

CONFIDENTIAL REPORT
PREPARED FOR:
John Doe, Esq.





Fact Sheet and Summary

Patient Information

Name: Doe, John

Date of Birth: 01.01.1965

Date of Injury: 12.10.2018

Date of Death: N/A

Primary Care Physician: Dr. John Doe [03.10.2011-02.20.2020] *Health Clinic*

Treating Physicians:

- **Dr. John Doe** – Neurologist [09.24.2010] *Neurology Clinic*
- **Dr. Jane Doe** – Radiologist [03.13.2013-11.17.2015] *Generic Hospital*
- **Dr. Jane Doe** – Orthopedic Surgeon [09.30.2013-09.20.2019] *Orthopedic Clinic*
- **Dr. John Doe** – Pain Clinic Doctor [11.15.2013-08.01.2019] *Pain Clinic*
- **Jane Doe, LVN** – Licensed Vocational Nurse [11.04.2014-02.20.2020] *Health Clinic*
- **Dr. John Doe** – Rheumatologist [10.20.2015-11.12.2019] *Health Clinic*
- **Dr. John Doe** – Chiropractor [01.04.2017-12.20.2018] *Chiropractic Clinic*
- **Dr. Jane Doe** – Radiologist [07.10.2017- 04.18.2019] *Generic Hospital*
- **Jane Doe, LCSW** – Licensed Clinical Social Worker [07.12.2017] *Generic Hospital*
- **Dr. Jane Doe** – Psychologist [07.10.2018-01.14.2019] *Mental Health Clinic*
- **Jane Doe, PT** – Physical Therapist [08.03.2018-10.02.2018] *Physical Therapy Clinic*
- **Dr. John Doe** – Occupational Medicine [12.10.2018-01.28.2020] *State of Arizona*
- **Jane Doe, OT** – Occupational Therapist [06.06.2019-07.19.2019] *Occupational Therapy*
- **Dr. Jane Doe** – Psychologist [09.09.2019-01.29.2020] *Mental Health Clinic*
- **Dr. Jane Doe** – Neurosurgeon [08.18.2020] *Generic Hospital*

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Records Reviewed

File Name/Designation	Total Pages	Relevant Pages
COS Medical 1.2 (1).pdf	62	52
Chiro_2.pdf	2	2
Chiro.pdf	3	3
Dr. Note and lab request.pdf	3	3
LL_MR 2.3.21.pdf	401	224
LL_MR_2 2.3.21.pdf	147	78
MH notes.pdf [Duplicates]	3	0
Misc Medical Records...etc).	41	35
Neuro notes.pdf	26	26
OR Report.pdf	6	6
PT.pdf	2	2
PT2.pdf	17	6
S Med Med Record and Reports.pdf	4	4
S. Med Bill.pdf	1	0
VA RAD (1).pdf	10	0
TOTAL	728	441

Prior Medical Conditions

The Following are Prior Medical Conditions Based on the Review of the Above Records:
Anisocoria
Arthritis
Benign Neoplasm of Colon
Bilateral Knee Injections
Cervical Disc Disease
Cervicalgia
Chronic Daily Headaches, Tension-Type
Chronic Pain
Chronic Urinary and Mild Stool Incontinence
Degenerative Joint Disease
Depression
Dermatitis or Eczema
Dysphagia Tier 1
Fibromyalgia

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Gastroesophageal Reflux Disease
Generalized Anxiety Disorder
Hearing Loss
Hemangioma of Skin and Subcutaneous Tissue
Hypertension
Icterus
Knee: Arthralgia
Kyphosis
Lack of Normal Lordosis of Cervical Spine
Left Shoulder Rotator Cuff Tendinopathy
Lumbalgia
Lumbar Back Injections
Lumbar Radiculopathy
Lumbar Stenosis
Mild Left Superficial Peroneal Sensory Neuropathy
MRI (Lumbar Spine, Cervical Spine)
Multifocal Degenerative Disc Disease (Mid Cervical, Lower Lumbar Spine, Bilateral Shoulders, Knees, Ankles, Feet)
Neural Foraminal Stenosis
Neuropathy
Obstructive Sleep Apnea
Osteoarthritis
Polyarthralgias
Post Traumatic Stress Disorder
Retrolisthesis of C5 on C6
Retrolisthesis at L4-5 and L5-S1 (Grade 1 Degenerative)
Rhinoplasty
Right Shoulder Impingement Syndrome
Rotator Cuff Tendinopathy
Shoulder Pain
Spinal Stenosis (Cervical)
Spondylosis (Lumbar Spine, Mild)
Tinnitus

Injuries Sustained from Accident

**The Plaintiff is Claiming the Following Injuries as a Result of the Accident:
(According to the Medical Records and Discovery Responses)**

Acute Strain Pattern, with Parasthesias likely 2/2 Local Nerve Compression

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Cervicalgia [Aggravated]
Lumbalgia [Aggravated]
Strain of Other Muscles, Fascia and Tendons at Shoulder and Upper Arm Level, Right Arm, Initial Encounter

Additional Medical Diagnoses

Other Medical Diagnoses found in the Medical Records AFTER the Date of the Incident that are Pertinent to this Claim:
Anxiety Disorder, unspecified [Aggravated]
Aggravation of Right Shoulder Degenerative Joint Disease with Impingement Syndrome
Biceps Tendinitis with the Splitting of the Biceps Tendon in the Proximal Bicipital Groove
Bowel and Bladder Incontinence [Aggravated]
Carpal Tunnel Syndrome
Cervical Disc Herniation with Posttraumatic Neck Pain and Radiculopathy
Cervical Neural Foraminal Stenosis
Cervical Radiculopathy
Cervical Retrolisthesis [Aggravated]
Cervical Spine Sprain/Strain
Cervical Spondylosis [Aggravated]
Chronic Daily Headaches, Tension-Type [Aggravated]
Herniations: C4 5, C5 C6, and C6 7
Lumbar Radiculopathy
Major Depressive Disorder, Recurrent Episode, Severe
Mood Disorder/Adjustment Disorder
Posttraumatic Aggravation of Underlying Degenerative Spinal Condition with Mechanical Axial Back Pain with Radiculopathy
Tendinosis of Distal Supraspinatus Tendon [Aggravated]
Type II Acromion with Moderate Degenerative Changes Acromioclavicular Joint [Aggravated]

Narrative Summary of the Case

The Facts

This case involves a 53-year-old man Mr. John Doe who was involved in a Motor Vehicle Accident on 12.10.2018. Mr. Doe was the restrained driver stopped at a red light in a company vehicle (2017 Ford F150). He stated he was waiting for the light to turn green when a Toyota Prius rear-ended and slid under his vehicle. Mr. Doe stated that he was told that the driver fell asleep behind the wheel. He reported the impact felt like an “explosion” and he was

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jolted multiple times. Mr. Doe stated that he was amnesic to the events of the collision. Amnesic means “the loss of memories”. He reported experiencing immediate pain in both of his shoulders, arms, hands, and neck. NOTE: Mr. Doe has a history of back pain, neck pain, shoulder pain, and sciatica [sharp or burning nerve pain that travels down the leg on one side].

The police and paramedics arrived. A police report was filed. According to Dr. Jane Doe’s report 08.18.2020, “Immediately after the collision the patient drove to Generic Hospital”. It is unclear if he was transported to the hospital via ambulance or an alternative way. The police, emergency services, and emergency room reports are all missing from the medical records provided and are being requested in this Fact Summary Report. Dr. Doe stated that Mr. Doe was evaluated by emergency room doctors with neck pain, lower back pain, bilateral shoulder, and leg pain. An X-ray of Mr. Doe’s cervical spine [AKA neck] was completed. The report showed minor, common age-related wear-and-tear in the neck. There was no evidence of an acute fracture, dislocation, or foreign body. Another X-ray of his right shoulder was done. The report showed early, minor wear-and-tear arthritis in the acromioclavicular joint [where the collarbone meets the top of the shoulder blade]. It was also noted that there was no evidence of acute fracture, dislocation or foreign body. This means the X-ray results show no signs of any recent bone breaks, misplaced joints, or foreign objects.

At 11:50 AM on 12.10.2018, Mr. Doe was seen by Occupational Doctor John Doe. Mr. Doe presented with acute low back pain, tightness, right shoulder pain with radiation to the elbow, and numbness and tingling to both hands and feet. His pain level was a 6 out of 10 on the Visual Analogue Pain Scale, which is considered intense pain. Mr. Doe denied weakness, bowel/bladder incontinence, or other symptoms at this time. Mr. Doe was diagnosed with “Strain of other muscles, fascia, and tendons at shoulder and upper arm level, right arm, initial encounter” and “Acute Strain Pattern with Paresthesias likely 2/2 Local Nerve Compression”. This means he had a sudden, recent muscle injury that is irritating a nearby nerve causing abnormal sensations like tingling and numbness caused by or a pinched nerve.

He was given Tylenol and was asked to return for a follow-up in one week. On 12.10.2018, the Medical Causation was noted by Dr. John Doe “The cause of this problem is related to work activities”.

John Doe attended a Chiropractor office visit on 12.13.2018 where he complained of increased pain and back spasms. In the two weeks leading up to his upcoming Occupational Medicine follow up, he attended 3 additional Chiropractor appointments where he continued to complain of pain and back spasms with little relief.

During Mr. Doe’s follow up with Occupational Medicine on 12.17.2018, it is noted he had increased stiffness and pain. Dr. Doe recommended that Mr. Doe rest, ice, compress, and elevate the affected areas as much as possible. Dr. Doe recommended over the counter pain medication and to follow-up in 2 weeks. He was placed on Regular Duty work status.

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He began seeing a Psychologist on 12.27.2018.

During his next Psychologist appointment on 12.31.2018, he expressed monitoring and discerning mood changes. He said he didn't notice, but his wife mentioned mood changes.

On 01.03.2019, Mr. Doe had a follow up with Occupational Medicine Dr. Doe. Mr. Doe stated his pain has gotten worse in his lower neck and upper back region. He complained of increased stiffness and hand weakness. He stated he was unsure if hand weakness was new or chronic. He described continuing to experience numbing and tingling. Mr. Doe continued to complain about right shoulder, low back, and neck pain. John Doe also experienced tenderness to touch on both sides of his neck during his examination. Dr. Doe continued to recommend rest, ice, compression, elevation, and Tylenol. It was recommended to follow-up in two weeks.

John Doe had a pain consultation with Dr. John Doe on 01.08.2019. It was then discovered Mr. Doe had neck and back pain about 15 years ago due to jumping out of planes and repeated airborne trauma in the Military. Back on 05.13.2013, Dr. Doe stated Mr. Doe had an MRI done outside of the VA hospital and it was determined he had Mild Spinal Stenosis around L1-2, L4-S1 [lower back bones]. This means he had a slight narrowing of the spinal canal in multiple areas of the lower back, often due to normal wear-and-tear.

Mr. Doe discussed previously having Posterior Lumbar Fusion Surgery done successfully. Posterior Lumbar Fusion is a lower back operation that joins two or more bones together. It is unknown when and where this surgery took place. The missing medical records are requested in this Fact Summary Report. Mr. Doe stated that after the motor vehicle accident he now has constant pain and bilateral [both] hand numbness. He states that he gets headaches that are similar to the ones he got before his rhinoplasty [nose job].

Mr. Doe was then diagnosed with Cervical and Lumbar Radiculopathy. It is noted that Mr. Doe was previously diagnosed with Lumbar Radiculopathy back on 09.30.2013. This appointment on 01.08.2019 is the first time, in the available medical records, where Cervical Radiculopathy was ever diagnosed. Cervical means the neck and Lumbar is the lower back. Radiculopathy is often a temporary condition caused by a pinched nerve in the spine. Most people recover fully with time and non-surgical care. The last time in the available records Mr. Doe was diagnosed with Lumbar Radiculopathy was 04.07.2014. Previously, on 01.06.2017, Mr. Doe denied Radiculopathy being currently present.

During Dr. Doe's assessment on 01.08.2019, it was noted that Mr. Doe had "obvious limitations due to pain" in his neck, tenderness in the muscles that run along the spine, a positive Spurling's test, a positive Phalen's test, and a positive facet loading test. A positive facet loading test means that when the Doctor gently moves the spine into positions that

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squeeze the small joints in the back, it recreates the pain - indicating those joints may be the source of discomfort. A positive Spurling's test indicates a pinched or irritated nerve root. A positive Phalen's test strongly suggests carpal tunnel syndrome.

Dr. Doe stated the plan was to order a CESI [Cervical Epidural Steroid Injection], if the MRI doesn't show any contraindications. CESI is a quick, minimally invasive procedure that places strong anti-inflammatory medicine into the neck to relieve pain and swelling around irritated spinal nerves. Dr. Doe documented, "back is getting better so will hold on lumbar MRI". Dr. Doe's recommendations are to continue his HEP [home exercise program], Physical Therapy 2 times per week for 3 weeks, consider Biofeedback/CBT [cognitive behavioral therapy], consider Acupuncture, continue his medication regimen prescribed by his PCP [primary care provider], increase Gabapentin [treats nerve pain] to 1200 mg 3 times a day [highest recommended maximum daily dose], continue Baclofen or Flexeril [muscle relaxants], follow up with PCP, and follow up with Dr. Doe at the Pain Clinic after an MRI within 3 months.

Mr. Doe was seen by Psychologist Dr. Jane Doe on 01.14.2019. Her diagnostic impression is "Anxiety Disorder, Unspecified". It is noted he continues to have sleep issues and increased dreams of his experiences in the services, flashbacks, and headaches. Dr. Doe noted Mr. Doe's wife stated he seemed anxious and more so in the last few months".

An MRI of the neck without contrast was done on 01.29.2019. The MRI results showed the following: Routine wear and tear in the neck has progressed slightly in a few spots, leading to some squeezing of the spinal cord and nerve openings.

On 02.04.2019, Mr. Doe had a CESI [Cervical Epidural Steroid Injection] and was experiencing 10 out of 10 pain on the Visual Analogue Pain Scale [considered worst pain possible].

On 02.20.2019, Mr. Doe presented at his PCP's office with headache and elevated blood pressure 163/97 [less than or equal to 120/80 is the normal blood pressure range] and 5-7 out of 10 pain which is considered moderate to very severe pain.

On 02.22.2019, Mr. Doe had a follow up appointment with Dr. Doe. Mr. Doe complained of 7 out of 10 pain. This is considered very severe pain on the Visual Analogue Pain Scale. He continued to complain of numbness/tingling, and right shoulder, low back, and neck pain. He was diagnosed with "Cervicalgia" and "Unspecified Mononeuropathy of Bilateral Upper Limbs". Simply put, he was diagnosed with neck pain and nerve irritation or damage in both of his arms or hands but the exact cause is not yet named. At this point in time, the "overall symptoms are same as prior, with different quality of radiation of pain from the lower back...feeling increased stiffness, despite conservative treatment", according to Dr. Doe. It is stated by Dr. Doe that the Nerve Conduction Study results showed Carpal Tunnel Syndrome

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that “would typically not be work related”. Dr. Doe advised Mr. Doe to wear wrist supports at night, apply Voltaren [treats joint pain] to the neck 4 times a day, and follow up in two weeks. Medical Causation is again noted, “The case of this problem is related to work activities”.

At Mr. Doe’s follow up with the Pain Clinic Dr. Doe on 03.08.2019 it is documented that Mr. Doe continues to have pain in the lower lumbar region, neck, and right shoulder. Mr. Doe stated that “the problem began on 12.10.2018 and seems to be following no particular pattern.”. He noticed it is made worse by moving it. Mr. Doe continues to experience numbness and tingling. He feels it is improving slightly with a pain level of 6 out of 10, which is considered intense pain on the Visual Analogue Pain Scale. Upon examination, it is noted that Mr. Doe has limited extension of the neck and rotation of the head to the left provokes pain. It is tender to the touch from C6, C7, and T1 [lower part of the neck and upper back area]. Mr. Doe is also tender to touch at L4-L5 [lower back] and on both sides of the paraspinal muscles [muscles that run along the spine], with the left side more tender than the right. His right shoulder range of motion was improving with Mr. Doe experiencing pain past 90 degrees with flexion [raising the arm straight up and front of the body] and abduction [lifting the arm straight out to the side, away from the body]. During his examination, it was noted Mr. Doe had a positive impingement sign. A positive impingement sign indicates that the tendon or bursa [fluid filled sac] in the shoulder is being painfully pinched against the overlying bone when the arm is moved.

An extension for additional Physical Therapy sessions was added for another 2 times per week for 3 weeks. It is noted there are missing medical records for this round of physical therapy Mr. Doe has completed. It was documented that he had approximately 9 sessions of Physical Therapy between February 2019 and June 2019. These missing medical records are being requested in this Fact Summary Report. Dr. Doe stated, “Patient presents for neck, low back, and right arm pain status post MVA on 12.10.2018. He continues to have moderate pain, though he feels this level is manageable”. Mr. Doe is to continue to use heat wraps and ice packs to minimize discomfort and return in 2 weeks for a follow up.

On 03.26.2019, Mr. Doe returns for a follow up with Occupational Medicine Dr. Doe. It is noted that Mr. Doe continues to have pain in his neck, back, and right shoulder. Upon examination it is noted that he continues to have limited extension and now full flexion of his neck. Rotation of his head still provokes pain. His neck is still tender to the touch in the same area as last time. He has a new sensation of numbness running down his right arm at this time. The muscles along the spine continue to be tender to the touch, with the left still being more tender than the right. Dr. Doe documented that both lower legs are noted to be swollen and he is wearing compression socks. Shoulder range of motion is improving but he still experiences pain upon moving past 90 degrees with flexion and abduction. Mr. Doe continues to display a positive impingement sign. There is now shoulder pain with external rotation as well, which was not noted during the previous examination on 03.08.2019. Mr. Doe continues to complain of numbness and tingling in the upper extremities. Dr. Doe states he will order a repeat MRI

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without contrast of the cervical spine and the right shoulder. He is to return in two weeks for a follow up. Mr. Doe's work status is regular duty.

On 04.05.2019, it is noted that Mr. Doe tested negative for Barbiturates, Amphetamines, Cocaine, Benzodiazepines, Marijuana, Opiates, and Phencyclidine. Also on 04.05.2019, Mr. Doe attended a Rheumatology appointment with Dr. Doe. He received bilateral knee injections, which he had been receiving on and off for years prior to the accident. He continues to complain of neck and low back pain. Mr. Doe stated an 8 out of 10 on the pain scale, which is very severe pain. At this time, it is noted that Mr. Doe stated he does not currently take any pain medications.

On 04.08.2019, Mr. Doe returns for a follow up with Dr. Doe. He stated he has 30-50% pain relief of his neck pain. Mr. Doe stated he continues to have low back, neck, shoulders, and ankle pain. He stated his pain has increased in the last 5 days. He admitted to forgetting to take his medications for a couple of days, which may explain the sudden increase. Mr. Doe self-reported that his pain is 10 out of 10 interfering with his daily living. Dr. Doe's plan is to schedule another CESI [cervical epidural steroid injection] in 3 months, follow up with Rheumatologist, order Tai Chi Chuan group classes through Occupational Therapy, follow up with PCP, and follow up with Pain Clinic in 3 months.

On 04.18.2019, another MRI of the Cervical Spine without contrast was done. The results showed: normal wear and tear in the neck bones and discs from C3 to C7. The main issues are at C5 to C6, where a bone slip and disc bulge is pressing on the spinal sac and blocking the nerve holes severely. Other spots show minor bulging and bone spurs. A picture of the spine is located at the end of this report for reference. Another MRI of the Upper Extremity Joint without Contrast – Right showed: A curved bone [Type II acromion] is rubbing on the joint with mild wear-and-tear, mild damage and swelling [tendinosis] in one of the main rotator cuff tendons, and inflammation with a small split in the biceps tendon. According to the available medical records, these are all new diagnoses that occurred after the MVA. The results of both MRIs indicated no acute injury and multiple areas of Degenerative Joint Disease.

He received knee injections in both of his knees on 04.22.2019.

On 04.23.2019, Mr. Doe had a follow up appointment with Dr. John Doe. He continues to complain of pain in his neck, back, and right shoulder. Rotating his head to the left provokes neck pain. Mr. Doe reported that there was "no change or improvement of pain or right arm numbness". He stated at this time his pain was manageable at a 4 out of 10 on the pain scale, which is considered moderate pain. Dr. Doe orders a referral to Generic Orthopedic Clinic to "evaluate the lack of progress" for Mr. Doe's neck, lower back, and right shoulder. Mr. Doe's continued work status is regular duty.

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Just one week later on 04.30.2019, Mr. Doe returned to his PCP's office for 8 out of 10 pain in his lower back and both ankles. This is considered very severe pain on the pain scale. The same day [04.30.2019], he returned to the Rheumatologist for injections in both knees. It was noted during this appointment Mr. Doe complained of lower back and neck pain.

Around 2 weeks later on 05.13.2019, Mr. Doe was seen in the Pain Clinic by Dr. Doe for a follow up appointment. Dr. Doe stated, "Today patient has a complaint of neck and back pain. Did not get a call or letter for therapy yet". Mr. Doe self-reported 10 out of 10 that the pain continues to interfere in his daily life. Dr. Doe noted, "Send to pain psych. Complaints of irritability and lack of patience with others. Affecting his marriage and life".

That same day [05.13.2019], Mr. Doe saw his PCP Dr. Doe. Mr. Doe stated that a couple of weeks prior he was mowing the lawn and he subsequently had severe pain primarily in his lower back and ankles. He was "hardly able to get out of bed for a couple of days. He feels the pain has not let up, but he still has been able to mow the lawn twice since". Mr. Doe stated he is "feeling depressed due to chronic pain and family issues". During the exam it was noted he "appears fatigued/low energy". It was noted Mr. Doe continues to have chronic shoulder pain [left greater than the right] and daily headaches. Carvedilol [a prescription blood pressure medication sometimes used "off-label" to prevent frequent headaches and migraines] was added to Mr. Doe's medication regimen to see if it helps with his chronic headaches.

The same day [05.13.2019], Mr. Doe had a telephone encounter with the Mental Health Clinic Office Assistant Jane Doe. She called Mr. Doe because he had requested to schedule an appointment with mental health and was unable to locate him in the clinic. According to the notes, Mr. Doe was frustrated over some aspect of his care. Ms. Doe was attempting to look over his chart and speak with him but he "indicated he was frustrated and ended the call". She documented that she called him back and apologized for his frustration. He "indicated he was not interested in talking to anyone now or discussing this further today, he indicated 'call back in a couple days' and ended the call before she could provide him with additional information".

On 05.16.2019, it was noted by Mental Health Clinic, "Return to clinic order unsuccessful attempt. Order disposition will be removed/no longer necessary. Left a message for veteran to contact clinic to schedule a return appointment".

On 05.21.2019, Mr. Doe returned to Occupational Medicine Dr. Doe for a follow up appointment. He stated his pain level was a 4 out of 10 and there was no change in pain. Mr. Doe complained of neck, back, and right shoulder pain. Mr. Doe has an upcoming Orthopedic appointment on 06.18.2019 to evaluate the lack of progress. He was placed on regular duty with no restrictions at this time.

On 06.06.2019, Mr. Doe attended his first Tai Chi Chuan class with Occupational Therapy.

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Mr. Doe attended a follow up Occupational Medicine appointment on 06.18.2019. According to Dr. Doe, a new workman's compensation claim was submitted due to "work-related stress". Dr. Doe documented, "The patient comes into clinic claiming stress from work related issues. This stress appears to have caused an elevation in his blood pressure with associated headache and eye pain. However, a formal psychological evaluation is needed to determine causation and compensability of his stress claim. The basis for this stress claim are multi-factorial including the 2018 motor vehicle accident in December 2018. He indicated that his bonus was much smaller than he thought it should have been. The patient cited multiple issues. Among the issues cited were that his company wanted to make him stop working from home but he indicated that it would be difficult due to the sedating nature of multiple medications he has been prescribed by the Generic Hospital system". Dr. Doe later documented, "He considers it to be severe. The problem began on 06/18/2019".

Mr. Doe's blood pressure was extremely elevated during this visit at 201/115. A normal blood pressure range is 120/80 or less. Dr. Doe stated that Mr. Doe was having headaches and eye pain "attributed to elevated blood pressure after having a discussion with his supervisor". Dr. Doe stated Mr. Doe "initially had very elevated energy level and some agitation in his speech. However during the course of speaking with the patient he began to assume a calm demeanor within a few minutes". Dr. Doe documented, "Medications listed by the patient include amitriptyline and duloxetine which the patient states are both for his diagnosis of spinal stenosis and not for psychotherapeutic treatments". Amitriptyline is typically prescribed to treat depression but can be prescribed for off-label conditions such as nerve pain and migraines. Duloxetine is typically prescribed to treat major depressive disorder and generalized anxiety disorder. It can be prescribed for off-label use to treat nerve pain, fibromyalgia, and chronic muscle or joint pain.

Dr. Doe requested authorization for transfer of care to a Psych Specialist. Dr. Doe stated, "I opine that the patient is not fit for duty of any kind with the company at this time in his current mental state. I believe that a formal psych specialty intervention would be needed prior to his returning to work". Mr. Doe's work status was updated by Dr. Doe, "Mr. Doe's recommended work status is No Work Capacity. The effective date for this work status is 6/18/2019. This work status designation ends 7/2/2019. Next appointment 7/2/2019".

On the same day, 06.18.2019, Mr. Doe went to an Orthopedic Evaluation appointment. Mr. Doe's chief complaints were: headaches, neck pain, low back pain, and shoulder pain. The muscles that run along the spine [Paraspinal Musculature] were still tender to the touch. Dr. Jane Doe, Orthopedic Surgeon, tested Mr. Doe's range of motion in his neck. There were substantial deficiencies in his range of motion during flexing, extending, and rotating his neck. Dr. Doe used a specialized device, called a Dynamometer, to test the physical strength and pushing force of his neck muscles. The normal ranges for lateral flexion [side bending/ear to shoulder] can vary based on gender, body weight, and testing direction. A typical range for men is 25 to 65 pounds. Mr. Doe's results on the right side were 27.4 pounds and on the left

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was 17.2 pounds. Dr. Doe requested authorization for Mr. Doe to undergo a course of chiropractic therapy 2 times a week for 4 weeks for the neck. This is to improve the ranges of motion, reduce pain, and for strengthening. Dr. Doe also requested authorization for Mr. Doe to undergo a consultation with a pain management specialist for medications. Dr. Doe would like to see Mr. Doe in 4 weeks for further evaluation. Dr. Jane Doe documented the causation of Mr. Doe's claims, "The patient's medical findings are consistent with his description of the job-related injuries dated December 10, 2018. Therefore, it is in my opinion, causation is to the industrial accident in question".

On 06.27.2019, Mr. Doe attended another Occupational Therapy Tai Chi Chuan group class.

On 07.01.2019, Mr. Doe emailed his Primary Care Physician, Dr. Doe, about his high blood pressure. Mr. Doe messaged, "My BP [blood pressure] has been high over the last 2 weeks, I have been taking my meds and have been off work. So I have been trying to relax. Starting 2 weeks ago 201/115 and not going below 139/82. Today it is 173/116 and all I did was answer a couple of texts from work and read some emails. I think my meds are off...Please help, I am having headaches and my eyes are hurting". It was then recommended by Dr. Doe to increase his Carvedilol [blood pressure medication] to twice a day, instead of just once. Follow up scheduled in 2 weeks.

On 07.01.2019, Mr. Doe had a Physical Therapy Evaluation for muscle pain in his shoulder and neck. Jane Doe, PT documented, "Patient is a 54-year-old male with chronic cervical spine pain who re-injured his neck in December 2018 following an MVA". Mr. Doe's neck active range of motion was tested. There was slight improvement, but his measurements were still well below the normal range. It was discovered that Mr. Doe had muscle tightness in his chest and back. Mr. Doe's upper back flexion and extension [T1-T4] and neck extension [C2-C6] were noted to be hypomobile, which means a joint has less movement than normal. Mr. Doe was tender to the touch from C2-T4 [neck to upper back area]. Mr. Doe continued to complain of neck pain. Mr. Doe is scheduled to attend Physical Therapy once a week for 4 to 8 weeks to treat his cervical spine AKA neck.

On 07.16.2019, Mr. Doe had his Orthopedic follow up appointment. "Mr. Doe presents with neck pain which radiates from the neck to the shoulder and then to the hands. Furthermore, there is numbness about the patient's bilateral hands and feet coupled with tingling sensations. The patient notes worsening muscle spasms in the bilateral wrists/hands". Dr. Doe went on to document, "Upon evaluation, there is tenderness to palpation [touch] about the cervical spine. Additionally, a limited range of motion is present". Mr. Doe's neck range of motion was tested again. While there was slight improvement, Mr. Doe's neck range of motion remains very limited. Dr. Doe stated, "A sensory deficit is present about the left C4-5 and C6-7 nerve distributions". A sensory deficit on the left nerve distributions is a reduced or altered feeling [numbness, tingling, etc.] along specific path areas

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on the left side of the neck, shoulder, arm, and hand. This pattern points to an issue affecting specific nerve roots from the mid-to-lower neck area of the spine.

From there, Dr. Doe documented Mr. Doe's extensive effort to improve his quality of life and functioning. To summarize, "Mr. Doe has tried and failed a course of conservative management. During my physical exam I noted decreased range of motion with pain, as well as deficit to C6-T1 nerve distribution motor strength as well as decreased upper extremity deep tendon reflexes". This means the physical exam showed the neck and arm movements are limited by pain, some the arm muscles are weaker than normal, and the arm reflexes are reduced. Dr. Doe continued, "He has had several chiropractic therapy sessions with only temporary benefit. He was administered epidural steroid injections to his cervical spine, providing only temporary relief. Mr. Doe has clear cervical pathology in the form of cervical spondylotic radiculopathy". Cervical pathology means there is a verifiable physical change or medical issue located in the cervical spine AKA neck. Spondylotic refers to cervical spondylosis which means normal, age-related arthritic wear and tear which can lead to small, rough edges called bone spurs. Radiculopathy means a pinched nerve.

Dr. Doe went on to explain the criteria needed to meet for Mr. Doe to be diagnosed with Cervical Spondylotic Radiculopathy:

"A) Mr. Doe has significant symptoms that correlate with physical exam findings AND radiologist interpreted imaging reports.

B) Mr. Doe has had persistent and progressive radicular pain [sharp, shooting, stabbing pain from compressed/irritated nerve root] with documented weakness secondary to nerve root compression [weakness caused by pinched nerve] and moderate to severe neck pain, despite several sessions of conservative therapy.

C) Mr. Doe has clinically significant function limitation, resulting in inability or significantly decreased ability to perform normal, daily activities at work or at-home duties".

Dr. Jane Doe provided Mr. Doe with 3 options moving forward:

Option 1: Includes lifestyle modifications like an exercise program, a stringent weight loss program, avoiding any activities that make him uncomfortable, and learning to live with the current amount of residual pain.

Option 2: Includes a series of conservative modalities to decrease the symptoms. Those modalities include: oral steroids, epidural injections, NSAIDs, Chiropractic Management, Physical Therapy and Acupuncture.

Option 3: Includes definitive management in the form of surgery. The surgery would remove the damaged disc(s) to stop the pressure on the spinal cord/nerves then join the vertebrae together with bone grafts and metal hardware for stability. Dr. Doe documented, "After reviewing the history of injury and examining the patient, I believe this patient is able to return to modified work duty with the following restrictions: No lifting over 10 pounds, no repetitive bending and no twisting".

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On 07.19.2019, Mr. Doe was discharged from Occupational Therapy Tai Chi Chuan group class for 2 no shows on 07.11.2019 and 07.18.2019. Mr. Doe attended 2 more Physical Therapy appointments on 07.23.2019 and 07.30.2019. Mr. Doe complained of soreness during those sessions. Mr. Doe was a no call/show on the last session of this first round of Physical Therapy. He attended 3 out of 4 scheduled Physical Therapy sessions in this first round. Mr. Doe received a LESI (Lumbar Steroid Epidural Injection AKA for the lower back) on 08.01.2019.

On 08.19.2019, Mr. Doe had a follow up with Dr. Jane Doe. Dr. Doe documented, “Mr. Doe relates of neck pain today, worse since his last examination. The patient is currently undergoing a course of physical therapy, with little improvement”. Mr. Doe’s neck range of motion was tested again today with little to no improvement in most areas. Dr. Doe stated, “Mr. Doe is here today for orthopaedic re-evaluation of industrial injuries sustained to his cervical spine”. Mr. Doe’s work status remains the same from the previous appointment. Dr. Jane Doe wrote a Doctor’s Surgery Note for Mr. Doe’s upcoming surgery. “Please excuse Mr. John Doe from work for 3 weeks following his surgery on September 20th, 2019. Mr. Doe is medically cleared to return to work once the three weeks have passed with the following limitations: No lifting, No bending, No twisting”.

On 09.19.2019, Psychologist Dr. Jane Doe wrote a Mental Health Leave of Absence Letter. “This letter is being written at the request of my patient, Mr. John Doe. Mr. Doe is being treated for a stress related condition. He has been off work for approximately 9 weeks on a leave of absence. He was seen on 9/16/2019, and he needs to stay off of work while he recovers from his surgery; to be determined by appropriate medical professional. I anticipate his stress will be adequately resolved such that he will be ready to return to work after recovery from the neck surgery. His plan is to be consistent at work and to continue to follow up in psychotherapy, as needed, to continue gaining stress management skills”.

On 09.20.2019, Mr. Doe underwent surgery on his neck called Anterior Cervical Discectomy and Fusion. This is the surgical removal of a bad disc that presses on a nerve or spinal cord. Then, a spacer and a bone graft is put in that space to join the bones together. During the surgery, Dr. Doe found that the neck had three injured levels [C4-5, C5-6, and C6-7] where discs [the soft cushions between the neck bones] and ligaments [the strong bands holding the bones together] are torn, bulging, or flattened. This is pressing heavily on the spinal cord and nerves that goes to the arms.

On 10.04.2019, Mr. Doe’s temporary disability payments started. It was noted that on 10.07.2019, Mr. Doe had an IME [Independent Medical Exam] scheduled. There is no medical record submitted with details on this appointment. The missing medical records are requested in this Fact Summary Report.

On 10.09.2019, Dr. Doe ordered that Mr. Doe’s work status is to remain off work until

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11.19.2019.

On his visit to the Rheumatologist on 10.28.2019, Mr. Doe continued to complain of 7 out of 10 neck and right shoulder pain.

On 11.25.2019, Mr. Doe sent his PCP Dr. Doe, a message. “My lower back keeps pinching and my feet and ankles feel like something is broken. (pain with every step, sometimes failing to support me)”. Dr. Doe’s response, “I received your message about back, feet, and ankle issues. Sounds like these areas are causing you significant discomfort and disability. I encourage you to schedule either a face to face or telephone visit so we can discuss treatment options to help relieve your suffering”.

On 12.24.2019, Mr. Doe returned to his PCP and complained of chronic daily headaches, and feet, ankle, and knee pain. Dr. Doe documented Mr. Doe stated that he is taking up to 13 pills of Gabapentin per day to help with the pain. Dr. Doe advised that the maximum dose is 3600 mg per day. Dr. Doe noted Mr. Doe’s “function: decreased –off work since 1/2019”. Dr. Doe recommended more pain clinic injections as needed “more recent injections didn’t help”.

Several days later, on 12.27.2019 Mr. Doe emailed his PCP Dr. Doe stating, “I am having problems in my feet and ankles. It feels like something is cutting into me and sometime it to the point I can’t walk”.

On 01.28.2020, Dr. Doe updated Mr. Doe’s work status to, “Return to modified work on 1-29-20, no heavy lifting over 15 lbs. and no repetitive bending”.

The next day 01.29.2020, Dr. Jane Doe updated Mr. Doe’s return to work status. “Mr. Doe is insightful and works hard in his recovery. He has made great progress at stress management. He is feeling able to return to work. He has a follow-up appointment on February 13, 2020. It is my professional opinion that he is able to return to work as of January 30, 2020. He is encouraged to manage the number of hours that he works to avoid excess stress in the future. He is cleared to return to full duty of 40 hours per week”.

On 02.04.2020, Mr. Doe started his next round of the next 8 Physical Therapy appointments. Mr. Doe’s chief complaint was that “he feels only discomfort right now and no pain. He gets numbness and tingling at night but symptoms come and go. He states he feels like he does not have any strength in both arms”. The Neck Disability Index 10 question survey was conducted. This test is used to measure how much neck pain affects a person’s everyday activities. Mr. Doe’s score was 23 which indicates Moderate Disability. Severe Disability is between 25 and 34. Mr. Doe’s neck range of motion was retested. Most areas showed regression. “Patient’s signs and symptoms are consistent with movement coordination impairments due to cervical spine fusion”. The neck surgery that Mr. Doe had has stopped movement in a specific part of the neck, leading to stiffness and limited turning.

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Jane Doe, PT stated, “Patient Clinical Presentation: The clinical presentation is unstable with unpredictable characteristics”. This means his symptoms, pain levels, and/or physical responses change a lot from day to day and are hard to predict. Mr. Doe then went on to attend the rest of his Physical Therapy appointments. Mr. Doe stated it was difficult to tolerate 3 hours of standing or sitting upright without needing to lay down due to discomfort. By the third appointment on 02.12.2020, he was able to tolerate sitting more than 3 hours without laying down but he “is paying for it”. Visit 4 on 02.17.2020, he stated there was “mostly no change” and “any movement with shoulder causes discomfort”. The last Physical Therapy record available was on 02.19.2020. Mr. Doe stated his neck wasn’t bothering him that much today because his feet were hurting more. It was documented that Mr. Doe “tolerated exercises well with minimal complaints of pain”. Mr. Doe attended 3 out of 4 scheduled Physical Therapy visits in the first round. He attended 5 out of 5 visits in the second round according to the medical records provided. It was noted that there were 3 other dates noted to be missing 02.24.2020, 02.26.2020, and 03.02.2020. They have been requested in this Fact Summary Report. At this moment, it cannot be determined whether he attended those appointments without reviewing those records.

On 02.20.2020, Mr. Doe came for an unscheduled visit requesting blood pressure check due to headache pressure behind eyes and increased irritability. He states, “He had a confrontation with his boss at work causing increased stress”. Mr. Doe’s blood pressure was elevated at 159/101 [normal range less than or equal to 120/80].

On 03.06.2020, it is noted [Unknown Mental Healthcare Provider – *Unknown Mental Health Facility*] that “patient is no longer at XYZ Company he was being asked to take a drug test to get a purple badge. He felt there was an invasion of privacy with the saliva test. Said if you won’t take the saliva test, you need to take the urine test. He was willing to take it but told him it was reasonable suspicion. He took the test and came back to work two days later”. This was an excerpt from the Neurology Evaluation notes on 08.18.2020.

On 03.30.2020, [Unknown Mental Healthcare Provider – *Unknown Mental Health Facility*] it was noted, “Patient is happy he did not take the drug test with people coughing on each other. Patient is doing quite a bit better”. The missing medical records are being requested in this Fact Summary Report.

Mr. Doe’s final evaluation in the provided medical records was a Neurosurgical Evaluation on 08.18.2020 with Dr. Jane Doe. Mr. Doe’s chief complaints were: “*Neck pain with radiation to bilateral upper extremities until fingertips, right worse than left. Numbness, weakness, tingling and burning sensation in neck and bilateral upper extremities until fingertips, right worse than left. Headaches. Short term memory issues. Cognitive issues. *Spinal stenosis in lumbar spine. Lower back pain radiates bilaterally to lower extremities. Shooting pain in bilateral feet. Numbness, weakness, tingling and burning sensation in lower back and bilateral lower extremities. Balance issues uses cane intermittently. Bilateral ear

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ringing”. It was noted that after Mr. Doe finished his last round of Physical Therapy, “The patient was then evaluated by an Orthopedic Surgeon and recommends the patient undergo right shoulder surgery”. There is no Orthopedic Evaluation in the timeframe noted [sometime between February 2020 and August 2020] in the available medical records and is being requested in this Fact Summary Report.

Dr. Doe documented that Mr. Doe reported the following current complaints: recent weight gain of about 25 pounds, urinary urgency, bowel and bladder incontinence twice a week since the accident, increased neck pain with sneezing and coughing, balance issues, buckling in both legs, constantly having to lean on surfaces for support with increasing lower back pain with more frequent radiation in both lower extremities, more frequent and worse radiation of pain and increased weakness in lower extremities since the accident, weakness/numbness of the extremities, limitation in range of motion, muscle loss in right calf, problems controlling mood, difficulties with activities of daily living (walking up stairs, climbing ladders, performing intercourse, bending, twisting, lifting, lifting arms above shoulders, looking upwards, sitting/standing/walking for prolonged periods of time, playing with his grandson, shoulder and bilateral hand pain disrupts sleep every night, difficulty getting up from lying on his back, increased pain with writing and typing. “I’ve dropped my phone so many times. I feel weak all the time. I recently have trouble driving”), constant neck pain 4-5 out of 10, intermittent neck pain 7 out of 10, constant low back pain 3-4 out of 10, and intermittent low back pain 8-10 out of 10.

Dr. Doe also noted, “July 2020: The patient was the driver in a vehicle driving straight when another vehicle was making a left-hand turn. The patient hit the other driver’s tail end. The patient’s vehicle was totaled. The patient reports no worsening pain from this collision. He did not require any particular treatments for this accident”. There were no records submitted for this MVA. These missing records are requested in this Fact Summary Report.

Dr. Doe documented, “History of low back pain treated by Dr. Doe with right-sided sciatica. Pain was tolerable prior to the subject accident. No active neck pain prior to the subject collision. Patient did not require any treatments for the neck prior to the accident”. Dr. Doe noted, “Past Medical History: High blood pressure. History of lumbar stenosis and left knee pain. Had honorable discharge in 2002 due to left knee pain. Patient uses a cane as needed on and off last 10 to 15 years”. Dr. Doe continued, “In the aftermath of the subject collision, patient had appropriate treatment at urgent care clinic with imaging studies, he had appropriate conservative measures including chiropractic intervention, medical therapy with escalation of the care to evaluation by pain management specialist and cervical epidural steroid injection/nerve block. This was properly followed by physical therapy and evaluation by orthopedic spine surgeon. He had appropriate follow-up and evaluation with MRIs of the cervical spine, which showed evidence of extruded disc herniation consistent with his complaints of neck pain or radiculopathy”. An extruded disc herniation is when the inner gel of a spinal disc pushes completely through the outer wall and leaks out into the spinal canal. It

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can cause neck/arm pain and/or numbness by pinching or irritating a nerve.

According to Jane Doe, “Based upon history, physical examination, review of the available records and imaging studies, I am of the opinion that the subject collision is directly responsible for his injuries, with cervical, lumbar spine, and bilateral shoulder injury, aggravation of underlying degenerative joint disease in his shoulders and aggravation of his lumbar spine disc disease condition.” Dr. Doe goes on to say, “He has undergone a number of conservative measures, interventional pain injection and surgical intervention mentioned above, which were medically reasonable, necessary and related to the subject collision. He is under care of an orthopedic Joint specialist who has recommended right shoulder surgery for him”.

Dr. Doe continued, “In my opinion, he will certainly require future medical care in form of access to spine surgeon, pain management specialist, orthopedic joint specialist, medical therapy, physical therapy, interventional pain injections including facet blocks, facet rhizotomy, epidural steroid injections, imaging studies of the cervical spine including x-rays, CT scan and MRIs. In case of lack of improvement from the less invasive options, with development adjacent segment breakdown in his neck, he should have access to additional surgical intervention in form of extension of that the cervical fusion”.

Dr. Doe closes with, “In my opinion, patient is permanently totally disabled in terms of performing cast requiring repetitive bending, lifting, twisting, pushing, pulling or stooping. He has a difficulty with past requiring him to be in a seated position for more than 2 hours at a time continuously. He will require appropriate vocational rehabilitation evaluation to determine his work capacity”.

Mr. Doe’s treatments consisted of Chiropractic intervention, epidural injections [1 cervical/1 lumbar/6 bilateral knee], neck surgery, Tai Chi Chuan group classes, 3 rounds of Physical Therapy, Mental Health Therapy, Primary Care visits, Orthopedic, and Neurosurgeon evaluations. Despite his continued efforts, he is now permanently disabled and will require extensive future care, including additional surgical intervention.

Discussion of Claims and Injuries

1. Low Back Pain – Mr. Doe complained of increasing low back pain, aggravated by the MVA on 12.10.2018. Despite receiving a LESI [Lumbar Epidural Steroid Injection] on 08.01.2019, 3 rounds of Physical Therapy [02.2019-03.2020], Chiropractic Intervention, Orthopedic and Neurosurgeon Evaluations – He was diagnosed with Lumbar Radiculopathy by Dr. John Doe on 01.08.2019. He was later diagnosed with Posttraumatic Aggravation of Underlying Degenerative Spinal Condition with Mechanical Axial Back Pain and Radiculopathy by Dr. Jane Doe on 08.18.2020. Mr. Doe’s Gabapentin dosage was subsequently increased to the daily maximum allowed amount to help reduce his pain and it

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was still not resolved.

2. Neck Pain – Mr. Doe complained of increased neck pain aggravated by the MVA on 12.10.2018. Despite receiving a CESI [Cervical Epidural Steroid Injection] on 02.04.2019, 3 rounds of Physical Therapy [02.2019-03.2020], Chiropractic Intervention, Orthopedic and Neurosurgeon Evaluations – Mr. Doe was diagnosed with Cervical Radiculopathy on 01.08.2019 by Dr. John Doe. He was also diagnosed with Cervical Sprain/Strain, Spondylosis, and Retrolisthesis by Dr. John Doe on 06.18.2019. He was later diagnosed on 09.20.2019 with Herniations C4 5, C5 C6, and C6, Intractable Neck Pain, and Cervical Neural Foraminal Stenosis by Dr. Jane Doe. Mr. Doe had a surgical procedure on 09.20.2019 to relieve the neck pain/discomfort called Anterior Cervical Discectomy and Fusion. He now has a permanent neck disability, according to Jane Doe on 08.18.2020.

3. Muscle Pain – Mr. Doe complained of pain in the neck, shoulders, back, arms, legs, feet, and ankles. He was diagnosed with Strain of Other Muscles, Fascia and Tendons at Shoulder and Upper Arm Level, Right Arm, Initial Encounter AND Acute Strain Pattern, with Paresthesias likely 2/2 Local Nerve Compression by Dr. John Doe on 12.10.2018. He was later diagnosed with Myofascial Pain on 07.01.2019 by Jane Doe, PT and again on 10.28.2019 by Dr. John Doe.

4. Arm and Shoulder Pain – Mr. Doe complained of arm and shoulder pain. He was first diagnosed with Strain of Other Muscles, Fascia and Tendons at Shoulder and Upper Arm Level, Right Arm, Initial Encounter by Dr. John Doe on 12.10.2018. He was diagnosed with Unspecified Mononeuropathy of Bilateral Upper Limbs by Dr. John Doe on 02.22.2019. He was then diagnosed with Right Shoulder Neck with Right Arm Radiculopathy by Dr. John Doe on 03.26.2019. He was also diagnosed with Biceps Tendinitis with the Splitting of the Biceps Tendon in the Proximal Bicipital Groove, Tendinosis of Distal Supraspinatus Tendon, and Type II Acromion with Moderate Degenerative Changes Acromioclavicular Joint by Dr. Jane Doe on 04.18.2019. He was later diagnosed with Aggravation of Right Shoulder Degenerative Joint Disease with Impingement Syndrome on 08.18.2020 by Dr. Jane Doe.

5. Bilateral Leg/Feet/Ankles Pain – Mr. Doe complained of bilateral leg, feet, and ankle pain with numbness and tingling. He was diagnosed with Lumbar Radiculopathy by Dr. John Doe on 01.08.2019.

6. Anxiety – Mr. Doe complained of feeling anxious. He was diagnosed with Anxiety Disorder, Unspecified by Dr. Jane Doe on 01.14.2019 and on 06.18.2019 by Dr. John Doe.

7. Stress – Mr. Doe complained of work-related stress. He was diagnosed with Anxiety Disorder, Unspecified by Dr. Jane Doe on 01.14.2019 and on 06.18.2019 by Dr. John Doe. He was also diagnosed with Depression on 05.13.2019 by Dr. John Doe. On 02.13.2020 he was diagnosed with Major Depressive Disorder, Recurrent Episode, Severe by an Unknown Mental Healthcare Provider according to Dr. Jane Doe on 08.18.2020. The missing medical

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records are requested in this Fact Summary Report. New blood pressure medication was added and increased due to the elevated stress it was placing on Mr. Doe's heart. Mr. Doe started a new workman's compensation claim on 06.18.2019 due to work related stress and was put off duty until at least 07.02.2019.

9. Headaches – Mr. Doe complained of increased daily chronic headaches. He was diagnosed with Cervical Radiculopathy on 01.08.2019 by Dr. John Doe [Pain Clinic Doctor – *Pain Clinic*]. He was also diagnosed with Chronic Daily Headaches, Tension-Type by Dr. John Doe on 05.13.2019.

10. Depression – Mr. Doe complained of feeling depressed. He was diagnosed with Depression on 05.13.2019 by Dr. John Doe On 02.13.2020 he was diagnosed with Major Depressive Disorder, Recurrent Episode, Severe by an Unknown Mental Healthcare Provider according to Dr. Jane Doe on 08.18.2020. The missing medical records are requested in this Fact Summary Report.

11. Weight Gain – Mr. Doe complained of a recent 25-pound weight gain. He was diagnosed with disorders of the: neck, back, shoulder, legs, feet, and ankles. [see diagnoses in 1-10 for details]. He was also diagnosed with Depression and Anxiety. All of the above diagnoses can cause weight gain due to reduced physical activity and muscle loss.

13. Balance Issues – Mr. Doe complained of increased balance issues. He was diagnosed with Lumbar Radiculopathy by Dr. John Doe on 01.08.2019. He was also diagnosed with Neuropathy by Dr. John Doe on 03.08.2019.

Discussion of Diagnoses

Injuries Sustained from Accident

1. Acute Strain Pattern, with Parasthesias likely 2/2 Local Nerve Compression – A sudden muscle strain that is swelling and pressing on a nearby nerve, causing a pins and needles sensation. Here's a breakdown of the diagnosis: Acute Muscle Strain: The sudden acceleration and deceleration tear or severely overstretch muscle fibers and ligaments (often in the neck or back, commonly associated with whiplash). Parasthesias: Numbing, tingling (pins and needles feeling), burning, itching, etc.) 2/2: is a medical term for caused by. Local Nerve Compression: The injured, inflamed muscle is swelling. Because space inside the body is limited, this swollen tissue is physically pressing against a nearby nerve, triggering those tingling or numb sensations. During a motor vehicle collision, the violent transfer of kinetic energy forces the muscles, ligaments, and tendons to stretch or tear well beyond their normal physiological limits. This structural damage triggers an acute muscle strain. The force of the crash can cause structural shifts (such as bulging or herniated discs, or severe muscle spasms) that directly pinch or trap a neighboring nerve root. This injury was caused by the motor vehicle accident on 12.10.2018.

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2. **Cervicalgia [Aggravated]** – Pain located in the neck. A car accident can significantly aggravate neck pain or turn a previously stable neck condition into a severe, painful issue. Rapid back-and-forth snapping stretches muscles, tendons, and ligaments past their normal limits. The sudden impact can bulge, slip, or herniate cervical discs that absorb shock in the neck. Underlying issues like cervical spondylosis or arthritis often flare up sharply due to sudden collision trauma and subsequent inflammation. Mr. Doe has reportedly been dealing with neck pain since 1987 that has been previously managed with medication and Chiropractic intervention. Mr. Doe's pain after the accident was aggravated to the point of needing surgery and subsequently being permanently disabled in the neck. This injury was aggravated by the motor vehicle accident on 12.10.2018.

3. **Lumbalgia [Aggravated]** – Pain in the lower back. Lumbalgia can be significantly aggravated by a car accident. Violent forces of deceleration, twisting, and jolting transfer directly through the seat into the lumbar spine. This can aggravate the lower back in several specific ways. A person may already have an asymptomatic bulging or degenerated disc due to age or frequent driving. The impact of a crash can push that disc further out, turning it into a herniated disc that actively presses against nearby nerves. The sudden, forceful movement can overstretch or tear the muscles, tendons, and ligaments that support the lower back. This leads to micro-tearing, severe inflammation, and intense muscle spasms. The small joints (facet joints) that link the vertebrae can be violently compressed or twisted during a rear-end collision, triggering sharp lower back pain that worsens with movement. If the accident causes new inflammation or disc displacement, it can pinch the sciatic nerve. This causes pain to radiate from the lower back down through the buttocks, thighs, and legs. Mr. Doe has had low back pain for 25 years. This injury was aggravated by the motor vehicle accident on 12.10.2018.

4. **Strain of Other Muscles, Fascia and Tendons at Shoulder and Upper Arm Level, Right Arm, Initial Encounter** – A fresh muscle, fascia, or tendon strain in the right shoulder and upper arm during the first active visit for the injury. A car accident can cause a right shoulder and upper arm muscle strain. Car accidents can cause this injury in many ways: bracing for impact, seatbelt restraint, airbag deployment, and body jolting. Mr. Doe was diagnosed on 12.10.2018 by Dr. John Doe. This injury was caused by the motor vehicle accident on 12.10.2018.

Discussion of Diagnoses

Additional Medical Diagnoses

1. **Anxiety Disorder, unspecified [Aggravated]** – When a person has strong feelings of worry or fear that upsets their daily life, but the symptoms do not fit the exact rules for a specific condition like panic disorder. A car accident can significantly worsen existing anxiety

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or trigger new, persistent anxiety disorders. A crash triggers a massive fight-or-flight response, flooding the body with adrenaline. If someone already has anxiety, their baseline nervous system is already sensitive, making it harder to calm down after the shock wears off. Dealing with injuries, car repairs, medical appointments, and financial stress after an accident creates a compounding burden that heavily strains mental health. Prior to the MVA, on 07.10.2018, he was diagnosed with Generalized Anxiety Disorder, “Veteran is experiencing chronic pain and fear of unknown debilitating back and neck issues. He declines mental health services at this time, stating ‘I want to see how the medicine my doctor prescribed for pain works’”. Shortly after the MVA, he was diagnosed with Anxiety Disorder, Unspecified by Dr. Jane Doe on 01.29.2019. “Medications listed by the patient include amitriptyline and duloxetine which the patient states are both for his diagnosis of spinal stenosis and not for psychotherapeutic treatments.” Dr. John Doe. Mr. Doe stated he felt stress about his declining physical abilities and work-related stress. Mr. Doe ended up with a permanent neck disability and chronic daily pain/discomfort – despite his continued efforts to rehabilitate himself after the MVA, leading to feelings of anxiety in his everyday life. This disorder was aggravated by the motor vehicle accident on 12.10.2018.

2. Biceps Tendinitis with the Splitting of the Biceps Tendon in the Proximal Bicipital Groove – The upper biceps tendon is inflamed and has begun to fray or split lengthwise inside its groove in the upper arm bone. When a vehicle collision occurs, gripping the steering wheel firmly upon impact or experiencing a sudden seatbelt jerk can force the shoulder into hyperextension [when a joint is forced to straighten or bend backward past its normal, healthy range of motion] or external rotation [an outward twisting movement that turns a limb away from the center of the body]. This acute mechanical stress results in a structural splitting tear accompanied by severe, localized inflammation. This injury was caused by the motor vehicle accident on 12.10.2018.

3. Bowel and Bladder Incontinence [Aggravated] – The accidental leakage of urine and stool because the muscles and nerves that help hold them are weak or damaged. A forceful jolt or spinal misalignment from a crash can worsen prior, stable degenerative disc or spinal stenosis conditions, triggering acute neurological symptoms. The day of the accident, Mr. Doe denied bowel or bladder incontinence. Dr. Jane Doe documented on 08.18.2020, “He reports urinary urgency, bowel, and bladder incontinence, twice a week, since the accident”. Mr. Doe had experienced some intermittent bowel and bladder incontinence prior to the accident. An aggravation of a neck or back injury from a motor vehicle accident can cause delayed-onset or worsening bowel and bladder incontinence if progressive spinal pathology [such as worsening disc herniation and spinal stenosis, which Mr. Doe has experienced since the MVA] gradually compromises the spinal cord or cauda equina [a bundle of spinal nerve roots that starts at the lower end of the spinal cord]. This disorder was aggravated by the motor vehicle accident on 12.10.2018.

4. Carpal Tunnel Syndrome – A common hand condition caused by pressure on the median

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nerve as it passes through a narrow passageway in the wrist. On 01.08.2019, Mr. Doe had a positive Phalen's test which strongly suggested carpal tunnel syndrome. On 02.22.2019, Dr. John Doe documented, "Nerve Conduction Study done. It showed carpal tunnel syndrome. This would typically not be work related". Carpal tunnel syndrome can happen after a car accident due to the direct impact, tight gripping, swelling and scar tissues, and aggravating old injuries. This injury was caused by the motor vehicle accident on 12.10.2018.

5. Cervical Disc Herniation with Posttraumatic Neck Pain and Radiculopathy – A sudden neck injury caused a cushion in the spine to bulge and press on a nerve, leading to neck pain and shooting pain down the arm. Mr. Doe was diagnosed with this during his operation on his neck on 09.20.2019 by Dr. Jane Doe. The sudden, violent acceleration and deceleration forces (commonly associated with whiplash) can snap the head and neck in unexpected directions. This extreme force can tear the outer ring of an intervertebral disc, causing the inner gel-like material to bulge or leak out. This injury was caused by the motor vehicle accident on 12.10.2018.

6. Cervical Neural Foraminal Stenosis [Aggravated] – The narrowing of the small bony doorways in the neck where the spinal nerves exit to reach the shoulders, arms, and hands. The violent snap of whiplash can bulge or rupture a spinal disc. The damaged disc pushes into the nerve opening. Trauma causes soft tissues in the neck to swell. This extra fluid crowds tight nerve spaces. The impact can shift the vertebrae out of their normal position. If there was mild, painless narrowing prior to the crash, the sudden force of the collision can make that old damage flare up and cause real pain. Mr. Doe was first diagnosed with Cervical Neural Foraminal Stenosis on 11.17.2015 by Dr. Jane Doe. The following is an excerpt from the medical records indicating the need for surgery: "We tried a course of conservative management but despite this course there was still a significant component of persistent, recalcitrant neck pain and arm pain. The MRI demonstrated significant neural foraminal compromise secondary to disc herniations at C4-5, C5-C6, and C6-7" – documented by Dr. Jane Doe on 09.20.2019. Secondary to means "caused by" in medical terms. *Translation:* despite Mr. Doe's efforts, surgery is still needed due to the narrowing of the spinal canal in the neck that were caused by bulging discs in the neck AKA herniations, which were caused by the motor vehicle accident on 12.10.2018. The cervical herniations were not diagnosed until 09.20.2019 and were directly caused by the accident. This injury was aggravated by the motor vehicle accident on 12.10.2018.

7. Cervical Radiculopathy – A pinched or irritated nerve in the neck. The violent back-and-forth snapping motion of a crash overstretches and inflames soft tissues around the neck. The physical impact can cause a cervical disc to bulge or rupture, pressing directly on a nearby nerve root. Swelling, trauma, or shifting bones can narrow the space where nerves exit the spine. Mr. Doe was first diagnosed with Cervical Radiculopathy on 01.08.2019 by Dr. John Doe. This injury was caused by the accident on 12.10.2018.

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8. Cervical Retrolisthesis [Aggravated] – A condition where one of the neck bones slips backward over the bone directly below it. Mr. Doe was diagnosed with a 3mm retrolisthesis on 11.17.2015. Mr. Doe was diagnosed [MRI of the cervical spine without contrast] with 4mm retrolisthesis on 04.18.2019. The sudden, forceful impact of a crash causes a neck vertebra to slip backward relative to the bone above or below it. During a collision (like a rear-end crash), the head and neck whip violently backward and forward. The extreme forces stretch, strain, or tear the supporting cervical ligaments and damage the intervertebral discs. When these stabilizing tissues are injured or weakened by trauma, they can no longer hold the vertebrae in proper alignment, allowing a bone to slip backward into retrolisthesis. A pre-existing minor slip can become highly unstable and migrate further backward. This injury was aggravated by the motor vehicle accident on 12.10.2018.

9. Cervical Spine Sprain/Strain – An overstretch or minor tear in the soft tissues (muscles, tendons, or ligaments) of the neck. A car accident is one of the most common causes of a cervical spine sprain or strain, often referred to as whiplash. Sudden impacts (especially rear-end collisions) force the torso forward while the head momentarily stays behind, creating an unnatural S-shape curve in the neck. The neck then snaps backward (hyperextension) before whipping forward (hyperflexion), stretching or tearing the local muscles, tendons, and ligaments. This rapid motion stresses the supporting structures of the cervical spine beyond their normal limits, causing micro-tears or acute inflammation. Mr. Doe was diagnosed by Dr. Jane Doe on 06.18.2019 based on MRI evidence. This injury was caused by the motor vehicle accident on 12.10.2018.

10. Cervical Spondylosis [Aggravated] – Natural, age-related wear-and-tear of the bones and cushions [discs] in the neck. Many people have it without feeling any pain. A sudden crash causes your neck to snap backward and forward. This rapid motion strains ligaments and damages spinal discs. The physical jolt can turn a silent, painless condition into a painful injury. It can also speed up the wear-and-tear process. Another term for spondylosis is osteoarthritis. On 08.01.2018, Mr. Doe was diagnosed with Degenerative Joint Disease Osteoarthritis [including in the mid neck] by Dr. John Doe. The first time Cervical Spondylosis is mentioned in the medical records is 04.18.2019 by Dr. Jane Doe. This injury was aggravated by the motor vehicle accident on 12.10.2018.

11. Chronic Daily Headaches, Tension-Type [Aggravated] – A dull, pressing ache on both sides of the head for 15 or more days a month over at least three months. A car accident can significantly aggravate chronic daily tension-type headaches. The sudden jolt of a crash overstretchs and tears muscles, tendons, and ligaments in the neck and upper shoulders. This severe muscle spasm and tightness directly fuels tension-type head pain. Inflammation in the cervical spine can compress or irritate nerves that refer pain up into the scalp, temples, and base of the skull. Physical and psychological trauma can trap your autonomic nervous system in a constant “fight-or-flight” stress loop, lowering your overall threshold for pain. Post-accident stress, pain medications, and poor sleep frequently trigger or worsen pre-existing

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headache disorders. Mr. Doe was first diagnosed on 07.27.2016 by Dr. John Doe. Just 17 days after the accident, on 12.27.2018, Mr. Doe began complaining of increased headaches which continued throughout the medical records up until the last appointment on 08.18.2020. This disorder was aggravated by the motor vehicle accident on 12.10.2018.

12. Herniations C4 C5, C5 C6, and C6 C7 – When the soft cushion between the neck bones pushes outward and presses on a nearby nerve. Herniations can be directly caused by a car accident. The sudden forward and backward snapping motion of a crash forces the neck beyond its normal range of motion. The lower cervical spine (especially C5-C6 and C6-C7) supports the weight of the head, making these discs very sensitive to sudden impact and compression. Pain, numbness, or weakness from these disc injuries may not show up until hours or even days after the collision. Mr. Doe was diagnosed prior to his surgery on 09.20.2019 by Dr. Jane Doe. This injury is caused by the motor vehicle accident on 12.10.2018.

13. Lumbar Radiculopathy – A pinched or irritated nerve in the lower back that causes pain, numbness, or tingling that travels down the leg. Lumbar Radiculopathy can be significantly aggravated by a car accident. Sudden force can cause a previously stable or silent disc bulge or herniation to press harder against a lumbar root. Trauma triggers swelling and inflammation in the lower back, which crowds the nerves in the spinal canal. The violent motion of a collision alters how the vertebrae bear weight, aggravating underlying arthritic changes or wear-and-tear. Symptoms like shooting leg pain, numbness, or tingling might not appear immediately, often worsening over days as inflammation sets in. Mr. Doe was first diagnosed on 09.30.2013 by Dr. John Doe. Lumbar Radiculopathy is frequently temporary and often resolves with rest and conservative care. Prior to the accident, the last note of Lumbar Radiculopathy was 04.07.2014 by Dr. John Doe. Mr. Doe was diagnosed on 01.08.2019 by Dr. John Doe. This injury was caused by the motor vehicle accident on 12.10.2018.

14. Major Depressive Disorder, Recurrent Episode, Severe – A serious medical illness with multiple episodes of deep sadness and low energy that make daily life very hard to manage. Common signs are: deep sadness, emptiness, hopelessness, total loss of interest in hobbies or things the person usually enjoys, extreme physical tiredness or lack of energy, sleeping too much or having bad insomnia, eating much more or much less than usual, hard time focusing, remembering, or making simple choices, strong feelings of worthlessness or guilt, and scary or repeated thoughts about death or suicide. A car accident can significantly aggravate pre-existing depression. Chronic pain from injuries keeps the body under constant stress and drains emotional energy. The sudden, violent nature of a crash triggers a prolonged fight-or-flight response, leading to chronic mental exhaustion. Inability to work, drive, or enjoy hobbies leads to isolation, financial strain, and a loss of independence. Mr. Doe mentioned feelings of depression and had 2 positive screeners for Depression on 07.10.2018 with Dr. Jane Doe and again on 07.10.2018 with Dr. John Doe but was never diagnosed with

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this disorder prior to the accident. Mr. Doe was officially diagnosed with Major Depressive Disorder, Recurrent Episode, Severe on 02.13.2020 from an unknown mental healthcare provider outside of the VA hospital. This was discussed in the Neurology Consultation Notes on 08.18.2020 by Dr. Jane Doe. The missing medical records are being requested in this Fact Summary Report. This disorder was caused by the motor vehicle accident on 12.10.2018.

15. Posttraumatic Aggravation of Underlying Degenerative Spinal Condition with Mechanical Axial Back Pain with Radiculopathy – *Here's the breakdown of this diagnosis:*

Posttraumatic Aggravation: Mr. Doe had an underlying condition in the spine that might not have been bothering him much before. The car accident triggered or worsened the condition, turning it into the active source of pain.

Underlying Degenerative Spinal Condition: This refers to normal, age-related wear-and-tear of the spine. It often includes things like arthritis in the spinal joints or discs that have thinned out over time. Many people have this without even knowing it until an injury “wakes it up”.

Mechanical Axial Back Pain: This is the deep, aching pain located directly in the lower back. It is “mechanical” because it usually changes with movement – it might feel worse when bending, twisting, or sitting for long periods, and improve during rest or changing positions.

Radiculopathy: This is often called sciatica. It happens when a nerve root in the spine becomes pinched or irritated. Instead of staying in the back, the pain travels, shoots, or radiates down into the buttock, thigh, calf, or foot. It can also cause numbness, tingling, or a pins and needles sensation.

While the car accident doesn't *cause* the gradual, age-related wear-and-tear of a degenerative spinal condition, the sudden and violent mechanical forces of a crash can instantly destabilize a compromised spine, turning a manageable condition into an acutely painful, symptomatic, and debilitating injury. Mr. Doe was diagnosed on 08.18.2020 by Dr. Jane Doe. This injury was aggravated by the car accident on 12.10.2018.

16. Tendinosis of Distal Supraspinatus Tendon – A chronic, non-inflammatory breakdown of the rotator cuff tendon in the shoulder due to overuse or aging. A car accident can cause or significantly worsen tendinosis of the distal supraspinatus tendon. The violent forces of a collision can strain, bruise, or micro-tear the rotator cuff. A locking seatbelt creates a heavy, rapid deceleration force across the chest and front of the shoulder. Striking the dashboard or bracing hard against the steering wheel drives a heavy compressive load up the arm into the shoulder joint. An asymptomatic or mild pre-existing case of tendinosis can become acutely painful, swollen, and symptomatic due to the sudden trauma of a crash. Mr. Doe was diagnosed on 04.18.2019 by Dr. Jane Doe. This injury was caused by the motor vehicle accident on 12.10.2018.

17. Type II Acromion with Moderate Degenerative Changes Acromioclavicular Joint [Aggravated] – A slightly curved shoulder bone and mild-to-moderate wear-and-tear arthritis in the small joint where the collarbone meets the shoulder. A car accident can significantly aggravate a pre-existing Type II Acromion with Moderate Degenerative Changes in the

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Acromioclavicular Joint. The sudden jolt of a collision causes rapid back-and-forth whipping or heavy seatbelt restraint across the shoulder girdle, putting extreme mechanical stress on the AC joint. Moderate degeneration means the joint's protective cartilage and cushioning disc are already thinned or worn. Sudden impact can cause bones to grind, flare up underlying inflammation, or damage surrounding soft tissues. A Type II curved acromion already narrows the subacromial space. Trauma-induced swelling can quickly trigger or worsen painful shoulder impingement. "Aggravation of right shoulder degenerative joint disease with impingement syndrome" documented by Dr. Jane Doe 08.18.2020. Mr. Doe had not been diagnosed prior to the accident. Mr. Doe was diagnosed on 04.18.2019 by Dr Jane Doe. This injury was aggravated by the motor vehicle accident on 12.10.2018.

Legal Forensic Nurse Discussion and Opinion Based on the Medical Records Provided

On 12.10.2018, Mr. Doe was involved in a motor vehicle accident where he was rear-ended by a person who allegedly fell asleep while driving. Immediately following the accident, Mr. Doe experienced immediate pain to his neck, both shoulders, lower back, and both legs. The paramedics and police arrived and a police report was filed. Immediately after the accident, Mr. Doe went to Generic Hospital and was evaluated in the Emergency Room. He reported to the Doctors of pain in the neck, both shoulders, lower back, and both legs. An X-ray of the right shoulder and cervical spine were done. They both showed no evidence of acute fracture, dislocation, or foreign body.

He then underwent 6 Chiropractic sessions, 3 rounds of Physical Therapy totaling approximately 20 visits, 2 Occupational Therapy Tai Chi Chuan group classes, CT Scan, 2 MRIs, Nerve Conduction Test, Neck Surgery [Anterior Cervical Discectomy and Fusion Surgery], 1 neck injection [Cervical Epidural Steroid Injection], 1 lower back injection [Lumbar Epidural Steroid Injection], and 6 bilateral knee injections. He met with multiple specialists including an Orthopedic Surgeon and a Neurological Surgeon. Mr. Doe began seeing a Psychologist due to the stress his chronic pain was causing him. The stress increased to an unmanageable amount and Mr. Doe was placed on leave due to work-related stress on 06.18.2019. He was cleared to return to work for 01.30.2020 – after 7 mental health therapy sessions. Mr. Doe was diagnosed with countless new and aggravated injuries/disorders, Major Depressive Disorder, eventually lost his job, and a permanently disabled neck – despite his continued efforts over an approximately 20-month long span of time.

Based on the reviewed medical records, it is my opinion that the motor vehicle accident on 12.10.2018 caused and/or aggravated Mr. Doe's injuries listed above, and his decline in his health and wellbeing. The symptoms Mr. Doe is presently experiencing are consistent side effects of the injuries he sustained during the motor vehicle accident. He has endured surgery, multiple consultations, increased medications, therapies, and imaging scans which have noted the symptoms he has experienced post-trauma are all directly related to the motor vehicle

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accident on 12.10.2018 and the injuries sustained are all capable of causing the decline in his health and well-being.

Legal Forensic Nurse “Next Step” Recommendations

Please schedule a call with our LFNC after you review to discuss this case.

- **Medical Record Retrieval:**

Please have your firm request the medical records listed below:

Record Type and Date	Facility	Date Requested	Date Received
Police Report 12.10.2018, 07.2020	<i>Generic Police Department</i>		
Emergency Room 12.10.2018, 07.2020	<i>Generic Hospital Emergency Department</i>		
Paramedic/Ambulance 12.10.2018, 07.2020	<i>Unknown</i>		
Psychiatrist Records Date Unknown (mentioned LL MR 2 2.3.21 Pg. 44)	<i>Mental Health Clinic</i>		
MRI 2013 Mentioned MRI was done outside VA 03.13.2013 (LL MR 2.3.21 Pg. 315)	<i>Unknown Facility Outside of VA Hospital</i>		
MRI 2010 Mentioned MRI was done outside of the VA (LL MR 2.3.21 Pg. 282)	<i>Unknown Facility Outside of VA Hospital</i>		
Chiropractor Notes 11.09.2018, 12.10.2018, 09.01.2019	<i>Chiropractic Clinic</i>		
CT Scan Sometime between 12.10.2018 and 08.18.2020 Mentioned on 08.18.2020 by Dr. Jane Doe (Neuro notes.pdf Pg. 1-26)	<i>Unknown Facility</i>		
MRI Shoulder	<i>Unknown Facility Outside</i>		

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Mentioned 01.06.2017 Patient had previous MRI of Shoulder to bring to Dr. Doe (LL_MR 2.3.21 Pg. 249)	<i>of VA Hospital</i>		
Spinal Fixation/Posterior Lumbar Fusion Surgery It was mentioned in Pain Doctor Notes (LL_MR 2.3.21 Pg. 132)	<i>Unknown Facility</i>		
Social Worker Notes 07.12.2017, 04.23.2014 (and any other dates seen by the Social Worker) LL_MR 2.3.21 Pg. 244	<i>Generic Hospital</i>		
Orthopedic Bilateral Shoulder Injections 08.2017 mentioned in Dr. Doe's notes (LL_MR 2.3.21 Pg. 156)	<i>Orthopedic Facility</i>		
Drug Test Results 12.10.2018 (forms filled out 12.10.2018 but no results in records sent)	<i>Workman's Comp</i>		
MRI Cervical Spine without Contrast 02.20.2019 (mentioned LL_MR 2.3.21 Pg. 128)	<i>Generic Hospital</i>		
Hospital Stay Date Unknown (mentioned Misc Medical Records (PT, Radiology, etc.) Pg. 12)	<i>Generic Hospital</i>		
IME Exam 10.07.2019 (Misc Medical Records (PT, Radiology, etc.)) Pg. 10	<i>Generic Doctor</i>		
IME Patient Worksheet 10.07.2019 (Misc Medical Records (PT, Radiology, etc.)) Pg. 10	<i>Generic Doctor</i>		
EMG [Electromyography] 2010 (Mentioned LL_MR 2.3.21) Pg. 55	<i>Unknown Facility</i>		
Psychotherapy Notes	<i>Unknown Facility Outside</i>		

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02.13.2020, 03.06.2020, 03.30.2020, 04.20.2020 (Mentioned Neuro notes Pg. 22)	<i>of Veteran's Affairs Hospital</i>		
Physical Therapy Notes It was mentioned that somewhere around Feb 2019 and June 2019 he had approximately 9 sessions in this time period by Orthopedic Surgeon Dr. Jane Doe on 06.18.2019 (Misc Medical Records (PT, Radiology, etc.).pdf Pg. 11-16), Discharge Notes sometime after 08.15.2019, 02.24.2020, 02.26.2020, 03.02.2020	<i>Physical Therapy Clinic</i>		
Orthopedic Notes 09.10.2019, 10.09.2019, 11.19.2019, 12.19.2019, 01.28.2020, 02.25.2010, 02.18.2010, 02.11.2010, 02.04.2010, 01.22.2010, 05.28.2009, 05.21.2009, 04.23.2009, 02.11.2009, Sometime between Feb 2020 and August 2020	<i>Orthopedic Clinic</i>		
Psychology Notes 09.09.2019, 09.16.2019, 10.14.2019, 10.30.2019, 12.09.2020, 01.13.2020, 01.29.2020, 03.13.2020 (Mentioned Misc Medical Records (PT Radiology, etc.)) Pg. 3	<i>Mental Health Clinic</i>		
Primary Care Secure Messaging 01.24.2020, 01.14.2020, 12.31.2019, 02.19.2019, 12.24.2018, 10.25.2018, 08.01.2018, 07.02.2018, 04.20.2018, 03.15.2018, 02.05.2018 (Nursing follow-up	<i>Health Clinic</i>		

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call), 01.19.2016 (telephone), 12.15.2015 (telephone),			
Primary Care Clinic Notes (Physician and/or Nurse) 08.13.2019, 05.14.2019, 08.03.2018, 01.10.2018, 12.26.2017, 11.06.2015, 08.05.2015, 04.21.2014, 11.30.2012, 09.15.2011, 09.30.2010, 06.30.2010, 02.24.2010, 12.09.2009, 04.22.2009, 01.22.2019, 12.17.2008, 11.17.2008	<i>Health Clinic</i>		
Pain Clinic Notes 02.02.2018, 01.22.2018, 02.07.2014,	<i>Pain Clinic</i>		
Surgical Notes Physician and/or Nursing 08.12.2015	<i>Generic Hospital</i>		

- **Expert Location and Screening:** Seek an expert with knowledge specifically pertaining to:
 - Orthopedics
 - Neurology
 - Psychiatry

Legal Nurse Detective can help find and facilitate experts for your case.

Possible Defenses:

- **Comorbidities/Patient History:** Osteoarthritis, Multifocal Degenerative Disc Disease, Neck Pain, Low Back Pain, Anxiety, Bowel and Bladder Incontinence, and Balance Issues.

The defense may argue Mr. Doe's comorbidities and medical history is the cause of his pain and suffering, not the motor vehicle accident. Down below you will find descriptions of how a car accident can aggravate these pre-existing conditions that Mr. Doe had.

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- **History of Osteoarthritis** – A car accident can significantly worsen existing osteoarthritis by causing acute inflammation, tearing supporting ligaments, and increasing abnormal friction on already worn cartilage.
- **History of Multifocal Degenerative Disc Disease** – The violent impact of a crash can significantly worsen or aggravate pre-existing disc degeneration at multiple levels. The violent force of a crash violently jolts the spine, compressing or overstretching discs already weakened by degeneration. A disc that was only mildly bulging or stable can rupture or herniate fully under crash forces. Structural shifts or inflammation can pinch nerve roots, leading to sharp pain, numbness, or tingling. Because multifocal disease affects multiple areas of the spine, trauma can trigger or intensify symptoms across several regions at once. “Posttraumatic aggravation of underlying degenerative spinal condition with mechanical axial back pain and radiculopathy” Dr. Jane Doe 08.18.2020. *Translation:* Mr. Doe’s Degenerative Spinal Condition was aggravated by the car accident and caused back pain with movement and shooting, radiating pain due to a pinched nerve.
- **History of Neck Pain** – A car accident can significantly worsen existing neck pain or trigger severe new pain. The abrupt back-and-forth snapping motion (whiplash) forces the cervical spine beyond its normal range of motion in fractions of a second. Muscles, tendons, and ligaments that are already tight or injured can sustain micro-tears or severe spasms from the G-forces of an impact. Pre-existing issues like degenerative discs, arthritis, or previous spine injuries have a much lower tolerance for trauma and flare up intensely under crash forces. Mr. Doe has reported to have neck pain since 1987 due to jumping out of planes in the military. “Pain was tolerable prior to the subject accident. No active neck pain prior to the subject collision. Patient did not require any treatments for the neck prior to the accident.” – Dr. Jane Doe 08.18.2020.

There was a clear progression in neck pain due to increased retrolisthesis [backward slipping of neck bone], increased stenosis [narrowing of spinal canal], decreased range of motion, and herniations [bulging discs] caused and/or aggravated by the motor vehicle accident on 12.10.2018. Retrolisthesis increased from 3 mm on 11.17.2015 to 4 mm on 04.18.2019.

Mr. Doe was first diagnosed with Cervical Neural Foraminal Stenosis on 11.17.2015 by Dr. Jane Doe. The following is an excerpt from the medical records on 09.20.2019 indicating the need for surgery: “We tried a course of conservative management but despite this course there was still a significant component of persistent, recalcitrant neck pain and arm pain. The MRI demonstrated significant

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neural foraminal compromise secondary to disc herniations at C4-5, C5-C6, and C6-7” Dr. Jane Doe.

Secondary to means “caused by” in medical terms. Translation: despite Mr. Doe’s efforts, surgery was needed due to the stubborn pain and the MRI showing significant narrowing of the spinal canal in the neck that were caused by bulging discs in the neck AKA herniations, which were caused by the motor vehicle accident on 12.10.2018. The cervical herniations were not diagnosed until 09.20.2019 and were directly caused by the accident. This injury was aggravated by the motor vehicle accident on 12.10.2018.

Herniations can be directly caused by a car accident. The sudden forward and backward snapping motion of a crash forces the neck beyond its normal range of motion. The lower cervical spine (especially C5-C6 and C6-C7) supports the weight of the head, making these discs very sensitive to sudden impact and compression.

- **History of Low Back Pain.** On 05.10.2013, Dr. John Doe stated “Spinal stenosis on outside MRI, mild, around L1-2, L4-S1”. But, later on 09.04.2018 an MRI Lumbar Spine without Contrast showed Multilevel Chronic Degenerative Disc Disease **without** Significant central spinal canal narrowing. Again, on 10.02.2018 [documented by Jane Doe, Physical Therapist], “MRI review consistent with lumbar DJD [degenerative joint disease] **without** spinal stenosis”. This was just around 2 months prior to the motor vehicle accident on 12.10.2018.

Mr. Doe had Posterior Lumbar Fusion Surgery in the past, which can provide permanent relief from its symptoms when combined with a decompression procedure. Lumbar Radiculopathy [pinched nerve in the lower back] was last diagnosed on 04.07.2014 and wasn’t mentioned in medical records prior to the MVA. He was later diagnosed on 01.08.2019 by Dr. John Doe. Lumbar Radiculopathy is frequently temporary and often resolves with rest and conservative care. He was diagnosed with Lumbar Radiculopathy 4+ years later after the motor vehicle accident on 12.10.2018.

- **History of Anxiety** – A car accident can significantly worsen existing anxiety or trigger new, persistent anxiety disorders. A crash triggers a massive fight-or-flight response, flooding the body with adrenaline. If someone already has anxiety, their baseline nervous system is already sensitive, making it harder to calm down after the shock wears off. Dealing with injuries, car repairs, medical appointments, and financial stress after an accident creates a compounding burden that heavily strains mental health. On 07.10.2018, he was diagnosed with Generalized Anxiety Disorder, “Veteran is experiencing chronic pain and fear of unknown debilitating

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back and neck issues. He declines mental health services at this time, stating ‘I want to see how the medicine my doctor prescribed for pain works’”. He was later diagnosed with Anxiety Disorder, Unspecified by Dr. Jane Doe on 01.29.2019. “Medications listed by the patient include amitriptyline and duloxetine which the patient states are both for his diagnosis of spinal stenosis and not for psychotherapeutic treatments.” Dr. John Doe.

- **History of Bowel and Bladder Incontinence** – Mr. Doe had complained of mild bowel and bladder incontinence years prior to the accident. On the day of the accident, Mr. Doe denied bowel or bladder incontinence. Dr. Jane Doe documented on 08.18.2020 “He reports urinary urgency, bowel, and bladder incontinence, twice a week, since the accident”. Mr. Doe had experienced some intermittent bowel and bladder incontinence prior to the accident. An aggravation of a neck or back injury from a motor vehicle accident can cause delayed-onset or worsening bowel and bladder incontinence if progressive spinal pathology [such as worsening disc herniation and spinal stenosis, which Mr. Doe has experienced since the MVA] gradually compromises the spinal cord or cauda equina [a bundle of spinal nerve roots that starts at the lower end of the spinal cord].
- **History of Balance Issues** – Mr. Doe stated that he has been walking with a cane on and off for 15+ years. A car accident can worsen existing balance issues or create new ones. The sudden force and violent motion of a crash impact the body’s complex balance networks in several ways: whiplash and neck injury, inner ear damage, soft tissue strain, etc.
- **Another Motor Vehicle Accident:** Motor Vehicle Accident that happened *after* 12.10.2018.

The defense may argue that Mr. Doe’s injuries were caused by the other motor vehicle accident he had in July 2020.

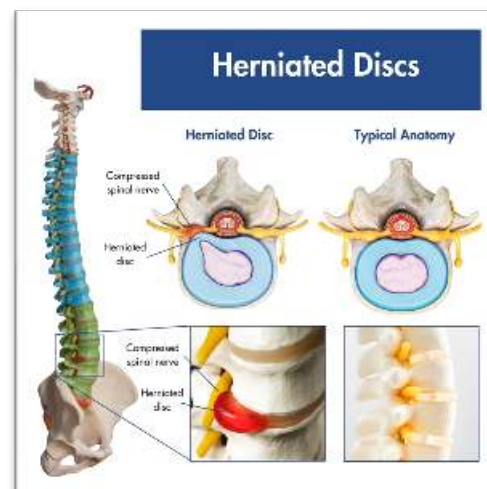
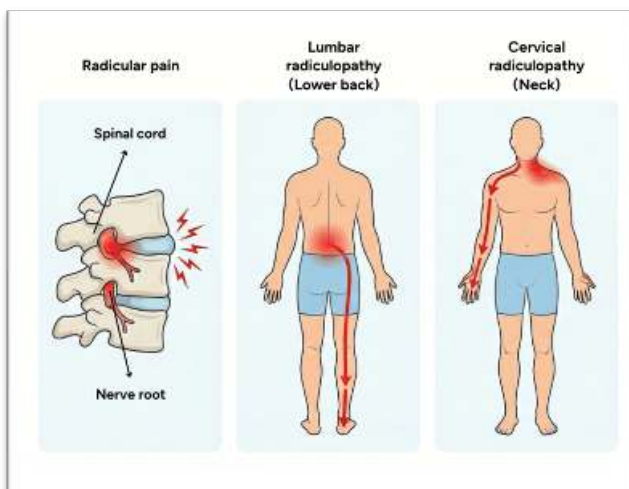
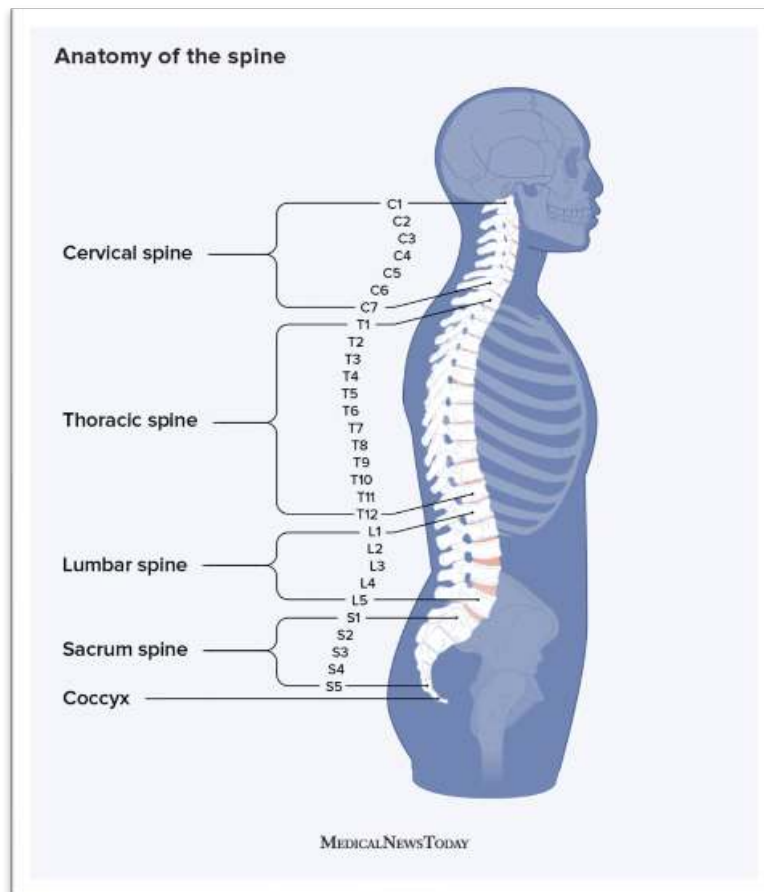
- **Another Motor Vehicle Accident July 2020** – There are no available records at this time detailing this accident [missing medical records requested in this Fact Summary Report]. It was noted by Dr. Jane Doe, “July 2020: The patient was the driver in a vehicle driving straight when another vehicle was making a left-hand turn. The patient hit the other driver’s tail end. The patient’s vehicle was totaled. The patient reports no worsening pain from this collision. He did not require any particular treatments for this accident”.

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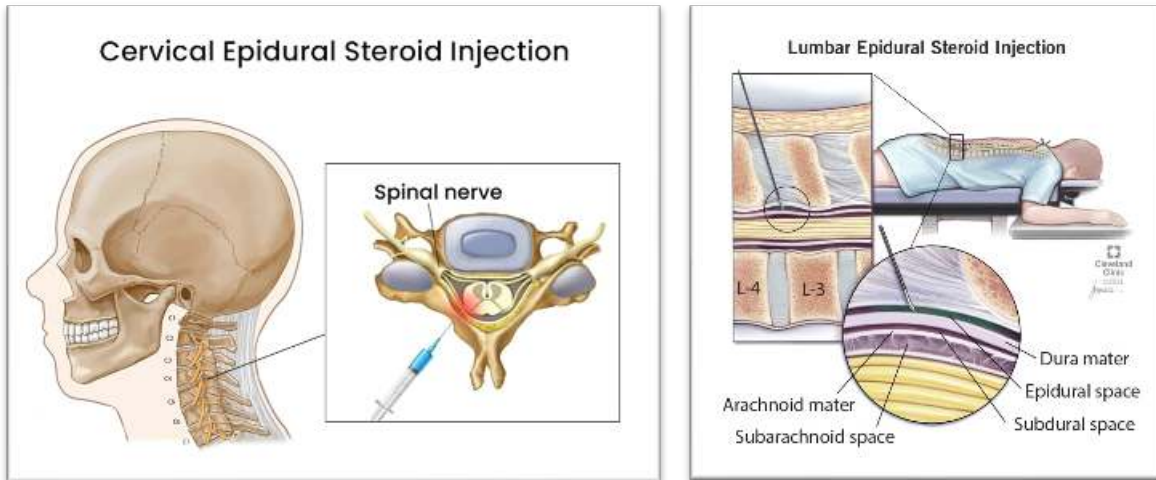


- **Research and Summarization of Authoritative Literature:**



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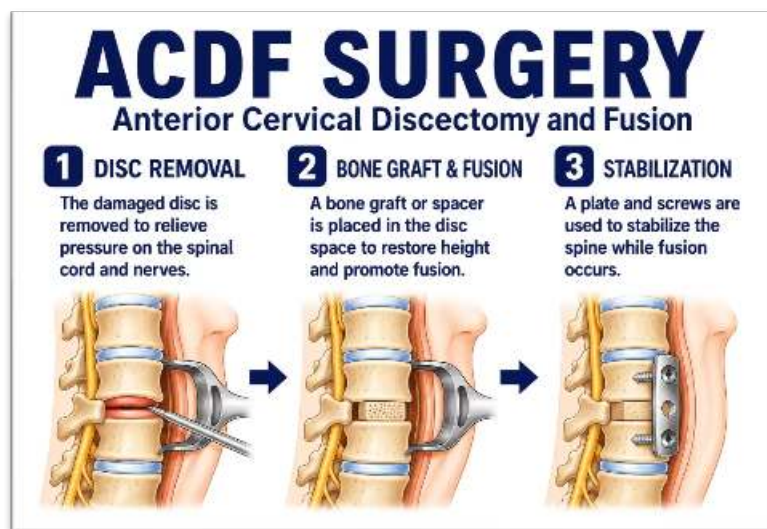
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Osteoarthritis – A manageable condition involving dynamic joint changes due to cartilage that wears down or thins over time. Cartilage is the smooth, slippery tissue covering the ends of bones in a joint – acting as a cushion and lubricant. Without smooth cartilage, bones can rub or experience extra stress, leading to joint changes, fluid buildup, and stiffness.

Radiculopathy – A pinched or irritated nerve root in the spine, which causes pain, numbness, tingling, or weakness that travels down an arm or a leg.

Epidural Steroid Injection – A medical procedure that places anti-inflammatory steroid medication into the space around the spinal cord and nerves to reduce swelling and relieve pain.



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