAYS cervical spine with Flex/Ext : Report dated 7/31/2018
Cervical spine straightening with mild degenerative disc disease at C5, there is 6 to a lesser degree. C4-C5. Multilevel mild spondylosis. Flexion and extension views demonstrate no ligamentous laxity or instability.

AP and lateral thoracic and lumbar spine with right and left lateral bending: Report dated 7/31/2018
Mild endplate osteophytosis of the mid thoracic and lumbar spine. Equal excursion of right and left lateral bending. No significant scoliosis measured on chronic exam.

X-ray lumbar spine with flexion and extension: Report dated 7/31/2018

Mild degenerative disc disease at L1-L2 mL, 2–3 with multilevel mild spondylosis, most evident at L4-S1. Vascular calcifications noted with slight levoconvex curvature. No evidence of subluxation with flexion extension views.

CT lumbar spine: Without contrast: Report dated 7/31/2018
Mild levoscoliosis of the lumbar spine with anterior osteophyte formation at L1-L3. Moderate facet hypertrophy is seen at right L4-S1 levels and mild facet hypertrophy seen within the remainder of the lumbar spine.
Disc bulges causing mild spinal canal narrowing at L2-L3, L3-L4, and L4-L5 with bilateral lateral recess narrowing at L4-L5.

X-rays lumbar spine: Report dated 8/22/2018
Spurring seen mildly throughout lumbar spine, or focal involving L2-L3. Mild sclerosing of left SI joint.

PROCEDURES
03/09/2017
FJI B L5S1
Post injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/08/2017
MBB B L5S1
Post Injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief and pain eventually returned

11/30/2017
RFA B L5S1
Sustained: ROM has improve significantly, 80% resolution of usual pain. Tender ache with right side more than left.

06/20/2019
RFA B L5S1
Sustained: Patients pain has returned

MEDICAL HISTORY
Diabetes type 2, HbA1C 6.8%
Memory impairment from mild TBI
Low back pain s/p slip & fall

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 500mg TID

NV & CA PMP REVIEWED 6/5/17-6/5/19 NO MEDS FOUND

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes rarely. The patient does not drink. The patient denies recreational drug use.

REVIEW OF SYSTEMS
Constitutional Symptoms: Fatigue
Visual: Decreased vision
ENT: Headache
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Geniturinary: Negative
Endocrine: Negative
Musculoskeletal:
Neurological: Arm numbness
Hematologic: Negative
Integumentary: Negative
Psychological: Negative

VITAL SIGNS
Height: 65.00 Inches
Weight: 200.00 Pounds
Blood Press: 128/72 mmHg
Pulse: 47 BPM

BMI: 33.3
Pain: 05

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: Mild discomfort
Transition: Slight limited
Ambulation: Patient can ambulate without assistance.
Gait: Gait is antalgic

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Tenderness: Moderate tenderness noted bilateral lower lumbar spine and very mild at Left SIJ
Trigger Points: None noted.
Spasm: Moderate spasm is noted in the paravertebral musculature.
Facet Tenderness: Facet joint tenderness is noted.
Spinous Tenderness: Spinous processes are non-tender.
ROM % of normal
Flexion: 75% with pain.
Extension: 75% with pain.
Pain is equal with flexion and extension.
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.
Pelvic Rock: Negative for SIJ pain bilaterally
Patrick's (FABER): Negative bilaterally
Yeoman: Negative bilaterally

Motor/Strength Testing:
Hip flexion (L2-L3): L 5/5, R 5/5
Hip abduction (L4-S1): L 5/5, R 5/5
Knee extension (L3-L4): L 5/5, R 5/5
Knee flexion (L5-S1): L 5/5, R 5/5
Ankle inversion (L4): L 5/5, R 5/5
Ankle eversion (S1): L 5/5, R 5/5
Ankle dorsiflexion (L4, L5): L 5/5, R 5/5
Ankle plantarflexion (S1): L 5/5, R 5/5
EHL(L5): L 5/5, R 5/5

Sensory:
L1: Normal bilaterally
L2: Normal bilaterally
L3: Normal bilaterally
L4: Normal bilaterally
L5: Normal bilaterally
S1: Normal bilaterally

Reflexes:
Knee (L4): Left 2+, right 2+
Ankle (S1): Left 2+, right 2+
No Clonus bilaterally

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented.
Mood/Affect: Mood and affect are normal.
Thought Processes: Thought processes are intact.
Concentration: Concentration is intact.
Suicidal Ideation: The patient denies suicidal ideation.

DIAGNOSIS
M51.27 LUMBOSACRAL DISCOPATHY
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS
M54.5 LOW BACK PAIN
M62.838 MUSCLE SPASM

COUNSELING
Home Exercise Program
The patient received extensive counseling regarding home exercise and stretching. Specific discussion included appropriate exercises for the patient, exercise tolerance and limitations. All questions were answered.

PRESCRIPTION
None

PLAN
** REFERRAL TO: PHYSICAL THERAPY: 3x / week for 8 weeks. Evaluate and treat. Therapeutic exercise & HEP
** DME: Lumbar brace

** RECORDS FROM: Jason Garber MD
** I recommend she see Dr. Shah for her memory concerns, doesn't remember if she took Aricept
** RETURN: 4 weeks for re-evaluation with kdt

Katherine D Travnicek MD

Copy to: Jason Garber MD Primary care provider Russell Shah

Electronically signed by KATHERINE TRAVNICEK Date: 10/16/2019 Time: 8:58:40

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8252
Fax 702-878-9096

OFFICE VISIT

Date of Service: November 13, 2019

Patient Name: **Joyce P Sekera**
Patient DOB: 3/22/1956

PAIN COMPLAINTS
Low back pain

Ms Sekera returns for follow up.

Memory - she is seeing Dr. Shah again who ordered a work up - pending currently.

Low back pain - this is mild now and PT is really helping currently with exercise and massage at 3x weekly. She has no pain down her legs, numbness, tingling.
Activities that aggravate the pain: Sitting, standing, bending
Activities that relieve the pain: Stretching, pelvic exercise, heat, massage
Description of the pain: Ache
Least pain throughout day (0-10): 2/10
Most pain throughout day (0-10): 3/10
Helpful treatments: Physical therapy, injections
Non-helpful treatments: N/A
She saw Dr. Shah, Garber MD and repeated her MRIs so I will request those records.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Unemployed
Therapy: Pt is currently receiving physical therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
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L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

XRAYS cervical spine with Flex/Ext : Report dated 7/31/2018
Cervical spine straightening with mild degenerative disc disease at C5, there is 6 to a lesser degree. C4-C5. Multilevel mild spondylosis. Flexion and extension views demonstrate no ligamentous laxity or instability.

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CT lumbar spine: Without contrast: Report dated 7/31/2018
Mild levoscoliosis of the lumbar spine with anterior osteophyte formation at L1-L3. Moderate facet hypertrophy is seen at right L4-S1

levels and mild facet hypertrophy seen within the remainder of the lumbar spine.
Disc bulges causing mild spinal canal narrowing at L2-L3, L3-L4, and L4-L5 with bilateral lateral recess narrowing at L4-L5.

X-rays lumbar spine: Report dated 8/22/2018
Spurring seen mildly throughout lumbar spine, or focal involving L2-L3. Mild sclerosing of left SI joint.

PROCEDURES
03/09/2017
FJI B L5S1
Post injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/08/2017
MBB B L5S1
Post Injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief and pain eventually returned

11/30/2017
RFA B L5S1
Sustained: ROM has improve significantly, 80% resolution of usual pain. Tender ache with right side more than left.

06/20/2019
RFA B L5S1
Sustained: Pain returning after 3 months.

MEDICAL HISTORY
Diabetes type 2, HbA1C 6.5
Memory impairment from mild TBI
Low back pain s/p slip & fall
Lumbar facet mediated pain

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 500mg qd

NV & CA PMP REVIEWED 6/5/17-6/5/19 NO MEDS FOUND

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes rarely. The patient does not drink. The patient denies recreational drug use.

REVIEW OF SYSTEMS
Constitutional Symptoms: Fatigue
Visual: Decreased vision
ENT: Negative
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Geniturinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Negative

VITAL SIGNS
Height: 66.00 Inches
Weight: 200.00 Pounds
Blood Press: 122/70 mmHg
Pulse: 87 BPM
BMI: 32.3
Pain: 03

PHYSICAL EXAMINATION

GENERAL APPEARANCE
Appearance: Mild discomfort
Transition: Slight limited
Ambulation: Patient can ambulate without assistance.
Gait: Gait is antalgic

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Alignment: increased lordosis
Tenderness: Mild tenderness noted bilateral lower L5-S1 and bilateral SIJ
Trigger Points: None noted.
Spasm: Mild spasm is noted in the paravertebral musculature.
Facet Tenderness: Facet joint tenderness is noted.
Spinous Tenderness: Spinous processes are non-tender.
ROM % of normal
Flexion: 75% with pain.
Extension: 100% with pain.
Pain is greater with flexion.
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.

Motor/Strength Testing:
Hip flexion (L2-L3): L 5/5, R 5/5
Hip abduction (L4-S1): L 5/5, R 5/5
Knee extension (L3-L4): L 5/5, R 5/5
Knee flexion (L5-S1): L 5/5, R 5/5
Ankle inversion (L4): L 5/5, R 5/5
Ankle eversion (S1): L 5/5, R 5/5
Ankle dorsiflexion (L4, L5): L 5/5, R 5/5
Ankle plantarflexion (S1): L 5/5, R 5/5
EHL(L5): L 5/5, R 5/5

Sensory:
L1: Normal bilaterally
L2: Normal bilaterally
L3: Normal bilaterally
L4: Normal bilaterally
L5: Normal bilaterally
S1: Normal bilaterally

Reflexes:
Knee (L4): Left 2+, right 2+
Ankle (S1): Left 2+, right 2+
No Clonus bilaterally

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented.
Mood/Affect: Mood and affect are normal.
Thought Processes: Thought processes are intact.
Concentration: Concentration is intact.
Suicidal Ideation: The patient denies suicidal ideation.

DIAGNOSIS
M51.27 LUMBOSACRAL DISCOPATHY
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS
M54.5 LOW BACK PAIN
M62.838 MUSCLE SPASM
F07.81 POST CONCUSSIVE SYNDROME

PRESCRIPTIONS
None

PLAN
** CONTINUE CURRENT PHYSICAL THERAPY REGIMEN
** RECORDS FROM: Jason Garber MD, Russell Shah
** RETURN: 4 weeks for re-evaluation with kdt

Katherine D Travnicek MD

Copy to: Russell Shah Jason Garber MD

Electronically signed by KATHERINE TRAVNICEK Date: 11/13/2019 Time: 8:46:49

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8252
Fax 702-878-9096

OFFICE VISIT

Date of Service: December 11, 2019

Patient Name: **Joyce P Sekera**
Patient DOB: 3/22/1956

PAIN COMPLAINTS
Low back pain

Ms Sekera returns for follow up today.

Low back pain - today is a good day, pain scores are mild, she had leg radiating pain but hasn't lately that she can remember. She denies leg weakness, numbness, tingling.
Activities that aggravate the pain: Some exercises at the physical therapy.
Activities that relieve the pain: Heat and stretching, massage, back brace
Description of the pain: Ache
Least pain throughout day (0-10): 2/10
Most pain throughout day (0-10): 3/10
Helpful treatments: Physical therapy, injections, back brace
Non-helpful treatments: N/A
She takes no oral pain medications.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Unemployed
Therapy: Pt is currently receiving physical therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular fissuring. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

XRAYS cervical spine with Flex/Ext : Report dated 7/31/2018
Cervical spine straightening with mild degenerative disc disease at C5, there is 6 to a lesser degree. C4-C5. Multilevel mild spondylosis. Flexion and extension views demonstrate no ligamentous laxity or instability.

AP and lateral thoracic and lumbar spine with right and left lateral bending: Report dated 7/31/2018
Mild endplate osteophytosis of the mid thoracic and lumbar spine. Equal excursion of right and left lateral bending. No significant scoliosis measured on chronic exam.

X-ray lumbar spine with flexion and extension report dated 7/31/2018
Mild degenerative disc disease at L1-L2 mL, 2–3 with multilevel mild spondylosis, most evident at L4-S1. Vascular calcifications noted with slight levoconvex curvature. No evidence of subluxation with flexion extension views.

CT lumbar spine without contrast: Report dated 7/31/2018
Mild levoscoliosis of the lumbar spine with anterior osteophyte formation at L1-L3. Moderate facet hypertrophy is seen at right L4-S1 levels and mild facet hypertrophy seen within the remainder of the lumbar spine.
Disc bulges causing mild spinal canal narrowing at L2-L3, L3-L4, and L4-L5 with bilateral lateral recess narrowing at L4-L5.

X-rays lumbar spine: Report dated 8/22/2018
Spurring seen mildly throughout lumbar spine, or focal involving L2-L3. Mild sclerosing of left SI joint.

MRI cervical spine: Report date 9/30/2019
1. The exam is slightly limited by motion artifact.
2. There is loss of the normal lordotic curvature of the cervical spine. In the correct clinical setting this may reflect injury. Clinical correlation is recommended.
3. At C5-6,there is bulging of the disc. This results in an anterior impression on the thecal sac.
4. At C6-7, there is a right paracentral disc herniation demonstrating elevation of the posterior longitudinal ligament and sffacement of the anterior thecal sac. There are no osteophytes. There is mild central canal stenosis to the right to 1.0cm

X-ray cervical spine: Report date 9/30/2019
1. There is straightening of the normal cervical lordosis which can be seen in acute cervical injury. Clinical correlation is recommeded.
2. There are no significant changes in vertebral body alignment on the lateral flexion/extension views to indicate ligamentouslaxity or instability.
3. There are degenerative changes at C4-5 and C5-6 with anterior osteophytes.
4. Please see the separate dictation for the MRI of the cervical spine dated the same day for additional findings.

MRI lumbar spine: Report date 9/30/2019
1. At L1-2, there is bulging of the disc. This results in anterior impression on the thecal sac.
2. At L2-3, there is bulging of the disc resulting in effacement of the anterior thecal sac. There is facet hypertrophy with bilateral facet effusions. Thereis mild bilateral foraminal stenosis.
3. At L3-4, there is facet hypertrophy with small bilateral facet effusions.
4. At L4-5, there is bulging of the disc resulting in effacement of the anterior thecal sac. There is facet hypertrophy. There is mild bilateral foraminal stenosis.
5. At L5-S1, there is facet hypertrophy, with bilateral facet effusions. There is mild left foraminal stenosis. There is mild central canal stenosis to 0.9cm.

CT lumbar spine: Report date 9/30/2019
1. There are degenerative changes throughout the lumbar spine with osteophte formation. There is also anterior endplate sclerosis at L1-2 and L2-3. There is facet hypertrophy, most pronounced in the lower lumbar spine.
2. No acute fractures.
3. Please see the separate dictation for the MRI of the lumbar spine dated the same day for additional findings related to soft disc pathology.

X-ray lumbar spine: Report date 9/30/2019
1. There are degenerative changes to the lumbar spine with osteophyte formation. There is also facet hypertrophy in the lumbar spine.
2. There are no significant changes in vetebral bady alignment on the lateral flexion/extension views to indicate ligamentous laxity or instability.
3. Please see separate dictation for the MRI of the lumbar spine dated the same date for additional findings.

PROCEDURES
03/09/2017
FJI B L5S1
Post injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/08/2017
MBB B L5S1
Post Injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief and pain eventually returned

11/30/2017
RFA B L5S1
Sustained: ROM has improve significantly, 80% resolution of usual pain. Tender ache with right side more than left.

06/20/2019
RFA B L5S1
Sustained: Pain returning after 3 months.

MEDICAL HISTORY
Diabetes type 2, HbA1C 6.5

Memory impairment from mild TBI
Low back pain s/p slip & fall
Lumbar facet mediated pain

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 500mg qd

NV & CA PMP REVIEWED 6/5/17-6/5/19 NO MEDS FOUND

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes rarely. The patient does not drink. The patient denies recreational drug use.

REVIEW OF SYSTEMS
Constitutional Symptoms: Fatigue
Visual: Decreased vision
ENT: Negative
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Geniturinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Negative

VITAL SIGNS
Height: 66.00 Inches
Weight: 200.00 Pounds
Blood Press: 140/86 mmHg
Pulse: 68 BPM
Respirations: 18 RPM
BMI: 32.3
Pain: 02

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: No discomfort
Transition: Normal
Ambulation: Patient can ambulate without assistance.
Gait: Gait is normal

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Alignment: Spine is straight and in normal alignment.
Tenderness: None noted.
Trigger Points: None noted.
Spasm: Moderate spasm is noted in the paravertebral musculature.
Facet Tenderness: No facet joint tenderness noted.
Spinous Tenderness: Spinous processes are non-tender.
ROM: Full ROM with pain.
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented.
Mood/Affect: Mood and affect are normal.
Thought Processes: Thought processes are intact.
Concentration: Concentration is intact.

Suicidal Ideation: The patient denies suicidal ideation.

DIAGNOSIS
M51.27 LUMBOSACRAL DISCOPATHY
M47.816 LUMBAR FACET JOINT ARTHROPATHY / SPONDYLOSIS
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS
M54.5 LOW BACK PAIN
S06.0 CONCUSSION
M62.838 MUSCLE SPASM

COUNSELING
Home Exercise Program
The patient received extensive counseling regarding home exercise and stretching. Specific discussion included appropriate exercises for the patient, exercise tolerance and limitations. All questions were answered.

PRESCRIPTIONS
None

PLAN
** Will hold on SCS trial, doing well currently
** RETURN: 3 months for re-evaluation and PRN when needed with kdt

Katherine D Travnicek MD

Copy to: Jason Garber MD Russell Shah Primary care provider

Electronically signed by KATHERINE TRAVNICEK Date: 12/11/2019 Time: 8:27:10

SimonMed
See Tomorrow Today

FINAL

SimonMed Centennial
DIAGNOSTIC IMAGING REPORT

Patient: **Sekera, Joyce** Sex: F DOB: Mar 22, 1956 Age: 63 Diag. Imaging # 3349958
Status: Outpatient
Referring Physician: Jason Garber M.D.

Exam # 27621613 - **Sep 30, 2019** - MRI 3T - LUMBAR SPINE W/O CONTRAST

Exam Performed at SimonMed Centennial

HISTORY: Lower back pain after a slip and fall injury at work on 11/04/16.

TECHNIQUE: Multisequence T1 and T2 weighted images were obtained.

COMPARISON: No prior studies are available for comparison.

FINDINGS: The conus medullaris appears normal. The lordotic curvature of the lumbar spine is preserved. No evidence for abnormal solid or cystic lesions is identified. No prevertebral or paravertebral masses or fluid collections are seen and there is no evidence for abnormal marrow replacing lesion. Segmental analysis of the lumbar spine is as follows:

At L1-2, there is bulging of the disc. This results in anterior impression on the thecal sac. There is no canal stenosis or foraminal stenosis.

At L2-3, there is bulging of the disc resulting in effacement of the anterior thecal sac. There is facet hypertrophy with bilateral facet effusions. There is mild bilateral foraminal stenosis. There is no central canal stenosis.

At L3-4, there is facet hypertrophy with small bilateral facet effusions. There is no posterior disc herniation, central canal stenosis, or foraminal stenosis.

At L4-5, there is bulging of the disc resulting in effacement of the anterior thecal sac. There is facet hypertrophy. There is mild bilateral foraminal stenosis. There is no central canal stenosis.

At L5-S1, there is facet hypertrophy, with bilateral facet effusions. There is mild left foraminal stenosis. There is mild central canal stenosis to 0.9 cm. There is no right foraminal stenosis.

IMPRESSION:

1. At L1-2, there is bulging of the disc. This results in anterior impression on the thecal sac.

2. At L2-3, there is bulging of the disc resulting in effacement of the anterior thecal sac. There is facet hypertrophy with bilateral facet effusions. There is mild bilateral foraminal stenosis.

3. At L3-4, there is facet hypertrophy with small bilateral facet effusions.

4. At L4-5, there is bulging of the disc resulting in effacement of the anterior thecal sac. There is facet hypertrophy. There is mild bilateral foraminal stenosis.

5. At L5-S1, there is facet hypertrophy, with bilateral facet effusions. There is mild left foraminal stenosis. There is mild central canal stenosis to 0.9 cm.

ELECTRONICALLY SIGNED BY: Kavanagh M.D., Joseph on Oct 01, 2019

dd: September 30, 2019

Reported by: Joseph Kavanagh M.D.
Electronically signed by: Joseph Kavanagh M.D.

Thank you for your kind referral. If you would like to speak with a Radiologist regarding this exam please call 1-855-RAD-TALK.

SimonMed
See Tomorrow Today

FINAL

SimonMed Centennial
DIAGNOSTIC IMAGING REPORT

Patient: **Sekera, Joyce** Sex: F DOB: Mar 22, 1956 Age: 63 Diag. Imaging # 3349958
Status: Outpatient
Referring Physician: Jason Garber M.D.

Exam # 27621628 - **Sep 30, 2019** - CT - LUMBAR SPINE W/O CONTRAST

Exam Performed at SimonMed Centennial

HISTORY: Low back pain after a slip and fall injury on 11/4/2016.

TECHNIQUE: CT of the lumbar spine was performed without intravenous contrast material. Sagittal and coronal reformatted images were provided. The CT scan was performed according to ALARA (As Low As Reasonably Achievable) protocol.

FINDINGS: There are degenerative changes throughout the lumbar spine with osteophyte formation. There is also anterior endplate sclerosis at L1-2 and L2-3. There is facet hypertrophy, most pronounced in the lower lumbar spine.

There is no acute fracture or dislocation. The vertebral body heights and intervertebral disc spaces are preserved. There are no suspicious bony lytic or sclerotic lesions.

Evaluation of the individual levels demonstrate:

At L1-2, there is no disc herniation, spinal stenosis or neural foraminal narrowing.

At L2-3, there is no disc herniation, spinal stenosis or neural foraminal narrowing.

At L3-4, there is no disc herniation, spinal stenosis or neural foraminal narrowing.

At L4-5, there is no disc herniation, spinal stenosis or neural foraminal narrowing.

At L5-S1, there is no disc herniation, spinal stenosis or neural foraminal narrowing.

IMPRESSION:

1. There are degenerative changes throughout the lumbar spine with osteophyte formation. There is also anterior endplate sclerosis at L1-2 and L2-3. There is facet hypertrophy, most pronounced in the lower lumbar spine.

2. No acute fractures.

3. Please see the separate dictation for the MRI of the lumbar spine dated the same day for additional findings related to soft disc pathology.

ELECTRONICALLY SIGNED BY: Kavanagh M.D., Joseph on Oct 01, 2019

dd: September 30, 2019

Reported by: Joseph Kavanagh M.D.
Electronically signed by: Joseph Kavanagh M.D.

Thank you for your kind referral. If you would like to speak with a Radiologist regarding this exam please call 1-855-RAD-TALK.

SimonMed

FINAL

SimonMed Centennial
DIAGNOSTIC IMAGING REPORT

Patient: **Sekera, Joyce** Sex: F DOB: Mar 22, 1956 Age: 63 Diag. Imaging # 3349958
Status: Outpatient
Referring Physician: Jason Garber M.D.

Exam # 27621434 - **Sep 30, 2019** - MRI 3T - CERVICAL SPINE W/O CONTRAST

Exam Performed at SimonMed Centennial

HISTORY: Neck pain after a slip and fall at work on 11/4/2016.

TECHNIQUE: Multisequence T1-weighted and T2-weighted images were obtained.

FINDINGS: The exam is slightly limited by motion artifact.

The posterior fossa structures are normal. The cervical cord structures are normal. There is loss of the normal lordotic curvature of the cervical spine. In the correct clinical setting, this may reflect injury. Clinical correlation is recommended. No prevertebral or paravertebral masses or fluid collections are identified.

Segmental analysis of the cervical spine is as follows:

At C2-3, there is no evidence for disc herniation, canal stenosis or neural foraminal stenosis.

At C3-4, there is no evidence for disc herniation, canal stenosis or neural foraminal stenosis.

At C4-5, there is no evidence for disc herniation, canal stenosis or neural foraminal stenosis.

At C5-6, there is bulging of the disc. This results in an anterior impression on the thecal sac. There is no central canal stenosis or foraminal stenosis.

At C6-7, there is a right paracentral disc herniation demonstrating elevation of the posterior longitudinal ligament and effacement of the anterior thecal sac. There are no osteophytes. There is mild central canal stenosis to the right to 1.0 cm. There is no foraminal stenosis.

At C7-T1, there is no evidence for disc herniation, canal stenosis or neural foraminal stenosis.

IMPRESSION:

1. The exam is slightly limited by motion artifact.

2. There is loss of the normal lordotic curvature of the cervical spine. In the correct clinical setting, this may reflect injury. Clinical correlation is recommended.

3. At C5-6, there is bulging of the disc. This results in an anterior impression on the thecal sac.

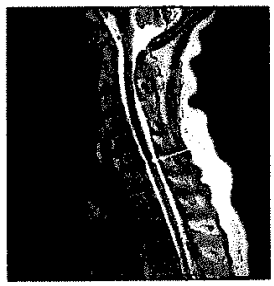
4. At C6-7, there is a right paracentral disc herniation demonstrating elevation of the posterior longitudinal ligament and effacement of the anterior thecal sac. There are no osteophytes. There is mild central canal stenosis to the right to 1.0 cm. Figure 1, Image 10, Series 2. The arrow is pointing to the posterior disc herniation at C6-7. Figure 2, Image 23, Series 4. The arrow is pointing to the herniating disc material effacing the right anterior thecal sac at C6-7.

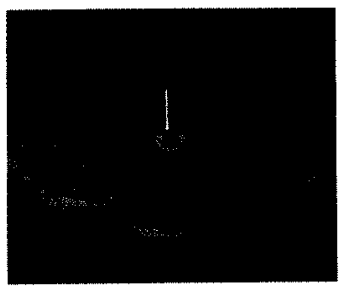
ELECTRONICALLY SIGNED BY: Kavanagh M.D., Joseph on Oct 01, 2019

dd: September 30, 2019

Reported by: Joseph Kavanagh M.D.
Electronically signed by: Joseph Kavanagh M.D.

Thank you for your kind referral. If you would like to speak with a Radiologist regarding this exam please call 1-855-RAD-TALK.





SimonMed

FINAL

SimonMed Centennial
DIAGNOSTIC IMAGING REPORT

Patient: **Sekera, Joyce** Sex: F DOB: Mar 22. 1956 Age: 63 Diag. Imaging # 3349958
Status: Outpatient
Referring Physician: Jason Garber M.D.

Exam # 27621676 - **Sep 30, 2019** - X-Ray - CERVICAL SPINE COMP W/FLEX \T\ EXT

Exam Performed at SimonMed Centennial

HISTORY: Neck pain after a slip and fall injury on 11/4/2016.

TECHNIQUE: AP. open-mouth. lateral neutral, lateral flexion, lateral extension, and swimmer s view radiographs of the cervical spine.

FINDINGS: There is straightening of the normal cervical lordosis which can be seen in acute cervical injury. Clinical correlation is recommended.

There are no significant changes in vertebral body alignment on the lateral flexion/extension views to indicate ligamentous laxity or instability.

There are degenerative changes at C4-5 and C5-6 with anterior osteophytes.

There is no fracture or dislocation. The dens is intact. The prevertebral soft tissues are unremarkable.

IMPRESSION:

1. There is straightening of the normal cervical lordosis which can be seen in acute cervical injury. Clinical correlation is recommended.

2. There are no significant changes in vertebral body alignment on the lateral flexion/extension views to indicate ligamentous laxity or instability.

3. There are degenerative changes at C4-5 and C5-6 with anterior osteophytes.

4. Please see the separate dictation for the MRI of the cervical spine dated the same day for additional findings.

ELECTRONICALLY SIGNED BY: Kavanagh M.D., Joseph on Oct 01, 2019

dd: September 30, 2019

Reported by: Joseph Kavanagh M.D.

Electronically signed by: Joseph Kavanagh M.D.

Thank you for your kind referral. If you would like to speak with a Radiologist regarding this exam please call 1-855-RAD-TALK.

SimonMed
See Tomorrow Today

FINAL

SimonMed Centennial
DIAGNOSTIC IMAGING REPORT

Patient: **Sekera, Joyce** Sex: F DOB: Mar 22, 1956 Age: 63 Diag. Imaging # 3349958
Status: Outpatient
Referring Physician: Jason Garber M.D.

Exam # 27621697 - **Sep 30, 2019** - X-Ray - LUMBOSACRAL SPINE COMP W/BENDING VIEWS MIN 6 VIEWS

Exam Performed at SimonMed Centennial

HISTORY: Low back pain after a slip and fall injury on 11/4/2016.

TECHNIQUE: AP, lateral neutral, lateral flexion, lateral extension, coned-down lateral, left oblique, and right oblique radiographs of the lumbar spine.

FINDINGS: There are degenerative changes to the lumbar spine with osteophyte formation. There is also facet hypertrophy in the lower lumbar spine.

There are no significant changes in vertebral body alignment on the lateral flexion/extension views to indicate ligamentous laxity or instability.

The facets demonstrate appropriate alignment on the oblique radiographs.

IMPRESSION:

1. There are degenerative changes to the lumbar spine with osteophyte formation. There is also facet hypertrophy in the lower lumbar spine.

2. There are no significant changes in vertebral body alignment on the lateral flexion/extension views to indicate ligamentous laxity or instability.

3. Please see the separate dictation for the MRI of the lumbar spine dated the same date for additional findings.

ELECTRONICALLY SIGNED BY: Kavanagh M.D., Joseph on Oct 01, 2019

dd: September 30, 2019

Reported by: Joseph Kavanagh M.D.

Electronically signed by: Joseph Kavanagh M.D.

Thank you for your kind referral. If you would like to speak with a Radiologist regarding this exam please call 1-855-RAD-TALK.

Patient Information	Specimen Information	Client Information
SEKERA, JOYCE **DOB: 03/22/1956 AGE: 63** Gender: F Fasting: Y Phone: 702.467.5457 Patient ID: SJ611501 Health ID: 8573017421321179	Specimen: LV756468F Requisition: 1003463 Lab Ref #: 1903V3B0 Collected: 03/26/2019 / 07:07 PDT Received: 03/27/2019 / 03:18 PDT Faxed: 06/10/2019 / 11:50 PDT	Client #: 88841239 MAIL500 MCGROREY, DONALD P MEDICAL CARE NOW 6440 N DURANGO DR STE 155 LAS VEGAS, NV 89149-8507

COMMENTS: FASTING:YES

Test Name	In Range	Out Of Range	Reference Range	Lab
LIPID PANEL (REFL)				
CHOLESTEROL, TOTAL	178		<200 mg/dL	QAW
HDL CHOLESTEROL		**42 L**	>50 mg/dL	QAW
TRIGLYCERIDES (REFL)				QAW
TRIGLYCERIDES		**198 H**	<150 mg/dL	
LDL-CHOLESTEROL		**104 H**	mg/dL (calc)	QAW
Reference range: <100				
Desirable range <100 mg/dL for primary prevention; <70 mg/dL for patients with CHD or diabetic patients with > or = 2 CHD risk factors.				
LDL-C is now calculated using the Martin-Hopkins calculation, which is a validated novel method providing better accuracy than the Friedewald equation in the estimation of LDL-C. Martin SS et al. JAMA. 2013;310(19): 2061-2068 (http://education.QuestDiagnostics.com/faq/FAQ164)				
CHOL/HDLC RATIO	4.2		<5.0 (calc)	QAW
NON HDL CHOLESTEROL		**136 H**	<130 mg/dL (calc)	QAW
For patients with diabetes plus 1 major ASCVD risk factor, treating to a non-HDL-C goal of <100 mg/dL (LDL-C of <70 mg/dL) is considered a therapeutic option.				
HEMOGLOBIN A1c		**6.5 H**	<5.7 % of total Hgb	QAW
For someone without known diabetes, a hemoglobin A1c value of 6.5% or greater indicates that they may have diabetes and this should be confirmed with a follow-up test.				
For someone with known diabetes, a value <7% indicates that their diabetes is well controlled and a value greater than or equal to 7% indicates suboptimal control. A1c targets should be individualized based on duration of diabetes, age, comorbid conditions, and other considerations.				
Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes for children.				
TSH	2.01		0.40-4.50 mIU/L	QAW

PERFORMING SITE:
QAW QUEST DIAGNOSTICS - LAS VEGAS, 4230 BURNHAM AVE, LAS VEGAS, NV 89119-5408 Laboratory Director: ELIZABETH D. IOLE, MD, CLIA: 29D0652720

Lab Results for SekEra, Joyce (Female, 03/22/1956)

practice fusion
Free cloud based EHR

Laboratory

Collection: 04/20/2017 08:52 am
Order #: 01681510
Accession #: 01681510

Name: Quest Diagnostics

Patient information

Patient ID: SJ611501
Mobile: 7024675457
Address: 7840 Nesting Pine Pl
Las Vegas, NV 89143

Requesting Provider

Name: Donald McGrorey

Attachments

attachment1
attachment1
attachment1
attachment1

COMPREHENSIVE METABOLIC PANEL

Observations	Result	Reference / UoM	Date/Status
Glucose, Fasting [1]	98	65-99 mg/dL	04/22/2017 12:44 am
BUN [1]	10	7-25 mg/dL	04/22/2017 12:44 am
Creatinine [1]	0.53	0.50-0.99 mg/dL	04/22/2017 12:44 am
BUN/Creatinine Ratio [1]	18.9	6.0-22.0 calc	04/22/2017 12:44 am
Calcium [1]	8.9	8.6-10.4 mg/dL	04/22/2017 12:44 am
Protein, Total [1]	6.7	6.1-8.1 g/dL	04/22/2017 12:44 am
Albumin [1]	4.0	3.6-5.1 g/dL	04/22/2017 12:44 am
Globulin [1]	2.7	1.9-3.7 g/dL	04/22/2017 12:44 am
A/G Ratio [1]	1.5	1.0-2.5 calc	04/22/2017 12:44 am
BILIRUBIN, TOTAL [1]	0.3	0.2-1.2 mg/dL	04/22/2017 12:44 am
Alkaline Phosphatase [1]	85	33-130 IU/L	04/22/2017 12:44 am
AST (SGOT) [1]	20	10-35 IU/L	04/22/2017 12:44 am
ALT (SGPT) [1]	29	6-29 IU/L	04/22/2017 12:44 am
Sodium [1]	139	135-146 mmol/L	04/22/2017 12:44 am
Potassium [1]	4.1	3.5-5.3 mmol/L	04/22/2017 12:44 am
Chloride [1]	104	98-110 mmol/L	04/22/2017 12:44 am
CO2 [1]	26	20-31 mmol/L	04/22/2017 12:44 am
eGFR African American [1]	119	>59 mL/min/1.73m2	04/22/2017 12:44 am
eGFR Non-AFR. American [1]	102	>59 mL/min/1.73m2	04/22/2017 12:44 am

Vendor note: The upper reference limit for Creatinine is approximately 13% higher for people identified as African-American.
Glucose reference range reflects a fasting state.
For non-fasting patients glucose reference range is 65 - 139 mg/dL.

LIPID PANEL

Observations	Result	Reference / UoM	Date/Status

CHOLESTEROL [1]	182	125-200 mg/dL	04/22/2017 12:44 am
Triglycerides [1]	93	0-150 mg/dL	04/22/2017 12:44 am
HDL Cholesterol [1]	● 44	46-199 mg/dL Below low normal	04/22/2017 12:44 am
CHOL/HDLC RATIO [1]	4.14	0.0-5.00	04/22/2017 12:44 am
LDL (Calculated) [1]	119	0-130 mg/dL	04/22/2017 12:44 am
Non-HDL Cholesterol [1]	138	0-159 mg/dL	04/22/2017 12:44 am

Vendor note: Desireable range <100 mg/dL for patients with CHD or diabetes and <70 mg/dL for diabetic patients with known heart disease.
Target for non-HDL cholesterol is 30 mg/dL higher than LDL- Cholesterol target.

CBC (H/H, RBC, INDICES, WBC, PLT)

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELL COUNT [1]	7.2	3.8-10.8 k/uL	04/22/2017 12:44 am
RBC [1]	4.31	3.80-5.10 Million/uL	04/22/2017 12:44 am
HEMOGLOBIN [1]	13.9	11.7-15.5 g/dL	04/22/2017 12:44 am
HEMATOCRIT [1]	42.2	35.0-45.0 %	04/22/2017 12:44 am
MCV [1]	98.1	80.0-100.0 fL	04/22/2017 12:44 am
MCH [1]	32.2	27.0-33.0 pg	04/22/2017 12:44 am
MCHC [1]	32.9	32.0-36.0 g/dL	04/22/2017 12:44 am
RED CELL DISTRIBUTION [1]	13.7	11.0-15.0 %	04/22/2017 12:44 am
PLATELET COUNT [1]	225	140-400 k/uL	04/22/2017 12:44 am
MEAN PLATELET VOLUME [1]	8.0	7.5-12.5 fL	04/22/2017 12:44 am

HEMOGLOBIN A1c

Observations	Result	Reference / UoM	Date/Status
Hemoglobin A1c [1]	● 6.5	0.0-5.6 %T.Hgb Above high normal	04/22/2017 12:44 am

Vendor note: For someone without known diabetes, a hemoglobin A1C value of 6.5% or greater indicates that they may have diabetes and this should be confirmed with a follow-up test.
For someone with known diabetes, a value <7% indicates that their diabetes is well controlled and a value greater than or equal to 7% indicates suboptimal control. A1C targets should be individualized based on duration of diabetes, age, co-morbid conditions, and other considerations.
Currently, no consensus exists for use of hemoglobin A1C for diagnosis of diabetes for children.

TSH

Observations	Result	Reference / UoM	Date/Status
TSH [1]	1.08	0.40-4.50 mIU/L	04/22/2017 12:44 am

Vendor note:
****
PATIENT COMMENTS:
DR DONALD MCGROREY
PATIENT FASTING.

PDF Report1

Observations	Result	Reference / UoM	Date/Status
See Attachment			04/20/2017 08:52 am

Performing Laboratory
[1] Quest Diagnostics-Elizabeth D. Iole, M.D. 4230 Burnham Ave. Las Vegas, NV 89119

WALTER M. KIDWELL, M.D.
PAIN INSTITUTE OF NEVADA

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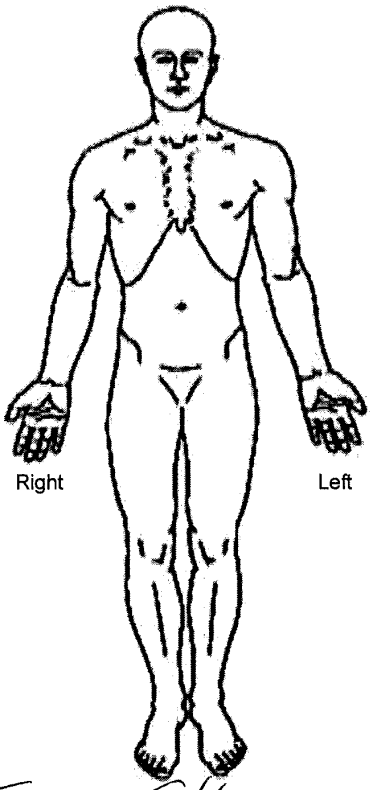

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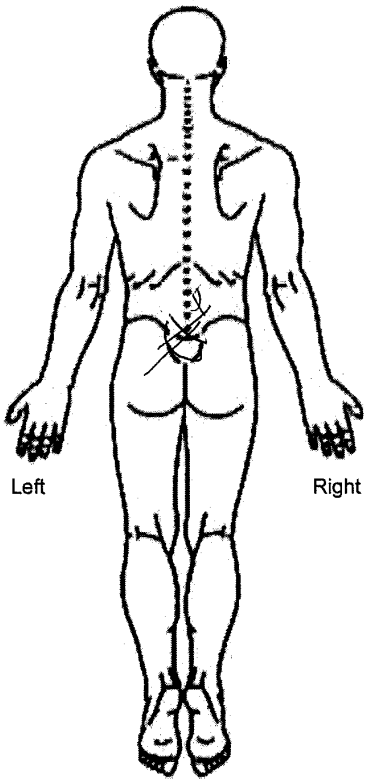

NAME Joyce Sekera
PRINT YOUR NAME

DATE 12-11-19

SEKERA001239

2079

Katherine Travnicek, M.D.

Board Certified in Physical Medicine Rehabilitation and Pain Medicine

7435 W. Azure Drive, Suite 190

Las Vegas, NV 89130

Patient name: Joyce SeKERA **Date:** 12/11/19

Patient email address: _____

Primary Care Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Primary Reason for Visit Today

Below please list your concerns and/or reasons for your visit today. Physical complaints will be the most important. Any concerns that are not addressed at your appointment today will be addressed at your next visit. **Any reasons/concerns not listed below will not be addressed.** This is our attempt to not only address pressing medical issues, but to ensure a shorter wait time as well as the wait time for our other patients.

1. Follow up

2. _____

[] Prescription Refills

[] Follow up on Lab Tests / Diagnostic procedures

[] Follow up care for other condition or symptoms

Katherine Travnicek, M.D.

WALTER M. KIDWELL, M.D.
PAIN INSTITUTE OF NEVADA

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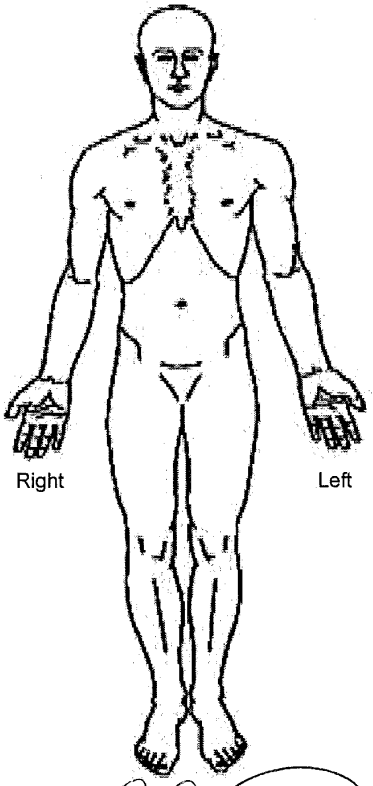

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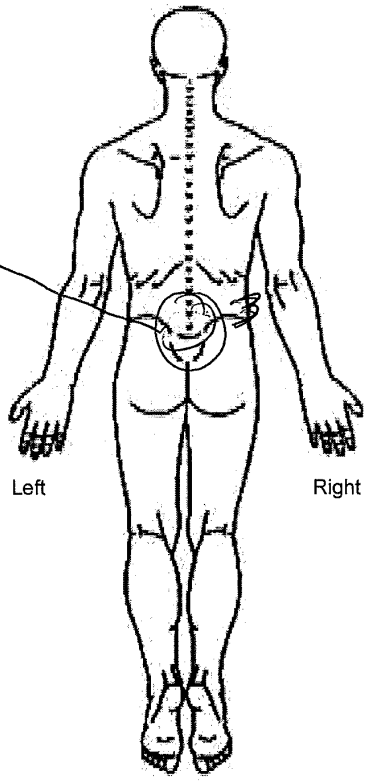

NAME Jayle Sekera

DATE 11-13-19

SEKERA001241

2081

WALTER M. KIDWELL, M.D.
PAIN INSTITUTE OF NEVADA

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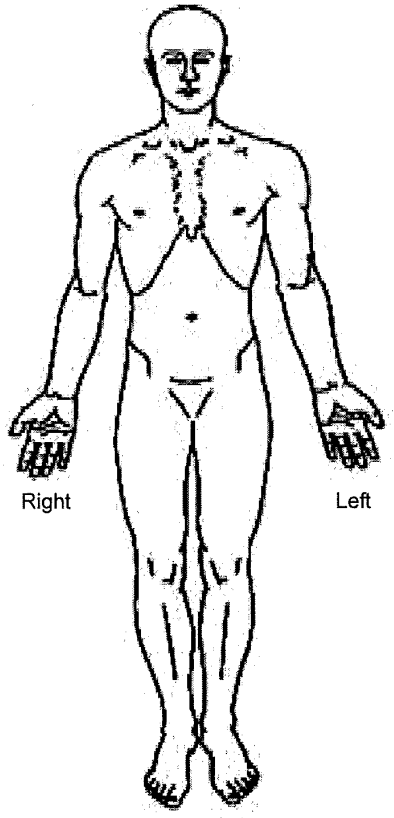

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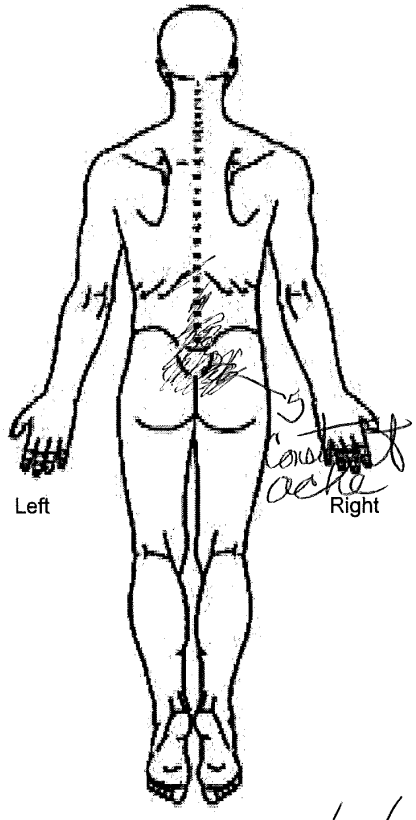

NAME Joyce Sekera
PRINT YOUR NAME

DATE 10/16/19

SEKERA001242

2082

Katherine Travnicek, M.D.

Board Certified in Physical Medicine Rehabilitation and Pain Medicine

7435 W. Azure Drive, Suite 190

Las Vegas, NV 89130

Patient name: Joyce SeKeRA Date: 10/16/19

Primary Care Name: Dr McGRORey Phone: _____

Pharmacy Name: Walgreens (FRY/ Durango) Phone: _____

Primary Reason for Visit Today

Below please list your concerns and/or reasons for your visit today. Physical complaints will be the most important. Any concerns that are not addressed at your appointment today will be addressed at your next visit. Any reasons/concerns not listed below will not be addressed. This is our attempt to not only address pressing medical issues, but to ensure a shorter wait time as well as the wait time for our other patients.

1. Lower Back Pain

2. _____

[] Prescription Refills

[] Follow up on Lab Tests / Diagnostic procedures

[] Follow up care for other condition or symptoms

Katherine Travnicek, M.D.

WALTER M. KIDWELL, M.D.
PAIN INSTITUTE OF NEVADA

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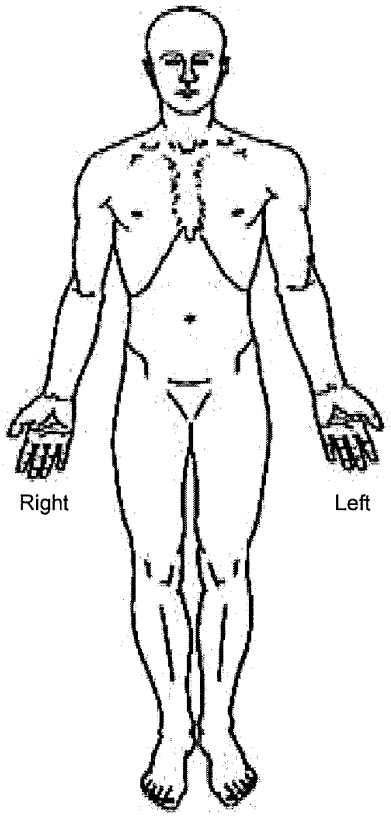

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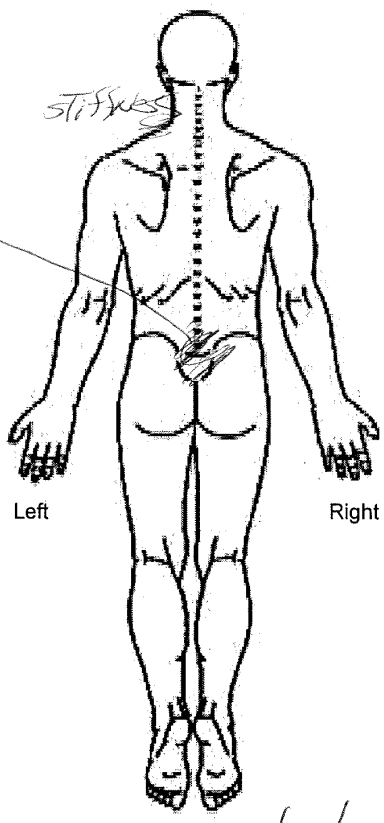

NAME Joyce SeKERA
PRINT YOUR NAME

DATE 6/10/19

SEKERA001244

2084

Katherine Travnicek, M.D.

Board Certified in Physical Medicine Rehabilitation and Pain Medicine

7435 W. Azure Drive, Suite 190

Las Vegas, NV 89130

Patient name: Joyce Sekera Date: 6/10/19

Primary Care Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Primary Reason for Visit Today

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1. Follow up

2. _____

[] Prescription Refills

[] Follow up on Lab Tests / Diagnostic procedures

[] Follow up care for other condition or symptoms

Katherine Travnicek, M.D.

INFORMED CONSENT

Pain Institute of Nevada

RADIOFREQUENCY RHIZOTOMY

Procedure(s) to be performed

- ☒ Radiofrequency Rhizotomy Cervical Facet Nerves
- ☒ Radiofrequency Rhizotomy Thoracic Facet Nerves
- ☒ Radiofrequency Rhizotomy Lumbar Facet Nerves
- ☒ Radiofrequency Rhizotomy Peripheral Nerve _____

Physician

- ☒ Walter M. Kidwell MD
- ☒ Katherine D. Travnicek MD

DESCRIPTION AND PURPOSE OF PROCEDURE

Radiofrequency rhizotomy (RFR) refers to destruction of a sensory nerve to treat or reduce pain. Radiofrequency rhizotomy means to destroy a sensory nerve with cauterization. Nerves will usually regenerate. Improvement varies from 6 months to 2 years. There is no guarantee of improvement. Pain may returj when nerves regenerate. Radiofrequency rhizotomy is performed with a needle. Fluoroscopy will be used. Sedation will be used unless specifically not requested.

BENEFITS The treatment goal is to reduce or relieve pain; however, there is no guarantee of improvement.

ALTERNATIVES Alternatives include conservative care, medications, other injections, and / or surgery.

RISKS OF THE PROCEDURE

Complications are rare and include: bleeding, infection, damage to nerves and structures of the spine, spinal headache, perforation of organs, collapsed lung, reaction to medications, increased pain, seizure, stroke, paralysis, damage to fetus if pregnant and death. You may be given antibiotics during the procedure. Your usual pain will generally be increased for a few days after the procedure. Surgery may be required to treat some complications. Sedation is used for patient comfort and to facilitate performance of the procedure. Complications of sedation are very rare and include aspiration, pneumonia, and loss of airway requiring emergency resuscitation or surgery. The risk of complications requiring transfusion is extremely low. The risks of transfusion of blood products include transfusion reaction, infection such as HIV or Hepatitis, and death.

I verify that I have read the above and that the nature and purpose of the procedure(s) have been explained to me (as noted above) as well as the risks of potential complications, side effects, benefits and alternatives. I have had the opportunity to ask questions and all questions have been answered to my satisfaction. I acknowledge that no guarantees have been made to me regarding outcome. I give my consent to and request the performance of the above named procedure(s).

I request the administration of anesthesia as may be considered necessary for my comfort or safety except as noted below.

I understand that photographs or videotaping may be requested for educational or legal purposes. I give my consent to taking such pictures or videos except as noted below.

Disclosure: Dr. Kidwell has part ownership at Valley View Surgery Center.

Exceptions to procedure, surgery, anesthesia or photography _____
(if none so state)

X _____ 6/10/19 _____
(signature of patient or guardian) *(date)* *(signature of witness)*

PHYSICIAN: I have counseled the patient regarding the nature and purpose of the proposed procedure including the attendant risks, benefits and alternatives to the procedure.

_____
(signature of counseling physician)

Sekera, Joyce DOB: 3/22/56
PATIENT IDENTIFICATION

(702) 467-5451

VVSC
6/20/19

Head

Neck

MB

LB

Sacrum
Abd
Groin
Testicles
L Knee
R Knee
L ankle
R ankle

LUE

RUE

LLE

RLE

HNP

DP

DB

FJA

FSN

CS

FS

Bleed
NSAID
SBE
Heart
Lung
OSA
DM
Allergies

RFR Pikaal L4-S1

Lumbar Exam: NP

SI joint tests: NP

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 63
DR: TRAVNICEK, KATHERINE M.D.
DOS: 06/20/19 SEX: F

PT ID	DATE

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PAIN INSTITUTE OF NEVADA

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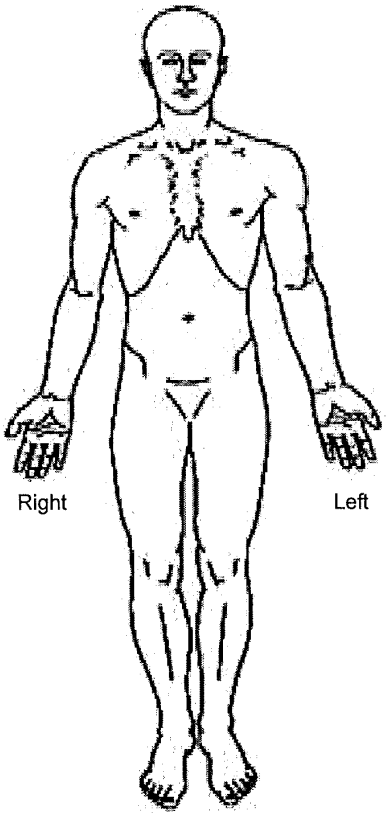

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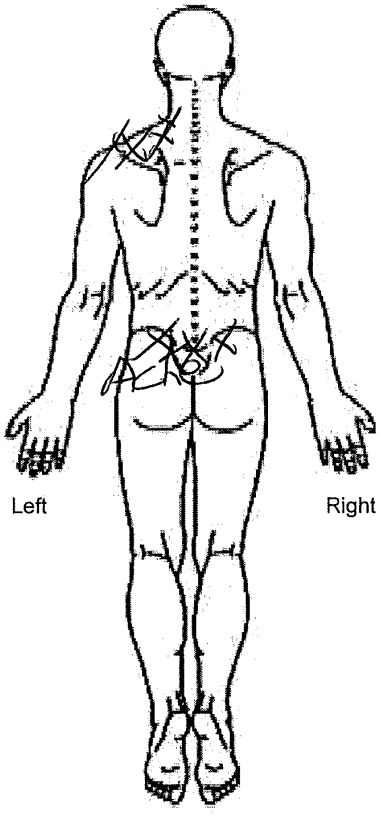

NAME Joyce Sekera
PRINT YOUR NAME

DATE 6-10-19

SEKERA001248

2088

Katherine Travnicek, M.D.

Board Certified in Physical Medicine Rehabilitation and Pain Medicine

7435 W. Azure Drive, Suite 190

Las Vegas, NV 89130

Patient name: Joyce Sekera Date: 6/10/19

Primary Care Name: Dr McGarrey Phone: 7024675457

Pharmacy Name: Walgreens Phone: 702 396 4428

Primary Reason for Visit Today

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1. Lower Back

2. Left Shoulder/Neck

[] Prescription Refills

[] Follow up on Lab Tests / Diagnostic procedures

[] Follow up care for other condition or symptoms

Katherine Travnicek, M.D.

WALTER M. KIDWELL, M.D.
PAIN INSTITUTE OF NEVADA

7435 W. Azure Drive, Suite 190
Las Vegas, NV 89130
Ph: (702) 878-8252
Fax: (702) 878-9096

INSTRUCTIONS FOR INJECTION PROCEDURE

BEFORE YOUR INJECTION

You must follow the instructions below **to avoid cancellation of procedure**.

Please arrive on time with insurance card and picture ID. Plan on being there for approximately 2-3 hours.

Physician fees and co-pays are due to our office 48 hours prior to the procedure. Surgery center fees and co-pays are due at time of procedure.

You will need a driver (family member or friend) after the procedure if you have sedation. No taxi, uber or lyft.

Note: 7 days prior to the procedures noted below, YOU MUST STOP the following medications: Arthrotec, Aspirin, Ascriptin, Bufferin, diclofenac (Voltaren), Excedrin, etodolac (Lodine), Fiorinal, flurbiprofen (Ansaid), ibuprofen (Advil, Motrin), indomethacin (Indocin), ketoprofen, ketorolac (Toradol), mobic (Meloxicam), nabumetone (Relafen), naproxen (Aleve), Norgesic, sulindac (Clinoril), Vitamin E and all herbal medications.
ALL CERVICAL INJECTIONS, ALL EPIDURALS, SELECTIVE NERVE ROOT BLOCKS, DISCOGRAPHY, SYMPATHETIC BLOCKS, & SCS TRIAL

If you are on an anti-coagulant or other blood thinning medication (Coumadin, plavix, Xarelto, etc): You must have medical clearance from prescribing physician to discontinue these medications. Patients on coumadin will need PT/INR bloodwork completed the night before the procedure.

Diabetic patients: For any steroid injection: you must check blood sugar the morning of the procedure. If your **blood sugar is more than 150**, call our office to reschedule your procedure. We must have your HbA1c done prior to any spinal cord stimulation surgery also.

If you are sick or have an acute infection and **on antibiotics**, please call the office to reschedule your procedure.

Do not eat or drink 8 hours prior to your arrival time, although, you can take your regular medications (except for the medications listed above) with a sip of water the morning of the procedure.

Please note we **do no write prescriptions at the surgery center**. You will need to schedule an appointment with our office. If you have any questions or concerns, don't hesitate to ask. Signature indicates you have read the instructions and will comply to avoid cancellation of your procedure.

Joyce Sekera
Patient Signature

Witness Signature

Joyce Sekera
Patient Print Name

6/10/19
Date

AFTER YOUR INJECTION

Do not drive for 24 hours.

Have someone assist you with walking for the first 2-3 hours after the injection, then resume your normal activities.

Do not shower or bathe until the day after the procedure.

You may resume discontinued medication the day after the procedure.

After local anesthetic wears off, you may experience pain at injection site. Apply ice for 1-2 days, then apply heat.

Common side effects due to corticosteroid injection: fluid retention, facial flushing, and insomnia for 1-2 days.
Rare complications: numbness or weakness that is progressively getting worse, loss of bowel or bladder control, fever more than 100.5, nausea and vomiting. Please call our office or answering service. If you feel it's a life threatening emergency, go to the emergency department or call 911 for ambulance transport.

See Reverse Side for Surgery Center Location Maps and Phone Numbers

WALTER M. KIDWELL, M.D.
PAIN INSTITUTE OF NEVADA

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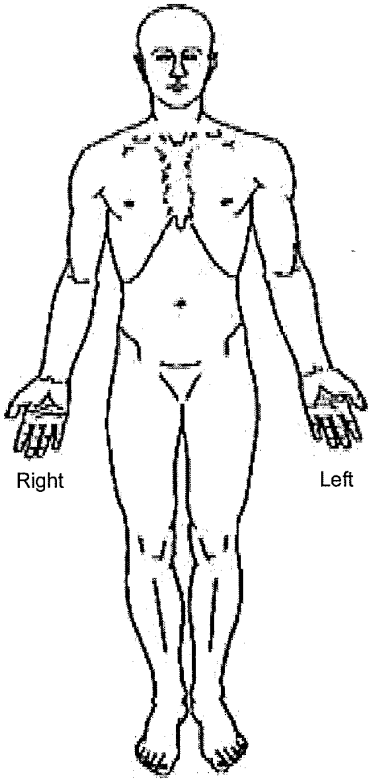
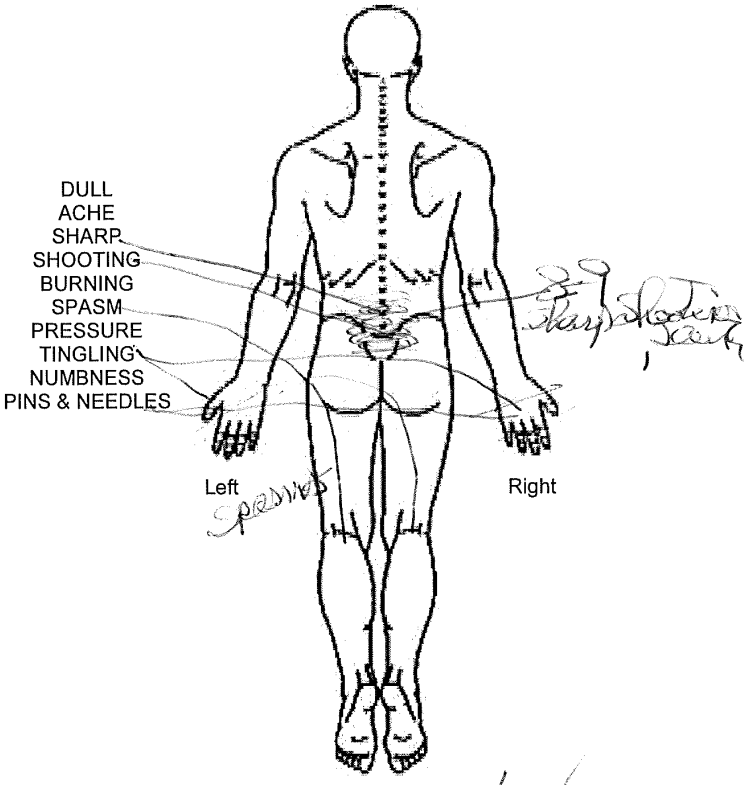
4/10: MODERATE PAIN. MINIMAL LIMITATION IN DAILY ACTIVITIES.
5/10: MODERATE PAIN. SOME LIMITATION IN DAILY ACTIVITIES.
6/10: MODERATE PAIN. MODERATE LIMITATION IN DAILY ACTIVITIES.
7/10: MODERATE SEVERE PAIN. DAILY ACTIVITIES VERY LIMITED.
8/10: MODERATELY SEVERE PAIN. DAILY ACTIVITIES VERY DIFFICULT.
9/10: SEVERE PAIN. SEVERELY LIMITS ABILTY TO DO DAILY ACTIVITIES.
10/10: SEVERE DISABLING PAIN. **CANNOT POSSIBLY BE WORSE. ESSENTIALLY UNABLE TO DO ANY ACTIVITY. UNABLE TO WORK.**





NAME Joy SeKeRA

DATE 9/17/18

SEKERA001251

2091

WALTER M. KIDWELL, M.D.
PAIN INSTITUTE OF NEVADA

7435 W. Azure Drive, Suite 190
Las Vegas, NV 89130
Ph: (702) 878-8252
Fax: (702) 878-9096

INSTRUCTIONS FOR INJECTION PROCEDURE

BEFORE YOUR INJECTION

You must follow the instructions below **to avoid cancellation of procedure**.

___ Please arrive on time with insurance card and picture ID. Plan on being there for approximately 2-3 hours.

___ Physician fees and co-pays are due to our office 48 hours prior to the procedure. Surgery center fees and co-pays are due at time of procedure.

___ You will need a driver (family member or friend) after the procedure if you have sedation. No taxi, uber or lyft.

___ **Note: 7 days prior to the procedures noted below, YOU MUST STOP** the following medications: Arthrotec, Aspirin, Ascriptin, Bufferin, diclofenac (Voltaren), Excedrin, etodolac (Lodine), Fiorinal, flurbiprofen (Ansaid), ibuprofen (Advil, Motrin), indomethacin (Indocin), ketoprofen, ketorolac (Toradol), mobic (Meloxicam), nabumetone (Relafen), naproxen (Aleve), Norgesic, sulindac (Clinoril), Vitamin E and all herbal medications. **ALL CERVICAL INJECTIONS, ALL EPIDURALS, SELECTIVE NERVE ROOT BLOCKS, DISCOGRAPHY, SYMPATHETIC BLOCKS, & SCS TRIAL**

___ **If you are on an anti-coagulant or other blood thinning medication (Coumadin, plavix, Xarelto, etc)**: You must have medical clearance from prescribing physician to discontinue these medications. Patients on coumadin will need PT/INR bloodwork completed the night before the procedure.

___ Diabetic patients: For any steroid injection: you must check blood sugar the morning of the procedure. If your **blood sugar is more than 150**, call our office to reschedule your procedure. We must have your HbA1c done prior to any spinal cord stimulation surgery also.

___ If you are sick or have an acute infection and **on antibiotics**, please call the office to reschedule your procedure.

___ **Do not** eat or drink 8 hours prior to your arrival time, although, you can take your regular medications (except for the medications listed above) with a sip of water the morning of the procedure.

Please note we **do no write prescriptions at the surgery center**. You will need to schedule an appointment with our office. If you have any questions or concerns, don't hesitate to ask. Signature indicates you have read the instructions and will comply to avoid cancellation of your procedure.

Patient Signature

Joyce Sekera
Patient Print Name

Witness Signature

9-17-18
Date

AFTER YOUR INJECTION

Do not drive for 24 hours.

Have someone assist you with walking for the first 2-3 hours after the injection, then resume your normal activities.

Do not shower or bathe until the day after the procedure.

You may resume discontinued medication the day after the procedure.

After local anesthetic wears off, you may experience pain at injection site. Apply ice for 1-2 days, then apply heat.

Common side effects due to corticosteroid injection: fluid retention, facial flushing, and insomnia for 1-2 days.
Rare complications: numbness or weakness that is progressively getting worse, loss of bowel or bladder control, fever more than 100.5, nausea and vomiting. Please call our office or answering service. If you feel it's a life threatening emergency, go to the emergency department or call 911 for ambulance transport.

See Reverse Side for Surgery Center Location Maps and Phone Numbers

RxSearch > Patient Request

Nevada PRESCRIPTION MONITORING PROGRAM

Joyce Sekera, 63F

Support: 775-687-5694 (tel:7756875694)

Narx Resources

NarxCare

Date: 06/10/2019 Download CSV (https://nevada.pmpaware.net/rx_search_requests/29451518/csv) Download PDF

Joyce Sekera

Risk Indicators

NARX SCORES			OVERDOSE RISK SCORE	ADDITIONAL RISK INDICATORS (0)
Narcotic	Sedative	Stimulant		
000	000	000	000 (Range 000-999)	

Explanation and Guidance (/narx-content/content/narxcare2/explain-these-scores.pdf) Explanation and Guidance (/narx-content/content/narxcare2/explain-overdose-risk-score.pdf) Explanation and Guidance (/narx-content/content/narxcare2/explain-these-red-flags.pdf)

This NarxCare report is based on search criteria supplied and the data entered by the dispensing pharmacy. For more information about any prescription, please contact the dispensing pharmacy or the prescriber. NarxCare scores and reports are intended to aid, not replace, medical decision making. None of the information presented should be used as sole justification for providing or refusing to provide medications. The information on this report is not warranted as accurate or complete.

Graphs

RX GRAPH ☑ Narcotic ☑ Sedative ☑ Stimulant ☑ Other

All Prescribers

Prescribers

1 - Rachael A Taylor

Timeline 06/10/2019 2m 6m 1y 2y

Morphine MgEq (MME)

320
200
80
0

Timeline 06/10 2m 6m 1y 2y

*Per CDC guidance, the MME conversion factors prescribed or provided as part of the medication-assisted treatment for opioid use disorder should not be used to benchmark against dosage thresholds meant for opioids prescribed for pain. Buprenorphine products have no agreed upon morphine equivalency, and as partial opioid agonists, are not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids. MME = morphine milligram equivalents. LME = Lorazepam milligram equivalents. mg = dose in milligrams.

Summary

Summary		Narcotics* (excluding buprenorphine)		Sedatives*		Buprenorphine*	
Total Prescriptions:	1	Current Qty:	0	Current Qty:	0	Current Qty:	0
Total Prescribers:	1	Current MME/day:	0.00	Current LME/day:	0.00	Current mg/day:	0.00
Total Pharmacies:	1	30 Day Avg MME/day:	0.00	30 Day Avg LME/day:	0.00	30 Day Avg mg/day:	0.00

SEKERA001253

PRESCRIPTIONS

Total Prescriptions: 1
Total Private Pay: 0

Fill Date	ID	Written	Drug	Qty	Days	Prescriber	Rx #	Pharmacy	Refill	Daily Dose *	Pymt Type	PMP
11/09/2016	1	11/04/2016	Hydrocodone-Acetamin 5-325 Mg	15	5	Ra Tay	1460267	Wal (0055)	0	15.00 MME	Worker's Comp	NV

*Per CDC guidance, the MME conversion factors prescribed or provided as part of the medication-assisted treatment for opioid use disorder should not be used to benchmark against dosage thresholds meant for opioids prescribed for pain. Buprenorphine products have no agreed upon morphine equivalency, and as partial opioid agonists, are not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids. MME = morphine milligram equivalents. LME = Lorazepam milligram equivalents. mg = dose in milligrams.

Providers

Total Providers: 1

Name	Address	City	State	Zipcode	Phone
Rachael A Taylor	7842 W Sahara Ave 7842 West Sahara Ave	Las Vegas	NV	89117	-

Pharmacies

Total Pharmacies: 1

Name	Address	City	State	Zipcode	Phone
Walgreen Co. (0055)	7755 N Durango Dr Dba: Walgreens # 07864	Las Vegas	NV	89131	(702) 396-4728

Physician (MD, DO):

Report contents are based on data entered by dispensers and their staff, and may contain errors. The Board of Pharmacy recommends independent verification with dispensers when prudent or necessary. Willful disclosure of prescription information may be subject to disciplinary action, civil penalties or criminal action.

Nevada PMP AWARE
For help using the application please contact:

775-687-5694 (tel:7756875694)

CURES 2.0

CURES SEARCH SUMMARY

On 06/10/2019 at 11:54 AM, the following subject was searched against the Controlled Substance Utilization Review & Evaluation System (CURES) database for reported transactions of dispensed controlled substance prescriptions.

KATHERINE TRAVNIK (CURES UserID TRAVNIK), searched the CURES database for the period of 06/10/2018 through 06/10/2019 with negative results, to wit:

Last Name: sekera
First Name: Joyce
DOB: 03/22/1956
Gender: F
Address:
City:
State:
Zip:
Search Mode: Partial Match

William D. Smith, MD

Western Regional Center for Brain & Spine Surgery
Comprehensive Neurosurgical Care

Street: 3061 S. Maryland Parkway, Suite 200
City/State/Zip: Las Vegas, NV 89109
Phone: (702) 737-1948
Fax: (702) 737-7195

Patient: Joyce P. Sekera **Patient #:** 379090 **DOB:** 03/22/1956 (63 years)

Date of Encounter: 08/05/2019

History of Present Illness

The patient is a 63 year old female who presents for a follow-up visit. Note for "Follow-up visit": I had the opportunity and pleasure of seeing this nice woman in my office today. She is now almost three years from her original injury. This 63-year-old woman continues to have severe low back pain. She apparently had a facet rhizotomy last week. I do not have the results of this or which levels were done. She states that it gave her some immediate relief, but it seems the pain is starting to return.

Additional reasons for visit:

Transition into care is described as the following:
The patient is transitioning into care and a summary of care was reviewed.

Allergies

No Known Allergies 02/26/2018
No Known Drug Allergies 02/26/2018

Past Medical History

Back pain, sacroiliac
Cervical spondylosis with myelopathy
Other secondary scoliosis, lumbosacral region
Lumbar spondylosis with myelopathy

Family History

Mother: In good health
Father: Deceased
Brother 1: In good health
Sister 1: In good health

Social History

Occupation/Work Status: Retirement (Health Related)
Marital Status: Single
Children; 1.
Living situation; Lives with his mother.
Tobacco use: Current some day smoker; Smokes 1-2 cigarettes a week.
Alcohol Use: No alcohol use
Illicit drug use: Never
HIV risk factors: None
Highest recreation level prior to spine condition; No Response.

Other Problems

Unspecified Diagnosis

Past Surgical

None (02/26/2018)

Diagnostic Studies

Chiropractor
Exercise Therapy
MRI Brain, Brain Stem
MRI, Cervical Spine
MRI, Lumbar Spine
Lumbar Spine X-ray

Vitals

08/05/2019 06:23 AM
Weight: 200 lb **Height:** 66 in
Body Surface Area: 2 m^2 **Body Mass Index:** 32.28 kg/m^2

Physical Exam

The physical exam findings are as follows:
On her examination today, she does have percussion tenderness of the mid to low back. She does have a positive finger Fortin test to the left.

Assessment & Plan

Lumbar spondylosis with myelopathy 721.42 | M47.16

- Patient Education: Low Back Pain: low back
- Patient Education: Smoking: Ways to Quit: smoking cessation
- How to access health information online
- Instructed / counseled on smoking cessation including modes of cessation. Readiness to quit and motivation assessed.
- **Review of Diagnostic Test**
  Comments: Once again, her CT scan shows a retrolisthesis at L5-S1 with lateral recess stenosis as well as changes of the SI joints bilaterally.

Other secondary scoliosis, lumbosacral region 737.43 | M41.57

- Follow up in 1 month or as needed

With this in mind, we will need to see if we can obtain Pain Management's notes. She is agreeable to this. We will not make any changes. I do believe that she should attempt to complete all injections. However, I do suspect that she ultimately will require surgical treatment.

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Katherine Travnicek, MD (702) 878-9096
Edson Erkulvrawtr, MD (702) 259-5554
Galliher Law (702) 735-0204

William D. Smith, MD

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Phone: (702) 737-1948
Fax: (702) 737-7195

Patient: Joyce P. Sekera **Patient #:** 379090 **DOB:** 03/22/1956 (63 years)

Date of Encounter: 07/08/2019

History of Present Illness

The patient is a 63 year old female who presents for a follow-up visit. Note for "Follow-up visit": This woman continues to complain of back pain. She had a rhizotomy done I believe a week or two ago. It gave her some temporary improvement, but the pain returned.

Additional reasons for visit:

Transition into care is described as the following:
The patient is transitioning into care and a summary of care was reviewed.

Allergies

No Known Allergies 02/26/2018
No Known Drug Allergies 02/26/2018

Past Medical History

Cervical spondylosis with myelopathy
Other secondary scoliosis, lumbosacral region
Back pain, sacroiliac
Lumbar spondylosis with myelopathy

Family History

Mother: In good health
Father: Deceased
Brother 1: In good health
Sister 1: In good health

Social History

Occupation/Work Status: Retirement (Health Related)
Marital Status: Single
Children; 1.
Living situation; Lives with his mother.
Tobacco use: Current some day smoker; Smokes 1-2 cigarettes a week.
Alcohol Use: No alcohol use
Illicit drug use: Never
HIV risk factors: None
Highest recreation level prior to spine condition; No Response.

Other Problems

Unspecified Diagnosis

Past Surgical

None (02/26/2018)

Diagnostic Studies

Chiropractor
Exercise Therapy
MRI Brain, Brain Stem
MRI, Cervical Spine
MRI, Lumbar Spine
Lumbar Spine X-ray

Vitals

07/08/2019 06:27 AM
Weight: 200 lb **Height:** 66 in
Body Surface Area: 2 m^2 **Body Mass Index:** 32.28 kg/m^2

Assessment & Plan

Back pain, sacroiliac 724.6 | M53.3

- Patient Education: Smoking: Ways to Quit: smoking cessation
- **Review of Diagnostic Test**
  Comments: Once again, I have reviewed her CT scan. The CT scan not only showed the rotatory scoliosis, but the left L5-S1 facet appears to have a fracture. This certainly is consistent with a work injury.

- How to access health information online
- Instructed / counseled on smoking cessation including modes of cessation. Readiness to quit and motivation assessed.

Lumbar spondylosis with myelopathy 721.42 | M47.16

- Patient Education: Low Back Pain: low back

With this in mind, once again, I do not see how this woman will be able to avoid surgical treatment for this. Rhizotomies in my opinion will give her some temporary relief, but certainly not long-term. Please do not hesitate to call me with questions. I will continue to see this woman as required.

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Phone: (702) 737-1948
Fax: (702) 737-7195

Patient: Joyce P. Sekera **Patient #:** 379090 **DOB:** 03/22/1956 (63 years)

Date of Encounter: 07/18/2019

History of Present Illness

The patient is a 63 year old female who presents for a follow-up visit. Note for "Follow-up visit": This woman was originally seen by myself on 02/22/18. The patient has a documented work injury while slipping on the floor at The Venetian. She had a loss of consciousness while striking her head. She believes that fell directly on her back. She was seen at Centennial Hills Hospital and released. She has an accepted body part of cervical and lumbar spine. This injury occurred on 11/04/16.

Over time, after multiple visits, her cervical spine actually improved dramatically. It has come to the point where this does not currently give her any difficulties. She has had multiple injections most recently a facet block at L5-S1. This gave her good relief, but unfortunately less than 24 hours.

Additional reasons for visit:

Transition into care is described as the following:
The patient is transitioning into care and a summary of care was reviewed.

Allergies

No Known Allergies 02/26/2018
No Known Drug Allergies 02/26/2018

Past Medical History

Other secondary scoliosis, lumbosacral region
Cervical spondylosis with myelopathy
Lumbar spondylosis with myelopathy
Back pain, sacroiliac

Family History

Mother: In good health
Father: Deceased
Brother 1: In good health
Sister 1: In good health

Social History

Occupation/Work Status: Retirement (Health Related)
Marital Status: Single
Children; 1.
Living situation; Lives with his mother.
Tobacco use: Current some day smoker; Smokes 1-2 cigarettes a week.
Alcohol Use: No alcohol use
Illicit drug use: Never
HIV risk factors: None
Highest recreation level prior to spine condition; No Response.

Other Problems

Unspecified Diagnosis

Past Surgical

None (02/26/2018)

Diagnostic Studies

Chiropractor
Exercise Therapy
MRI Brain, Brain Stem
MRI, Cervical Spine
MRI, Lumbar Spine
Lumbar Spine X-ray

Vitals

07/18/2019 03:28 PM
Weight: 200 lb **Height:** 66 in
Body Surface Area: 2 m^2 **Body Mass Index:** 32.28 kg/m^2

Physical Exam

The physical exam findings are as follows:
On her most recent examination, she has mechanical back pain with percussion tenderness. She does have a mild SI joint pain syndrome consistent with a positive finger Fortin test, a mild Gaenslen's maneuver, and Faber's test. She does have mild left L5 dermatomal loss of sensation with sciatic notch tenderness. She does have good power. Flexion and extension of the lumbar spine is greatly limited.

Assessment & Plan

Back pain, sacroiliac 724.6 | M53.3

- *WRCBSS Post Op and Discharge Instructions Dr. Smith
- **Review of Diagnostic Test**
  Comments: The key image is certainly her CT scan. Her CT scan of her lumbar spine was performed at Desert Radiology. This was approximately I believe 20 months after her injury. While it does show some significant degenerative changes, the most striking finding is at the L5-S1 region. There is a very mild retrolisthesis of L5 on S1. There are changes of the SI joints bilaterally. Most striking is the fact that there is a fracture at the left facet, which at this time has sclerotic margins. This is consistent with an injury of over one year. The axial image is slice location 157 and it's really quite impressive. There is also surprisingly a small rotatory subluxation at the same level at L5-S1. There are some mild lateral bulging discs. The radiologist did not seem to mention this problem with the facets, but it is really quite traumatic. There is some lateral recess stenosis at L4-5 as well.

Lumbar spondylosis with myelopathy 721.42 | M47.16

- Patient Education: Low Back Pain: low back
- Patient Education: Smoking: Ways to Quit: smoking cessation
- How to access health information online
- Instructed / counseled on smoking cessation including modes of cessation. Readiness to quit and motivation assessed.

At this time, this woman has failed aggressive nonoperative treatments. Given this, she certainly meets surgical criteria. I believe her primary issues is currently this fracture of the left L5-S1 facet with signs of instability. This certainly will need a surgical treatment. I would recommend a minimally invasive oblique ALIF at L5-S1 followed by posterior decompression and fixation. This would allow for reduction of her mild rotatory scoliosis as well. The other question would be whether or not the L4-5 region should be added given the fact that there is bilateral narrowing at L4-5 with lateral recess stenosis. Most likely this should be treated, as well so this woman can hopefully go on with her daily activities.

Of note, by her recollection, she has never been seen by a physician for back pain prior to this accident of 2016. I find this woman without signs of malingering. She certainly has chronic pain and this accident has changed her entire life. Certainly, even with a very successful surgery she will have limitations consistent with motion and movement. The data suggests that she has a 10 to 15% chance of requiring another surgery within a decade of this type of surgeons that I have recommended.

We will give you a financial reckoning, as well. Worker's Comp has denied our first request for surgery. They do not give a good reason. However, once again given the fact that Worker's Comp allowed this patient to go through nonoperative treatments, which she has now failed to progress, it does not make logical sense why they would not let her go on to the surgical treatment that would be a very reasonable approach for this patient.

Please do not hesitate to call me with any questions if I have not answered your specific questions.

ADDENDUM: The patient does have signs of radiographic SI joint sclerosis and osteophyte formation. She may ultimately be a candidate for an SI joint fusion, as well.

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Street: 3061 S. Maryland Parkway, Suite 200
City/State/Zip: Las Vegas, NV 89109
Phone: (702) 737-1948
Fax: (702) 737-7195

Patient: Joyce P. Sekera **Patient #:** 379090 **DOB:** 03/22/1956 (63 years)

Date of Encounter: 06/03/2019

History of Present Illness

The patient is a 63 year old female who presents for a follow-up visit. Note for "Follow-up visit": This woman returns today. She has been seeing me in my office now for almost a year and a half. This woman has an accepted Worker's Comp injury. This occurred in November of 2016. She had a loss of consciousness after slipping on a floor and developed neck and back pain. She has an accepted body part of both the cervical and lumbar region. She has been seen by Pain Management. She takes daily opioids. She has had injections and a cervical rhizotomy that gave her some relief and she has been through chiropractic treatment as well. The injections in her lower back gave her some temporary relief, but her back pain is really quite remarkable.

Additional reasons for visit:

Transition into care is described as the following:
The patient is transitioning into care and a summary of care was reviewed.

Allergies

No Known Allergies 02/26/2018
No Known Drug Allergies 02/26/2018

Past Medical History

Other secondary scoliosis, lumbosacral region
Cervical spondylosis with myelopathy
Back pain, sacroiliac
Lumbar spondylosis with myelopathy

Family History

Mother: In good health
Father: Deceased
Brother 1: In good health
Sister 1: In good health

Social History

Occupation/Work Status: Retirement (Health Related)
Marital Status: Single
Children; 1.
Living situation; Lives with his mother.
Tobacco use: Current some day smoker; Smokes 1-2 cigarettes a week.
Alcohol Use: No alcohol use
Illicit drug use: Never
HIV risk factors: None
Highest recreation level prior to spine condition; No Response.

Past Surgical

None (02/26/2018)

Diagnostic Studies

Chiropractor
Exercise Therapy
MRI Brain, Brain Stem
MRI, Cervical Spine
MRI, Lumbar Spine
Lumbar Spine X-ray

Vitals

06/03/2019 04:12 PM
Weight: 200 lb **Height:** 66 in
Body Surface Area: 2 m² **Body Mass Index:** 32.28 kg/m²

Assessment & Plan

Lumbar spondylosis with myelopathy 721.42 | M47.16

- Patient Education: Low Back Pain: low back
- Patient Education: Smoking: Ways to Quit: smoking cessation
- How to access health information online
- Instructed / counseled on smoking cessation including modes of cessation. Readiness to quit and motivation assessed.
- **Review of Diagnostic Test**
  Comments: Her initial MRI that I was able to review showed a disc bulge at C5-6. On her lumbar MRI, there is evidence of an anular fissure in L4-5 and modic changes at L1-2 and L2-3. There is also a small synovial cyst as well as what appears to be an underlying preexisting lumbar scoliosis. Films have been performed. They fortunately show only really a single level of rotational abnormality at the L5-S1 region. The L1-2 and L2-3 regions do show bone spurring anteriorly with signs of stability. On reviewing the axial images of her CT scan of the lumbar spine that was performed 07/13/18, it is really quite significant. It shows that there is facet disruption and there is a posterior retrolisthesis at L5-S1 and there does appear to be a Pars fracture under her facet joint on the left side.

Back pain, sacroiliac 724.6 | M53.3

- Follow up in 1 month or as needed

At this time, once again, I recommend single level minimally invasive techniques at L5-S1 for reduction of her deformity, decompression of nerve roots, and hopefully significant improvement of her pain. Apparently, there has been a delay as a second opinion from Dr. Erkulvrawtr of Pain Management has been requested. Once again, this woman does have radiographic evidence of an injury consistent with a traumatic event that occurred in November of 2016. She has been allowed to go through nonoperative treatment. Now it is time to allow this poor woman to proceed with surgical treatment, which would be the standard of care.

Please do not hesitate to call me with questions.

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Patient: Joyce P. Sekera **Patient #:** 379090 **DOB:** 03/22/1956 (63 years)

Date of Encounter: 05/02/2019

History of Present Illness

The patient is a 63 year old female who presents for a follow-up visit. Note for "Follow-up visit": This nice lady is now over two and a half years after documented work injury. This was back in 2016. She had a slip on a wet floor striking her head. She was then allowed to go through multiple cervical rhizotomies. She has had injections in her lower back also performed under the Worker's Compensation system. They gave her good temporary relief, but no long-term relief.

Additional reasons for visit:

Transition into care is described as the following:
The patient is transitioning into care and a summary of care was reviewed.

Allergies

No Known Allergies 02/26/2018
No Known Drug Allergies 02/26/2018

Past Medical History

Cervical spondylosis with myelopathy
Back pain, sacroiliac
Other secondary scoliosis, lumbosacral region
Lumbar spondylosis with myelopathy

Family History

Mother: In good health
Father: Deceased
Brother 1: In good health
Sister 1: In good health

Social History

Occupation/Work Status: Retirement (Health Related)
Marital Status: Single
Children; 1.
Living situation; Lives with his mother.
Tobacco use: Current some day smoker; Smokes 1-2 cigarettes a week.
Alcohol Use: No alcohol use
Illicit drug use: Never
HIV risk factors: None
Highest recreation level prior to spine condition; No Response.

Past Surgical

None (02/26/2018)

Diagnostic Studies

Chiropractor
Exercise Therapy
MRI Brain, Brain Stem
MRI, Cervical Spine
MRI, Lumbar Spine
Lumbar Spine X-ray

Vitals

05/02/2019 10:00 AM
Weight: 200 lb **Height:** 66 in
Body Surface Area: 2 m² **Body Mass Index:** 32.28 kg/m²

Physical Exam

The physical exam findings are as follows:
Her examination today remains significantly unchanged. She has a TUG test of 12 seconds. She is diminished at the L5 dermatome on the right. Flexion and extension of the lower lumbar spine is perhaps 60 to 70% of normal. She does have a Lasegue's maneuver on the right at 30 degrees.

Assessment & Plan

Other secondary scoliosis, lumbosacral region 737.43 | M41.57

- Patient Education: Low Back Pain: low back
- Patient Education: Smoking: Ways to Quit: smoking cessation
- *WRCBSS Post Op and Discharge Instructions Dr. Smith
- How to access health information online
- Instructed / counseled on smoking cessation including modes of cessation. Readiness to quit and motivation assessed.
- **Review of Diagnostic Test**
  Comments: Her films were again reviewed today. She has rotatory subluxation of L5-S1 with significant foraminal stenosis and loss of discal height.

This woman once again has failed nonoperative treatments. She is now a surgical candidate. The surgical procedure is relatively simple and straightforward. I would recommend a minimally invasive technique for an oblique ALIF at L5-S1 with posterior decompression and fixation. She will require an overnight stay in the hospital. Our studies show that patients have over a 90% success rate from this operation. Unfortunately, given the fact that her symptoms are now two and a half years from her injury, it is much less predictable regarding her return to work. This is certainly a direct result of Worker's Compensation taking excessive time in determining what her next step is. Certainly, if she was being approved for injections by Worker's Comp it is unclear why the standard of care as to treatment is now being denied. I will be glad to review this with any independent investigator.

Please don't hesitate to call me with questions.

Cc: Farmers W/C (866) 846-3114 (faxed)
Doug Clark, ESQ (702) 862-8562
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Katherine D. Travnicek, MD (702) 878-9096

William D. Smith, MD

William D. Smith, MD

Western Regional Center for Brain & Spine Surgery
Comprehensive Neurosurgical Care

Street: 3061 S. Maryland Parkway, Suite 200
City/State/Zip: Las Vegas, NV 89109
Phone: (702) 737-1948
Fax: (702) 737-7195

Patient: Joyce P. Sekera **Patient #:** 379090 **DOB:** 03/22/1956 (63 years)

Date of Encounter: 04/01/2019

History of Present Illness

The patient is a 63 year old female who presents for a follow-up visit. Note for "Follow-up visit": This woman has a work injury that was documented from 2016. She was having both neck and back pain. The facet rhizotomies of the cervical spine have really calmed down her neck discomfort to an issue that is not of primary significance. However, she continues to have severe back pain with standing, bending, and walking, as well as bilateral leg discomfort. She has had nonoperative treatments to include physical therapy, injection therapy, and different medications. Despite this, she has had continued worsening of her symptoms.

Additional reasons for visit:

Transition into care is described as the following:
The patient is transitioning into care and a summary of care was reviewed.

Allergies

No Known Allergies 02/26/2018
No Known Drug Allergies 02/26/2018

Past Medical History

Back pain, sacroiliac
Cervical spondylosis with myelopathy
Lumbar spondylosis with myelopathy
Other secondary scoliosis, lumbosacral region

Family History

Mother: In good health
Father: Deceased
Brother 1: In good health
Sister 1: In good health

Social History

Occupation/Work Status: Retirement (Health Related)
Marital Status: Single
Children: 1.
Living situation: Lives with his mother.
Tobacco use: Current some day smoker; Smokes 1-2 cigarettes a week.
Alcohol Use: No alcohol use
Illicit drug use: Never
HIV risk factors: None
Highest recreation level prior to spine condition: No Response.

Medication History

Medications Reconciled.

Past Surgical

None (02/26/2018)

Diagnostic Studies

Chiropractor
Exercise Therapy
MRI Brain, Brain Stem
MRI, Cervical Spine
MRI, Lumbar Spine
Lumbar Spine X-ray

Vitals

04/01/2019 05:18 AM
Weight: 200 lb **Height:** 66 in
Body Surface Area: 2 m^2 **Body Mass Index:** 32.28 kg/m^2

Physical Exam

The physical exam findings are as follows:
Today in my office, she continues to have reduced flexion and extension of her lumbar spine with palpable paraspinal muscle spasms. Her TUG test is 12 seconds. She has diminished sensation bilaterally in an L5 dermatome. She does have good power.

Assessment & Plan

Other secondary scoliosis, lumbosacral region 737.43 | M41.57

- Patient Education: Low Back Pain: low back
- Patient Education: Smoking: Ways to Quit: smoking cessation
- How to access health information online
- Instructed / counseled on smoking cessation including modes of cessation. Readiness to quit and motivation assessed.
- **Review of Diagnostic Test**
  Comments: The patient has had plain films, CT scan, and MRI. These show rotatory subluxation of L5-S1 with foraminal stenosis and loss of discal height. I believe this are all consistent with a traumatic injury.

Lumbar spondylosis with myelopathy 721.42 | M47.16

- Follow up in 1 month or as needed

Once again, this woman has signs and symptoms of a disc injury from a traumatic injury. Her films are consistent with this. They are also consistent with her examination. With this in mind, she is a surgical candidate. We are awaiting approval from the Worker's Compensation system. This woman was interviewed and examined by myself personally and all films were reviewed directly by myself as well.

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Street: 3061 S. Maryland Parkway, Suite 200
City/State/Zip: Las Vegas, NV 89109
Phone: (702) 737-1948
Fax: (702) 737-7195

Patient: Joyce P. Sekera **Patient #:** 379090 **DOB:** 03/22/1956 (62 years)

Date of Encounter: 03/07/2019

History of Present Illness

The patient is a 62 year old female who presents for a follow-up visit. Note for "Follow-up visit": I had the opportunity and pleasure of seeing this very nice woman in my office today. She returns after having had her injections and facet radiofrequency rhizotomy. Very briefly, this woman originally injured herself in 2016. She was working in sales I believe at The Venetian. She slipped on a wet floor striking her head and neck and she had a loss of consciousness. She initially had neck and back pain. She did have cervical rhizotomies I believe and this actually significantly improved her neck pain to the point where it is a relatively minor problem although it does flare up from time to time. Currently, her largest issue is certainly her mechanical back pain with intermittent leg pain more severe on the right than on the left. Standing, walking, and bending worsens her pain. She had injections done by Pain Management. These gave her excellent pain relief, but unfortunately it was only for a brief duration of time. She avoids pain medications and narcotics as she does not like to take them.

Additional reasons for visit:

Transition into care is described as the following:
The patient is transitioning into care and a summary of care was reviewed.

Allergies

No Known Allergies 02/26/2018
No Known Drug Allergies 02/26/2018

Past Medical History

Cervical spondylosis with myelopathy
Lumbar spondylosis with myelopathy
Back pain, sacroiliac
Other secondary scoliosis, lumbosacral region

Family History

Mother: In good health
Father: Deceased
Brother 1: In good health
Sister 1: In good health

Social History

Occupation/Work Status: Retirement (Health Related)
Marital Status: Single
Children: 1.
Living situation; Lives with his mother.
Tobacco use: Current some day smoker; Smokes 1-2 cigarettes a week.
Alcohol Use: No alcohol use
Illicit drug use: Never
HIV risk factors: None
Highest recreation level prior to spine condition; No Response.

Past Surgical

None (02/26/2018)

Diagnostic Studies

Chiropractor
Exercise Therapy
MRI Brain, Brain Stem
MRI, Cervical Spine
MRI, Lumbar Spine
Lumbar Spine X-ray

Vitals

03/07/2019 05:53 AM
Weight: 200 lb **Height:** 66 in
Body Surface Area: 2 m^2 **Body Mass Index:** 32.28 kg/m^2

Physical Exam

The physical exam findings are as follows:
On physical examination, she is a pleasant woman who appears her stated age. She has a difficult time going from a sitting to a standing position. Her TUG test is perhaps 12 seconds. She has diminished sensation in an L5 dermatome on the right side. She does have good power throughout. She does have a Lasègue's maneuver at 30 degrees on the right. She has very mild diminished sensation loss at L5 on the right.

Assessment & Plan

Other secondary scoliosis, lumbosacral region 737.43 | M41.57

- Patient Education: Low Back Pain: low back
- Patient Education: Smoking: Ways to Quit: smoking cessation
- How to access health information online
- Instructed / counseled on smoking cessation including modes of cessation. Readiness to quit and motivation assessed.
- *WRCBSS Post Op and Discharge Instructions Dr. Smith
- **Review of Diagnostic Test**
  Comments: Once again, all films were reviewed. This includes a CT scan, MRI, and plain films. It does once again show that she has a rotatory subluxation at L5-S1 with a foraminal stenosis and loss of discal height all consistent with a traumatic injury.

This woman has been through Worker's Compensation approved nonoperative treatment over the past three years without successful long-term treatment of her mechanical back pain and radicular symptoms. With this in mind, she is indeed a surgical candidate. Therefore, I would recommend minimally invasive techniques for an interbody fusion at L5-S1 with reduction of the rotatory scoliosis with a posterior decompression and pedicle screw fixation.

The risks and benefits of surgery were discussed in detail. The risks discussed include the risks of infection, bleeding, CSF leak, neurologic injury, anesthetic complication, pneumonia, heart attack, stroke, hardware failure, the need for revision surgery, and continued pain.

The patient understands and agrees with this. We will attempt to get her scheduled once we get approval through the Worker's Compensation system. Once again, this woman was interviewed and examined by myself. All films were reviewed directly by myself. It would be my expert medical opinion that this woman's need for surgery is the direct result of the work-related injury described in 2016.

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Phone: (702) 737-1948
Fax: (702) 737-7195

Patient: Joyce P. Sekera **Patient #:** 379090 **DOB:** 03/22/1956 (62 years)

Date of Encounter: 02/07/2019

History of Present Illness

The patient is a 62 year old female who presents for a follow-up visit. Note for "Follow-up visit": I had the opportunity and pleasure of seeing this woman in my office today. This woman is here via the Worker's Compensation system. This 61-year-old woman was a salesperson at a ticket booth. She slipped on a wet floor striking her head and had a loss of consciousness. This date of injury occurred in 2016. She has been through rhizotomies and has had a brief relief of pain. She has pain when changing position. She does use a heating pad. Recumbency also helps. She was sent to my office for a surgical consultation. Unfortunately, I cannot find notes from Nevada Pain Institute. While she has had rhizotomies, I am not sure if she has had a directed facet block at L5-S1 for identification of pain generator.

Additional reasons for visit:

Transition into care is described as the following:
The patient is transitioning into care and a summary of care was reviewed.

Allergies

No Known Allergies 02/26/2018
No Known Drug Allergies 02/26/2018

Past Medical History

Lumbar spondylosis with myelopathy
Cervical spondylosis with myelopathy
Other secondary scoliosis, lumbosacral region
Back pain, sacroiliac

Family History

Mother: In good health
Father: Deceased
Brother 1: In good health
Sister 1: In good health

Social History

Occupation/Work Status: Retirement (Health Related)
Marital Status: Single
Children; 1.
Living situation; Lives with his mother.
Tobacco use: Current some day smoker; Smokes 1-2 cigarettes a week.
Alcohol Use: No alcohol use
Illicit drug use: Never
HIV risk factors: None
Highest recreation level prior to spine condition; No Response.

Past Surgical

None (02/26/2018)

Diagnostic Studies

Chiropractor
Exercise Therapy
MRI Brain, Brain Stem
MRI, Cervical Spine
MRI, Lumbar Spine
Lumbar Spine X-ray

Vitals

02/07/2019 06:03 AM

Assessment & Plan

Other secondary scoliosis, lumbosacral region 737.43 | M41.57

- Patient Education: Low Back Pain: low back
- Patient Education: Smoking: Ways to Quit: smoking cessation
- Referral to Pain Management
- How to access health information online
- Instructed / counseled on smoking cessation including modes of cessation. Readiness to quit and motivation assessed.
- **Review of Diagnostic Test**
  Comments: We had ordered a CT scan. The CT scan is really quite interesting. It does show a rotatory subluxation at L5-S1 of approximately ten degrees. There are significant facet changes including what appears to be a poorly healed fracture on the superior articular facet. There is moderate foraminal stenosis at this level. She does also have bilateral signs of SI joint dysfunction.

I believe that she should also have bilateral SI joint injections. If she has had these and has not had improvement then we would discuss surgical treatment. At this time, my working diagnosis would be most likely the L5-S1 region although I cannot rule out the SI joint unless I see pain management injection notes. I hope this answers any questions you have. This woman remains on temporary total disability.

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Russell J. Shah MD
Neurology /Neurophysiology

NEUROLOGY ReEvaluation

PATIENT NAME: SEKERA, JOYCE
DOB: 03-22-1956
Gender: F
Date of Injury: 11-04-2016
Date of Evaluation: 11-09-2019

JOYCE SEKERA was seen on 11-09-2019 for a neurologic reevaluation.

HISTORY OF INJURY

Date of Injury:11-04-2016

Medications:

DATE	NAME	DOSAGE	SIG	DISCONTINUE DATE
11-09-2019	METFORMIN	500MG	QD	
10-23-2017	Metfomin			
07-10-2017	METFORMIN			
07-10-2017	CELEBREX			
05-02-2017	methocarbamol			
05-02-2017	ibuprofen			
04-11-2017	ZPAK		AS DIRECTED	
02-07-2017	ROBAXIN	UNKNOWN	PRN	
02-07-2017	METHOCARBOMOL	UNKNOWN	TWICE DAILY PRN	
12-20-2016	IBUPROFEN	600MG	1 TAB PRN HA	

REVIEW OF SYSTEMS

Constitutional Normal appetite, normal steady weight, no malaise, no generalized weakness, no diaphoresis, no unexplained weight loss

ENMT Negative unless documented in the HPI and/or Present complaints. No sore throat, no painful swallowing, no change of speech, (-) slurred speech, no tongue numbness, no perioral numbness

Cardiac: Negative unless documented in the HPI and/or Present complaints. No palpitations, no chest pain, no shortness of breath during activities is present. No syncope

Respiratory: Negative unless documented in the HPI and/or Present complaints. No asthma, no bronchitis, no fever, no chills, no coughing and no shortness of breath is present.

GI: Negative unless documented in the HPI and/or Present complaints. (-) nausea, no vomiting, no diarrhea and no constipation is present. No blood in the stool

GU: Negative unless documented in the HPI and/or Present complaints. No bowel urgency, (-) bladder urgency, no bowel incontinence, no bladder incontinence, no painful urination, and no blood in the urine

Visual: Negative unless documented in the HPI and/or Present complaints. (-) double vision, (+) blurred vision and (-) eye pain is present.

Neurologic: Negative unless documented in the HPI and/or Present complaints. (+) headache, (+) neck pain, (+) mid back pain, (+) low back pain, (-) weakness in the arms, (-) weakness in the hands, (-) weakness in the legs, (-) weakness on walking, (+) numbness or tingling in the arms, (-) numbness or tingling in the legs. + leg pains

Psychiatric: Negative unless documented in the HPI and/or Present complaints. (-) depression, (-) anxiety, (-) restlessness, no sleep onset difficulties, no active or recent suicidal ideation, thought, attempt or plan.

RECORD REVIEW

chart

PRESENT COMPLAINT

She has been seeing pain management for the last 2 years and periods with no pain medications. She does not recall the names of the doctors and has not seen Dr. Cash and does not recall the Aricept but recalls the name. She does not recall things and her memory has never improved. She is more forgetful, not remembering and not working. She did not have a problem with memory before the fall and hit the back of

the head and was confused and had went to Centennial Hospital. She is writing items down and has just mild intermittent dizziness now. She has aches in the low back bilateral, hamstrings, calves bilateral but the right calve more and the burning of the nerve with Dr. Travineck has helped. She does not recall Dr. Kidwell. She saw Dr. William Smith but then Dr. Jason Garber who told her no surgery for the low back as Dr. William Smith was on a long absence period at work. She is not working anymore in sales of ticket position.

She is not taking any pain medication and not ibuprofen nor Tylenol and has some numbness and tingling and in the hands and no weakness. Her memory of dates and remembering appointments, task is a problems now continuously. She is not able to recall and does not feel anxious, restless nor depressed. She has no further spontaneous crying emotional spells and feels okay in her mood. She is worried about her memory and has no family history of Alzheimer's dementia and denies having had a seizure post head truama.

EXAMINATION

Vital Signs:

TEMP	PULSE	RESP	HT	WT	BMI	BP SYST	BP DIAST	COMMENT	SPO2
98.5	73		66	205.6	33	152	72	RESP IN NORMAL RANGE	

General: The patient is awake, alert appropriate and non-toxic appearing
The patient appears to be in no distress. 6/6 registration, recall 1 and 5 minutes, okay historical date, okay simple naming, spelling, calculations, 3 step commands, no right/left confusion, no staring off, no spacing out, no automatism, oriented to name,place, time of the day, day of the week, appropriately concerned about medical well being, did not know when she had last seen me, confused on dates and tells me that the XRT procedure with Dr. Travineck was in 8/2019 and then could not think and thought earlier this year, appears to have some confusion on her recall of events and dates. No pyschomotor retardation, no bradykinesia, no masked facies

The patient is a poor historian, Mood appears okay

Obesity

Cranial Nerves: EOMI , fundi sharp, no temporal artery tenderness, TMJ no tenderness with dislocated TMJ left joint, VFF, no field cut, PEARLA, aniceteric, normal sensation face and tongue midline, no dysarthria, non toxic appearing, shoulder shrug intact
Hearing was intact.
The smile is symmetric.

Motor :

Normal power
Reflexes 2 to 2+

Positive tenderness lumbar paraspinals and spinous proces tenderness, tightness cervial paraspinal and lumbar paraspinals,no florid spasm no cervical axial comrpession, no Lhermittes, no Spurlings, no Tinels at the fibular head, tarsal tunnel, no calve tenderness, no Homsna, no Tinels at the carpal tunnel , no Adsons and no Phalens

Coordination: Unremarkable

Gait: Nonwide based gait which is symmetric.

Romberg was performed and demonstrated with no sway.

IMPRESSION from 11/4/2016 Trauma

1. Post traumatic brain syndrome

- MRI brain after reviewed the SDMI report from 2016 again with the patient
- likely a permanent neurocognitive disorder
- check all records
- eeg/nbt
- may try Namenda
- mind stimulation exercises
- seems to have no pain and not with pseudodementia but has difficulty with the memory focally and worsening. No clear family history of Alzheimers and no new focal stroke like history events being told
- face to face time 50 minutes, compliance, counseling, coordinationof care, records requested and chart reviewed with greater than 50% of the evaluation time on education

2. Cervical strain/headaches

- spine restrictions

3. Lumbar strain with leg pain/ache

- spine restrictions
- weight loss

4. Carpal tunnel syndrome

- wrist splints
- education
- reevaluate on follow up

Sincerely,

Russell J. Shah, MD

F A X

Kelly Hawkins
Physical Therapy

Kelly Hawkins Centennial Hills CHO
7125 Grand Montecity Parkway Ste 120
Las Vegas, NV 89149-0261
Phone: (702) 515-1540
Fax: (702) 410-7335

To: Travnicek, Katherine
Fax number: (702) 878-9096

From:
Fax number: (702) 410-7335
Total Pages : 4

Date: 12-09-19

Regarding : Joyce Sekera

Phone number for follow-up:
(702) 515-1540

Please find attached the plan of care for Joyce Sekera. Please sign and fax back. Thank you.

Miguel A. Nunez, PTA

Kelly Hawkins
Physical Therapy

Physical Therapy Progress Note

Date of Visit:	12-09-19	**Therapist:**	Miguel A. Nunez, PTA
Patient Name:	Sekera, Joyce	**Referring Provider:**	Katherine Travnicek, MD
Patient #:	0280220		
Date of Birth:	03-22-1956	**Surgical Classification**	
Age:	63	**Certification Period:**	11-11-19 - 01-05-20

Date of Onset: 11-04-16

Diagnosis:

M51.27	Other intervertebral disc displacement, lumbosacral region
M54.5	Low back pain

SUBJECTIVE:
Joyce Sekera, attended for therapy evaluation on 11-11-19 for evaluation of Physical Therapy. The patient has attended 10 treatment sessions since the evaluation. Treatment to date has focused on the client's chief complaints of:

- Difficulty dressing
- Difficulty sleeping
- Difficulty walking
- Loss of function
- Loss of motion - pain
- Pain when sitting

Presenting Problems:
The patient reports today's pain at Low back to be 2 out of 10 at best and 5 out of 10 at worst.
Comments: Pt reports current LBP is 3/10

Functional Status	Prior	Current
Activities of daily living		Severe
Lifting items from floor		Severe
Sitting		Severe
Standing		50%
Walking		Severe

Work Status:
Not Working

Pt reports she is compliant with HEP. Pt states that the forward stretches given to her made her symptoms worse. Pt states she still has pain on the left side of their back and left leg.

OBJECTIVE:
Observations:
Upon review of the objective findings section this patient presents with the following additional complicating factors effecting their function and safety:

EDUCATION:

Topics Discussed
- Rehabilitation Plan
- Exercise / Activity
- Reviewed Goals / POC
- Home Exercise Program
- Activities of Daily Living
- Transfer / Mobility Training
- Posture / Body Mechanics

Methods
- Discussion
- Demonstration

Response
- Verbalized Understanding
- Returned Demonstration

Recipient
- Patient

ASSESSMENT:

The progress visit was completed. Subjective and objective data was gathered by MINU. Assessment of progress towards goals and plan for future visits was determined by COOK.

Pt is progressing towards goals with observed increase in trunk AROM. Pt continues to experience pain in L/S with minor pain in L LE. Pt decreased toleracnet to forward directed movements of LE and responds well to extension biased movement of spine. Pt will benefit form cont skilled PT for increased trunk mobility and increased trunk and LE strength for decrease pain and improved tolerance to ADLs.

** No objective measurements taken, will be taken next visit**

Patient, Guardian, or Legal Representative consents to treatment plan and goals and gives verbal informed consent.

Goals	Short-Long	Time Frame	Result	Comment
HEP-Patient will be independent in a physical therapy home exercise program.	Short Term	4 weeks		
MMT-Patient will achieve a muscle strength of 5/5 for the R hip flexion.	Short Term	4 weeks		
ROM-Patient will increase AROM of the L/S to min restricted.	Short Term	4 weeks		
HEP-Patient will be instructed in a physical therapy home program to help address their impairment and functional deficits.	Long Term	8 weeks		
MMT-Patient will achieve a muscle strength of 5/5 for Bilat Hamstrings.	Long Term	6 weeks		

PLAN:

7125 Grand Montecity Parkway Ste 120 Las Vegas, NV 89149-0261
Phone: (702) 515-1540 Fax: (702) 410-7335

Patient: Sekera, Joyce
Date of Birth: 03-22-1956
Date of Service: 12-09-19

The patient's treatment will include ADL Training, e-Stim unattended no wound, home exercise program instruction, hot pack / cold pack, joint and soft tissue mobilization, manual therapy, neuromuscular re-education, therapeutic activities and therapeutic exercises. In order for the stated goals to be achieved, it is recommended for the patient to be seen for 3 times per week for the next 8 week(s). At that time the patient will be re-evaluated and an updated treatment plan will be created. The treatment plan will include the procedures, interventions and modalities as outlined in the planned services section (specific treatment values identified under the patient activity section of the daily note). The patient will be seen 3 times per week for 8 weeks, for a total of 24 visits.
Thank you for your referral. We will keep you updated on this patient's progress.

Best regards,

Miguel Nunez PTA
This document was electronically signed on 12-09-19 at 08:31a by Miguel Nunez PTA.

Cody Okuda PT
This document was electronically cosigned on 12-09-19 at 08:33a by Cody Okuda PT.

TO BE COMPLETED BY PHYSICIAN:
I certify that the above rehabilitative services are medically necessary and authorized, and that the patient's plan will be reviewed every thirty (30) days.

Katherine Travnicek, MD Signature _____ Date 12-9-2019

Please sign the above plan of care and return to:
Kelly Hawkins Centennial Hills CHO
7125 Grand Montecity Parkway Ste 120
Las Vegas, NV 89149-0261
Phone: (702) 515-1540
Fax: (702) 410-7335

Kelly Hawkins
Physical Therapy

Physical Therapy Progress Note

Date of Visit:	12-10-19	**Therapist:**	Victor Carrasco, PT
Patient Name:	Sekera, Joyce	**Referring Provider:**	Katherine Travnicek, MD
Patient #:	0280220		
Date of Birth:	03-22-1956	**Surgical Classification**	
Age:	63	**Certification Period:**	11-11-19 - 01-05-20

Date of Onset: 11-04-16

Diagnosis:

M51.27	Other intervertebral disc displacement, lumbosacral region
M54.5	Low back pain

SUBJECTIVE:
Joyce Sekera, attended for therapy evaluation on 11-11-19 for evaluation of Physical Therapy. The patient has attended 11 treatment sessions since the evaluation. Treatment to date has focused on the client's chief complaints of:

- Difficulty dressing
- Difficulty sleeping
- Difficulty walking
- Loss of function
- Loss of motion - pain
- Pain when sitting

Presenting Problems:
The patient reports today's pain at Low back to be 2 out of 10 at best and 5 out of 10 at worst.
Comments: Pt reports current LBP is 3/10

Functional Status	Prior	Current
Activities of daily living		Severe
Lifting items from floor		Severe
Sitting		Severe
Standing		50%
Walking		Severe

Work Status:
Not Working

Pt reports she is compliant with HEP. Pt states stretching forward gives her dizziness and feels like she is going to fall. Felt sore from yesterdays session

OBJECTIVE:
Observations:
Upon review of the objective findings section this patient presents with the following additional complicating factors effecting their function and safety:

LUMBAR EVALUATION

RANGE OF MOTION:
Lumbar ROM (standing):

Flexion: Refused movement due to being anxious about dizziness w/ movement
Extension: min restricted, no change in sxs
R rotation: mod restriction
L rotation: mod restricted

L/R side glide: mod restricted, no change, difficulty keeping shoulders level.

MANUAL MUSCLE TEST:

Lower Extremity	Initial	Goal	Last	Current	Comments
MMT	11-11-19		11-11-19	12-10-19	
R Hip Abd	5		5	5	
L Hip Abd	5		5	5	
R Hip Flex	4-	5	4-	4	
L Hip Flex	5		5	5	
R Knee Ext	5		5	5	
L Knee Ext	5		5	5	
R Knee Flex	4	5	4	4+	
L Knee Flex	4	5	4	4+	

EDUCATION:

Topics Discussed
- Rehabilitation Plan
- Exercise / Activity
- Reviewed Goals / POC
- Home Exercise Program
- Activities of Daily Living
- Transfer / Mobility Training
- Posture / Body Mechanics

Methods
- Discussion
- Demonstration

Response
- Verbalized Understanding
- Returned Demonstration

Recipient
- Patient

ASSESSMENT:
The progress visit was completed. Subjective and objective data was gathered by VICA.

7125 Grand Montecity Parkway Ste 120 Las Vegas, NV 89149-0261
Phone: (702) 515-1540 Fax: (702) 410-7335

Patient: Sekera, Joyce
Date of Birth: 03-22-1956
Date of Service: 12-10-19

Assessment of progress towards goals and plan for future visits was determined by COOK.

Pt is progressing towards goals with observed increase in trunk AROM. Pt continues to experience pain in L/S with minor pain in L LE. Pt was anxious about lumbar flexion due to dizziness w/ movement. PT requires VC's for proper exercise technique as well. Pt would benefit from skilled PT by increasing function and decreasing pain.

Patient, Guardian, or Legal Representative consents to treatment plan and goals and gives verbal informed consent.

Goals	Short-Long	Time Frame	Result	Comment
HEP-Patient will be independent in a physical therapy home exercise program.	Short Term	4 weeks		
MMT-Patient will achieve a muscle strength of 5/5 for the R hip flexion.	Short Term	4 weeks		
ROM-Patient will increase AROM of the L/S to min restricted.	Short Term	4 weeks		
HEP-Patient will be instructed in a physical therapy home program to help address their impairment and functional deficits.	Long Term	8 weeks		
MMT-Patient will achieve a muscle strength of 5/5 for Bilat Hamstrings.	Long Term	6 weeks		

PLAN:
The patient's treatment will include ADL Training, e-Stim unattended no wound, home exercise program instruction, hot pack / cold pack, joint and soft tissue mobilization, manual therapy, neuromuscular re-education, therapeutic activities and therapeutic exercises. In order for the stated goals to be achieved, it is recommended for the patient to be seen for 3 times per week for the next 8 week(s). At that time the patient will be re-evaluated and an updated treatment plan will be created. The treatment plan will include the procedures, interventions and modalities as outlined in the planned services section (specific treatment values identified under the patient activity section of the daily note). The patient will be seen 3 times per week for 8 weeks, for a total of 24 visits.
Thank you for your referral. We will keep you updated on this patient's progress.

Best regards,

Victor Carrasco PT
This document was electronically signed on 12-10-19 at 09:21a by Victor Carrasco PT.

Cody Okuda PT
This document was electronically cosigned on 12-11-19 at 03:07p by Cody Okuda PT.

TO BE COMPLETED BY PHYSICIAN:
I certify that the above rehabilitative services are medically necessary and authorized, and that the patient's plan will be reviewed every thirty (30) days.

Katherine Travnicek, MD Signature — Date: 12-11-19

Please sign the above plan of care and return to:

Patient: Joyce Sekera

7125 Grand Montecity Parkway Ste 120 Las Vegas, NV 89149-0261
Phone: (702) 515-1540 Fax: (702) 410-7335

Faxed 12-11-19 AM
SEKERA001285

2125

Patient: Sekera, Joyce
Date of Birth: 03-22-1956
Date of Service: 12-10-19

Kelly Hawkins Centennial Hills CHO
7125 Grand Montecity Parkway Ste 120
Las Vegas, NV 89149-0261

Phone: (702) 515-1540
Fax: (702) 410-7335

Kelly Hawkins
Physical Therapy

Physical Therapy Initial Evaluation

Date of Visit:	11-11-19	**Therapist:**	Alejandro Preciado, DPT
Patient Name:	Sekera, Joyce	**Referring Provider:**	Katherine Travnicek, MD
Patient #:	0280220		
Date of Birth:	03-22-1956	**Surgical Classification**	
Age:	63	**Certification Period:**	11-11-19 - 01-05-20

Date of Onset: 11-04-16

Diagnosis:

M51.27	Other intervertebral disc displacement, lumbosacral region
M54.5	Low back pain

SUBJECTIVE:
Joyce Sekera is a 63 year old female who presents to therapy today. The patient reports the date of injury to be 11/4/16. The reported mechanism of injury was secondary to a slip and fall incident.

Presenting Problems:
The patient reports:
- Difficulty dressing, moderate
- Difficulty sleeping, moderate
- Difficulty walking, severe
- Loss of function, moderate
- Loss of motion - pain, moderate
- Pain when sitting, severe

The patient reports today's pain at Low back to be 2 out of 10 at best and 5 out of 10 at worst.
Comments: Pt reports current LBP is 3/10
PAST MEDICAL HISTORY

Functional Status	Prior	Current
Activities of daily living		Severe
Lifting items from floor		Severe
Sitting		Severe
Standing		50%
Walking		Severe

FAXED 11/13/19 MP

Work Status:
Not Working

Pt states pain has remained constant since her injury. Pt reports interrupted sleep, increased pain with bending over and difficulty sitting in a car for greater than 15 minutes due to pain,.

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Phone: (702) 515-1540 Fax: (702) 410-7335

SEKERA001287

2127

Patient: Sekera, Joyce
Date of Birth: 03-22-1956
Date of Service: 11-11-19

Assessment of Complexity:
Medical and Therapy History: 1-2 personal factors and/or comorbidities that impact the plan of care.
Patient Examination: Examination of body systems was completed using standardized tests and measures addressing 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions.
Clinical Presentation: Evolving clinical presentation with changing characteristics.
Clinical Decision Making: Moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.

Based on the documented information above, the patient complexity is determined to be moderate.

PLAN:
The patient's treatment will include ADL Training, e-Stim unattended no wound, home exercise program instruction, hot pack / cold pack, joint and soft tissue mobilization, manual therapy, neuromuscular re-education, therapeutic activities and therapeutic exercises. In order for the stated goals to be achieved, it is recommended for the patient to be seen for 3 times per week for the next 8 week(s). At that time the patient will be re-evaluated and an updated treatment plan will be created. The treatment plan will include the procedures, interventions and modalities as outlined in the planned services section (specific treatment values identified under the patient activity section of the daily note). The patient will be seen 3 times per week for 8 weeks, for a total of 24 visits.

Thank you for your referral. We will keep you updated on this patient's progress.

Best regards,

Alejandro Preciado DPT
This document was electronically signed on 11-12-19 at 10:52p by Alejandro Preciado DPT.

TO BE COMPLETED BY PHYSICIAN:
I certify that the above rehabilitative services are medically necessary and authorized, and that the patient's plan will be reviewed every thirty (30) days.

Katherine Travnicek, MD Signature _____ Date 11-13-19

Please sign the above plan of care and return to:
Kelly Hawkins Centennial Hills CHO
7125 Grand Montecity Parkway Ste 120
Las Vegas, NV 89149-0261
Phone: (702) 515-1540
Fax: (702) 410-7335

Visual Analogue Scale

	Low back
What is your pain RIGHT NOW?	4
What is your TYPICAL or AVERAGE pain?	4
What is your pain level AT ITS BEST? (how close to 0 does your pain get at its best)	2
What is your pain AT ITS WORST? (how close to 0 does your pain get at its worst)	5

What percentage of your awake hours is your pain at its worst?

Oswestry Low Back Disability Index
Score: 56% - Severe Impairment

OBJECTIVE:
Observations:
Upon review of the objective findings section this patient presents with the following additional complicating factors effecting their function and safety:

LUMBAR EVALUATION

RANGE OF MOTION:
Lumbar ROM (standing):

Flexion: mod restricted, increased pain, hesitant motion
Extension: min restricted, no change in sxs
R rotation: max restricted
L rotation: max restricted

L/R side glide: max restricted, no change, difficulty keeping shoulders level.

MANUAL MUSCLE TEST:

Lower Extremity MMT	Initial 11-11-19	Goal	Comments
Right Hip Abduction	5		
Left Hip Abduction	5		
Right Hip Adduction	5		
Left Hip Adduction	5		
Right Hip Flexion	4-	5	
Left Hip Flexion	5		
Right Knee Extension	5		
Left Knee Extension	5		
Right Knee Flexion	4	5	
Left Knee Flexion	4	5	

Vital Signs:
Ht: 5' 6" Wt: 160.00 BMI: 25.82

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Phone: (702) 515-1540 Fax: (702) 410-7335

EDUCATION:

Topics Discussed
- Rehabilitation Plan
- Exercise / Activity
- Reviewed Goals / POC
- Home Exercise Program
- Activities of Daily Living
- Transfer / Mobility Training
- Posture / Body Mechanics

Methods
- Discussion
- Demonstration

Response
- Verbalized Understanding
- Returned Demonstration

Recipient
- Patient

ASSESSMENT:

Objective findings are consistent with the diagnosis as documented on the referring medical doctors prescription. Following a thorough therapy evaluation patient presents with limited functional mobility. During the initial evaluation the following impairments and functional deficits have been identified:

Physical and or physiological impairments have been identified: low back pain, decreased L/S AROM, general weakness,

Functional deficits have been identified: Difficulty performing ADLs and IADLs, difficulty caring for her grandchildren, difficulty walking, difficulty sleeping

Skilled therapy treatment will be continued to address the above mentioned impairments and functional deficits. Please refer to the Plan section for a list of specific treatment interventions. The patient's rehab potential is good. She is aware of her diagnosis. The plans and goals have been developed and discussed with the patient. Patient, Guardian, or Legal Representative consents to treatment plan and goals and gives verbal informed consent.

Goals	Short-Long	Time Frame	Result	Comment
HEP-Patient will be independent in a physical therapy home exercise program.	Short Term	4 weeks		
MMT-Patient will achieve a muscle strength of 5/5 for the R hip flexion.	Short Term	4 weeks		
ROM-Patient will increase AROM of the L/S to min restricted.	Short Term	4 weeks		
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Phone: (702) 835-0088 Fax: (702) 826-3162

Jason E. Garber MD, FAANS
Stuart S. Kaplan MD, FAANS
Gregory L. Douds MD, FAANS
Scott G. Glickman DO
Patrick S. McNulty MD
Albert H. Capanna MD

Patient: Joyce Sekera **Patient#:** 11250 **DOB:** 03/22/1956

Date of Encounter: 9/17/2019 8:45:00 AM

History of Present Illness: The patient presents today after being the victim of a slip and fall accident at the Venetian Hotel on 11/04/2016. The patient apparently slipped on liquid on the floor. Since that time she has had axial mechanical back pain with intermittent radiation to her buttocks with intermittent extension down her lower extremities. She also has axial mechanical neck pain with intermittent medial scapular radiation with intermittent extension down her upper extremities left greater than right.

The patient had physical therapy in the past as well as injections. I do not have the injection reports at this time.

On examination today, the patient has no focal motor weakness on examination. The patient's reflexes are zero throughout. Strength however appears to be intact.

It is my understanding that the patient has no prior history of any spinal pathology ever necessitating treatment prior to the accident in question. She will follow-up with me after her new imaging studies.

Patient was involved in a slip and fall. n/a. Location: n/a.
Date of injury was 11/04/2016.
Location of injury: venetian Date(s) of prior injuries: n/a

Allergies: NKDA

Past Medical History: - Date of last EKG: n/a n/a. - Date of last chest x-ray: n/a n/a. n/a n/a. - Arthritis n/a. - Result of mammogram: n/a - Date of last mammogram: n/a n/a. n/a. - Diabetes pre diabetes. - If yes, date of Blood transfusion: n/a n/a. n/a.

Family History: Mother Alive - Health Status: goodFather Deceased - Age n/a - Cause of Death: stage 4 cancer
Brother - Health Status: good
Sister - Health Status: good

Social History: Patient Occupation: sales - Medical disability - short term -Date last worked: 11/04/2016
Marital Status: Single. Children: Yes - Number of Adult (age 18 and over): 1 - Number of Child (age 0-17): n/a
Patient Lives Alone: No - Patient lives with: mother
Smoking Status: Yes - Smoke per/day: less than 1 pack per day - Alcohol Consumption: Occasionally
Illicit Drug Usage: Never
Risk of HIV: No

Patient: Joyce Sekera **Patient#:** 11250 **DOB:** 03/22/1956

Date of Encounter: 9/17/2019 8:45:00 AM

Medications: No current medications on file
Past Surgical History: Problems with anesthesia: No
Prior spine surgery: No

Diagnostic Studies: - Chiropractic - Epidural steroid injections Date: 09/05/2019
Physician performed injection: dr,travnicek - MRI thoracic spine - MRI lumbar spine - CT brain - CT cervical spine - CT thoracic spine - CT lumbar spine - X-ray thoracic spine - X-ray lumbar spine n/a

Review of Systems: - Weight gain - Neck pain - Arm pain - Back pain - Leg pain - Leg weakness

Vitals: Weight: 200 lbs. Height: 66 in. BMI: 32.3

Physical Exam:
General:
Mental Status: Alert
General Appearance: well-nourished, well groomed, Not Sickly
Orientation: Oriented X3
Build & Nutrition: Well nourished and Well developed
Posture: Normal posture
Eye Pupil: Equal and direct reaction to light normal.
Chest and lung exam: Normal Excursion with symmetric chest walls.
Cardiovascular examination: Normal heart sounds regular rate and rhythm with no murmurs.
Abdomen Inspection: No Visible peristalsis
Neurologic Mental Status:
Speech: No impairments of naming, No impairment of word repetition.
Cognitive Function: No impairment of Attention, No impairment of Concentration, No impairment of long term memory, No impairment of short term memory..
Sensory Light Touch: Intact Globally.
Reflexes: Left Biceps: 0. Right Biceps: 0. Left Triceps: 0. Right Triceps: 0. Left Brachioradialis: 0. Right Brachioradialis: 0. Left Achilles: 0. Right Achilles: 0. Left Patella: 0. Right Patella: 0.
Upper Extremities: Bilateral Detloid 5/5. Bilateral Bicep 5/5. Bilateral Tricep 5/5. Bilateral Wrist Extensors 5/5. Bilateral Wrist Flexors 5/5. Bilateral Intrinsics 5/5.
Lower Extremities: Bilateral Illopsoas 5/5. Bilateral Quadriceps 5/5. Bilateral Hamstrings 5/5. Bilateral Tibialis Anterior 5/5. Bilateral Gastroc-Soleus 5/5. Bilateral EHL 5/5.
Coordination: No Impairment of heel-to-shin , No Impairment of finger-to-nose, No Impairment of rapid alternating movements.
Associations - Intact
Thought Processes/Cognitive Function: Appropriate fund of knowledge

Review of Diagnostic Test:
MRI of the cervical spine performed 12/21/2016 reveals a central disc protrusion at C6-7.

MRI of the lumbar spine performed 12/21/2016 reveals a disc herniation L4-5 with facet arthropathy and synovial cyst left L5-S1 with facet arthropathy L4-5 and L5-S1.

Patient: Joyce Sekera **Patient#:** 11250 **DOB:** 03/22/1956

Date of Encounter: 9/17/2019 8:45:00 AM

Assessment and Plan:
I have ordered new imaging studies, specifically x-rays and MRIs of the cervical and lumbar spines, a copy of Dr. Travnicek's injection history and she is to follow up with me thereafter.

M54.5 - LOW BACK PAIN
M51.26 - OTH IV DISC DISPLACEMENT LUMBAR RGN
#16860- AP/LAT, FLEX/EXT CERVICAL SPINE X-RAY (72050), AP/LAT FLEX/EXT LUMBAR SPINE X-RAY (72110), CT Lumbar Spine W/O Contrast (72131), MRI Cervical Spine W/O Contrast (72141), MRI Lumbar Spine W/O Contrast (72148),
Follow up after study

Electronically Signed: JASON GARBER on/at 09/17/2019 10:19:58

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Scott G. Glickman DO
Patrick S. McNulty MD
Albert H. Capanna MD

Patient: Joyce Sekera **Patient#:** 11250 **DOB:** 03/22/1956

Date of Encounter: 10/10/2019 8:45:00 AM

History of Present Illness: Patient presents today with ongoing axial mechanical back pain and lower extremity radiculopathy. She does have some paraspinal cervical discomfort and pain as well.

Patient was involved in a slip and fall. n/a. Location: n/a.
Date of injury was 11/04/2016.
Location of injury: venetian Date(s) of prior injuries: n/a

Allergies: NKDA

Past Medical History: - Date of last EKG: n/a n/a. - Date of last chest x-ray: n/a n/a. n/a n/a. - Arthritis n/a. - Result of mammogram: n/a - Date of last mammogram: n/a n/a. n/a. - Diabetes pre diabetes. - If yes, date of Blood transfusion: n/a n/a. n/a.

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Risk of HIV: No

Medications: No current medications on file
Past Surgical History: Problems with anesthesia: No
Prior spine surgery: No

Diagnostic Studies: - Chiropractic - Epidural steroid injections Date: 09/05/2019
Physician performed injection: dr,travnicek - MRI thoracic spine - MRI lumbar spine - CT brain - CT cervical spine - CT thoracic spine - CT lumbar spine - X-ray thoracic spine - X-ray lumbar spine n/a

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Neurologic Mental Status:
Speech: No impairments of naming, No impairment of word repetition.
Cognitive Function: No impairment of Attention, No impairment of Concentration, No impairment of long term memory, No impairment of short term memory..
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Lower Extremities: Bilateral Illopsoas 5/5. Bilateral Quadriceps 5/5. Bilateral Hamstrings 5/5. Bilateral Tibialis Anterior 5/5. Bilateral Gastroc-Soleus 5/5. Bilateral EHL 5/5.
Coordination: No Impairment of heel-to-shin , No Impairment of finger-to-nose, No Impairment of rapid alternating movements.
Associations - Intact
Thought Processes/Cognitive Function: Appropriate fund of knowledge

Review of Diagnostic Test:
MRI of the cervical spine reveals a disc bulge at C6-7. No frank cord compression is noted. Mild straightening of the cervical spine consistent with spasm is noted.

MRI of the lumbar spine reveals multilevel lumbar spondylitic disease with some degree of facet arthropathy. No disc herniations are noted.

Assessment and Plan:
The patient has ongoing axial mechanical back pain with radiculopathy. The patient has ongoing symptomatology which has failed conservative management. I recommended a stimulator trial.

M54.2 - CERVICALGIA
M54.5 - LOW BACK PAIN
Referral to Pain Management for Stimulator Trial
Follow up after specialist

Patient: Joyce Sekera **Patient#:** 11250 **DOB:** 03/22/1956

Date of Encounter: 10/10/2019 8:45:00 AM

Electronically Signed: JASON GARBER on/at 10/10/2019 11:04:08

PAIN INSTITUTE OF NEVADA

7435 W Azure Road, Ste 190, Las Vegas, NV 89130-4425 ++ 702.878.8252 ++ 702.878.9096
Mailing address: 7065 W Ann Road, Ste 130 #548, Las Vegas, NV 89130-4990
www.paininstitute.com

FAX TRANSMITTAL

Date: 10/23/19 **Number of Pages:** 4

TO: Jackie **COMPANY:** Keith Gallier

Phone Number: 702-735-0049 **Fax Number:** 702-735-0204

The following information is confidential and is intended for the use of the above-indicated person only. If you do not receive the number of pages indicated above, please notify the person noted below immediately.

RE: Sekera, Joyce

Hello,

Your client, Joyce Sekera, was seen for a consultation with DR. Traynicek on 10/16/19 and I have attached the not for your records. Dr. Traynicek is recommending the following:

PLAN

REFERRAL TO: PHYSICAL THERAPY: 3x / week for 8 weeks. Evaluate and treat. Therapeutic exercise & HEP

** DME: Lumbar brace ** RECORDS FROM: Jason Garber MD

** I recommend she see Dr. Shah for her memory concerns, doesn't remember if she took Aricept

** RETURN: 4 weeks for re-evaluation with kdt

Ms. Sekera is scheduled to return for a follow up appointment on 11/13/19 @ 8:15am.

Please advise if we can proceed with the above recommendations under the patient's lien.

If you have any questions, please do not hesitate to contact me direct.

FROM: Rachel **EXT NO.** 233 **EMAIL:** rachel@paininstitute.com

10/23/19 faxed (RB)

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8252
Fax 702-878-9096

OFFICE VISIT

Date of Service: October 16, 2019

Patient Name: **Joyce P Sekera**
Patient DOB: 3/22/1958

PAIN COMPLAINT
Low back

Joyce returns for follow up today.
The patient is s/p radiofrequency rhizotomy bilateral L5-S1 in June 2019
Sustained improvement: She feels she had significant pain relief but it returned and she can't remember when exactly.
Low back pain is a constant dull ache and involves whole low back with some posterior thigh pain. She denies numbness, tingling or weakness.
Activities that aggravate the pain: Sitting, standing, walking
Activities that relieve the pain: Apply pressure while sitting down
Description of the pain: Dull, ache, stiffness
Least pain throughout day (0-10): 2/10
Most pain throughout day (0-10): 6/10
Helpful treatments: Ice and heat, laying down
Non-helpful treatments: N/A
She can't bend over and pick up grandkids and can't do certain activities with them (sports).
Dr. Smith is on some sabbatical and won't be returning for some time ? It's unclear if he'll return to practice. She was transferred to Dr. Garber who recommended a SCS trial. She read the risks and would like to hold off. He ordered a bunch of new imaging which I don't have so will request.

She is seeing her PCP for diabetes and she hasn't seen Dr. Shah lately. Her memory is still impaired and I recommend seeing him again.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Retired
Therapy: Pt is not currently receiving physical or chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular fissuring. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

XRAYS cervical spine with Flex/Ext : Report dated 7/31/2018
Cervical spine straightening with mild degenerative disc disease at C5, there is 6 to a lesser degree. C4-C5. Multilevel mild spondylosis. Flexion and extension views demonstrate no ligamentous laxity or instability.

AP and lateral thoracic and lumbar spine with right and left lateral bending: Report dated 7/31/2018
Mild endplate osteophytosis of the mid thoracic and lumbar spine. Equal excursion of right and left lateral bending. No significant scoliosis measured on chronic exam.

X-ray lumbar spine with flexion and extension: Report dated 7/31/2018
Mild degenerative disc disease at L1-L2 mL, 2-3 with multilevel mild spondylosis, most evident at L4-S1. Vascular calcifications noted with slight levoconvex curvature. No evidence of subluxation with flexion extension views.

CT lumbar spine: Without contrast: Report dated 7/31/2018
Mild levoscoliosis of the lumbar spine with anterior osteophyte formation at L1-L3. Moderate facet hypertrophy is seen at right L4-S1 levels and mild facet hypertrophy seen within the remainder of the lumbar spine.
Disc bulges causing mild spinal canal narrowing at L2-L3, L3-L4, and L4-L5 with bilateral lateral recess narrowing at L4-L5.

X-rays lumbar spine: Report dated 8/22/2018
Spurring seen mildly throughout lumbar spine, or focal involving L2-L3. Mild sclerosing of left SI joint.

PROCEDURES
03/09/2017
FJI B L5S1
Post injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/08/2017
MBB B L5S1
Post injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief and pain eventually returned

11/30/2017
RFA B L5S1
Sustained: ROM has improve significantly, 80% resolution of usual pain. Tender ache with right side more than left.

06/20/2019
RFA B L5S1
Sustained: Patients pain has returned

MEDICAL HISTORY
Diabetes type 2, HbA1C 6.8%
Memory impairment from mild TBI
Low back pain s/p slip & fall

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 500mg TID

NV & CA PMP REVIEWED 6/5/17-6/5/19 NO MEDS FOUND

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes rarely. The patient does not drink. The patient denies recreational drug use.

REVIEW OF SYSTEMS
Constitutional Symptoms: Fatigue
Visual: Decreased vision
ENT: Headache
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Genitourinary: Negative
Endocrine: Negative
Musculoskeletal:
Neurological: Arm numbness
Hematologic: Negative
Integumentary: Negative
Psychological: Negative

VITAL SIGNS
Height: 65.00 Inches
Weight: 200.00 Pounds
Blood Press: 128/72 mmHg
Pulse: 47 BPM
BMI: 33.3
Pain: 05

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: Mild discomfort
Transition: Slight limited
Ambulation: Patient can ambulate without assistance.
Gait: Gait is antalgic

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Tenderness: Moderate tenderness noted bilateral lower lumbar spine and very mild at Left SIJ
Trigger Points: None noted.
Spasm: Moderate spasm is noted in the paravertebral musculature.
Facet Tenderness: Facet joint tenderness is noted.

Spinous Tenderness: Spinous processes are non-tender.
ROM % of normal
Flexion: 75% with pain.
Extension: 75% with pain.
Pain is equal with flexion and extension.
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.
Pelvic Rock: Negative for SIJ pain bilaterally
Patrick's (FABER): Negative bilaterally
Yeomen: Negative bilaterally

Motor/Strength Testing:
Hip flexion (L2-L3): L 5/5, R 5/5
Hip abduction (L4-S1): L 5/5, R 5/5
Knee extension (L3-L4): L 5/5, R 5/5
Knee flexion (L5-S1): L 5/5, R 5/5
Ankle inversion (L4): L 5/5, R 5/5
Ankle eversion (S1): L 5/5, R 5/5
Ankle dorsiflexion (L4, L5): L 5/5, R 5/5
Ankle plantarflexion (S1): L 5/5, R 5/5
EHL(L5): L 5/5, R 5/5

Sensory:
L1: Normal bilaterally
L2: Normal bilaterally
L3: Normal bilaterally
L4: Normal bilaterally
L5: Normal bilaterally
S1: Normal bilaterally

Reflexes:
Knee (L4): Left 2+, right 2+
Ankle (S1): Left 2+, right 2+
No Clonus bilaterally

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented.
Mood/Affect: Mood and affect are normal.
Thought Processes: Thought processes are intact.
Concentration: Concentration is intact.
Suicidal Ideation: The patient denies suicidal ideation.

DIAGNOSIS
M51.27 LUMBOSACRAL DISCOPATHY
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS
M54.5 LOW BACK PAIN
M62.838 MUSCLE SPASM

COUNSELING
Home Exercise Program
The patient received extensive counseling regarding home exercise and stretching. Specific discussion included appropriate exercises for the patient, exercise tolerance and limitations. All questions were answered.

PRESCRIPTION
None

PLAN
** REFERRAL TO: PHYSICAL THERAPY: 3x / week for 6 weeks. Evaluate and treat. Therapeutic exercise & HEP
** DME: Lumbar brace
** RECORDS FROM: Jason Garber MD
** I recommend she see Dr. Shah for her memory concerns, doesn't remember if she took Aricept
** RETURN: 4 weeks for re-evaluation with kdt

Katherine D Travnicek MD

Copy to: Jason Garber MD Primary care provider Russell Shah

Electronically signed by KATHERINE TRAVNICEK Date: 10/16/2019 Time: 8:58:40

PAIN INSTITUTE OF NEVADA

7435 W Azure Road, Ste 190, Las Vegas, NV 89130-4425 ++ 702.878.8252 ++ 702.878.9096
Mailing address: 7065 W Ann Road, Ste 130 #548, Las Vegas, NV 89130-4990
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FAX TRANSMITTAL

Date: 10/23/19 **Number of Pages:** 4

TO: Jackie **COMPANY:** Keith Gallier

Phone Number: 702-735-0049 **Fax Number:** 702-735-0204

The following information is confidential and is intended for the use of the above-indicated person only. If you do not receive the number of pages indicated above, please notify the person noted below immediately.

RE: Sekera, Joyce

Hello,

Your client, Joyce Sekera, was seen for a consultation with DR. Travnicek on 10/16/19 and I have attached the not for your records. Dr. Travnicek is recommending the following:

PLAN

REFERRAL TO: PHYSICAL THERAPY: 3x / week for 8 weeks. Evaluate and treat. Therapeutic exercise & HEP

** DME: Lumbar brace ** RECORDS FROM: Jason Garber MD

** I recommend she see Dr. Shah for her memory concerns, doesn't remember if she took Aricept

** RETURN: 4 weeks for re-evaluation with kdt

Ms. Sekera is scheduled to return for a follow up appointment on 11/13/19 @ 8:15am.

Please advise if we can proceed with the above recommendations under the patient's lien.

If you have any questions, please do not hesitate to contact me direct.

FROM: Rachel **EXT NO.** 233 **EMAIL:** rachel@paininstitute.com

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8252
Fax 702-878-9096

OFFICE VISIT

Date of Service: October 16, 2019

Patient Name: **Joyce P Sekera**
Patient DOB: **3/22/1958**

PAIN COMPLAINT
Low back

Joyce returns for follow up today.
The patient is s/p radiofrequency rhizotomy bilateral L5-S1 in June 2019
Sustained improvement: She feels she had significant pain relief but it returned and she can't remember when exactly.
Low back pain is a constant dull ache and involves whole low back with some posterior thigh pain. She denies numbness, tingling or weakness.
Activities that aggravate the pain: Sitting, standing, walking
Activities that relieve the pain: Apply pressure while sitting down
Description of the pain: Dull, ache, stiffness
Least pain throughout day (0-10): 2/10
Most pain throughout day (0-10): 6/10
Helpful treatments: Ice and heat, laying down
Non-helpful treatments: N/A
She can't bend over and pick up grandkids and can't do certain activities with them (sports).
Dr. Smith is on some sabbatical and won't be returning for some time ? It's unclear if he'll return to practice. She was transferred to Dr. Garber who recommended a SCS trial. She read the risks and would like to hold off. He ordered a bunch of new imaging which I don't have so will request.

She is seeing her PCP for diabetes and she hasn't seen Dr. Shah lately. Her memory is still impaired and I recommend seeing him again.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Retired
Therapy: Pt is not currently receiving physical or chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular fissuring, Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facal hypertrophy bilaterally. AP dimension spinal canal 10 mm.

XRAYS cervical spine with Flex/Ext : Report dated 7/31/2018
Cervical spine straightening with mild degenerative disc disease at C5, there is 6 to a lesser degree. C4-C5. Multilevel mild spondylosis. Flexion and extension views demonstrate no ligamentous laxity or instability.

AP and lateral thoracic and lumbar spine with right and left lateral bending: Report dated 7/31/2018
Mild endplate osteophytosis of the mid thoracic and lumbar spine. Equal excursion of right and left lateral bending. No significant scoliosis measured on chronic exam.

X-ray lumbar spine with flexion and extension: Report dated 7/31/2018
Mild degenerative disc disease at L1-L2 mL, 2–3 with multilevel mild spondylosis, most evident at L4-S1. Vascular calcifications noted with slight levoconvex curvature. No evidence of subluxation with flexion extension views.

CT lumbar spine: Without contrast: Report dated 7/31/2018
Mild levoscoliosis of the lumbar spine with anterior osteophyte formation at L1-L3. Moderate facet hypertrophy is seen at right L4-S1 levels and mild facet hypertrophy seen within the remainder of the lumbar spine.
Disc bulges causing mild spinal canal narrowing at L2-L3, L3-L4, and L4-L5 with bilateral lateral recess narrowing at L4-L5.

X-rays lumbar spine: Report dated 8/22/2018
Spurring seen mildly throughout lumbar spine, or focal involving L2-L3. Mild sclerosing of left SI joint.

PROCEDURES
03/09/2017
FJ I B L5S1
Post injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/08/2017
MBB B L5S1
Post Injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief and pain eventually returned

11/30/2017
RFA B L5S1
Sustained: ROM has improve significantly, 80% resolution of usual pain, Tender ache with right side more than left.

06/20/2019
RFA B L5S1
Sustained: Patients pain has returned

MEDICAL HISTORY
Diabetes type 2, HbA1C 6.8%
Memory impairment from mild TBI
Low back pain s/p slip & fall

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 500mg TID

NV & CA PMP REVIEWED 6/5/17-6/5/19 NO MEDS FOUND

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes rarely. The patient does not drink. The patient denies recreational drug use.

REVIEW OF SYSTEMS
Constitutional Symptoms: Fatigue
Visual: Decreased vision
ENT: Headache
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Genitourinary: Negative
Endocrine: Negative
Musculoskeletal:
Neurological: Arm numbness
Hematologic: Negative
Integumentary: Negative
Psychological: Negative

VITAL SIGNS
Height: 65.00 Inches
Weight: 200.00 Pounds
Blood Press: 128/72 mmHg
Pulse: 47 BPM
BMI: 33.3
Pain: 05

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: Mild discomfort
Transition: Slight limited
Ambulation: Patient can ambulate without assistance.
Gait: Gait is antalgic

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Tenderness: Moderate tenderness noted bilateral lower lumbar spine and very mild at Left SIJ
Trigger Points: None noted.
Spasm: Moderate spasm is noted in the paravertebral musculature.
Facet Tenderness: Facet joint tenderness is noted.

Spinous Tenderness: Spinous processes are non-tender.
ROM % of normal
Flexion: 75% with pain.
Extension: 75% with pain.
Pain is equal with flexion and extension.
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.
Pelvic Rock: Negative for SIJ pain bilaterally
Patrick's (FABER): Negative bilaterally
Yeoman: Negative bilaterally

Motor/Strength Testing:
Hip flexion (L2-L3): L 5/5, R 5/5
Hip abduction (L4-S1): L 5/5, R 5/5
Knee extension (L3-L4): L 5/5, R 5/5
Knee flexion (L5-S1): L 5/5, R 5/5
Ankle inversion (L4): L 5/5, R 5/5
Ankle eversion (S1): L 5/5, R 5/5
Ankle dorsiflexion (L4, L5): L 5/5, R 5/5
Ankle plantarflexion (S1): L 5/5, R 5/5
EHL(L5): L 5/5, R 5/5

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