Chronological Synopsis of Records

DD/MM/YYYY

TO: FFFFF
ddddd Insurance

RE:

Claimant:	JJJJJJJ
DOB:	mm/dd/yyyy
Insured:	KKKKK
Claim No:	xxxxxxxx
DOI:	mm/dd/yyyy
XXX Number:	xxxxxx
Exam Date:	mm/dd/yyyy
Exam Location:	TTTTTT
Examiner(s):	GGGGGG, MD, Orthopedic Surgeon

November 28, 2015: PHI Air Medical records indicate Mr. XXX was complaining of chest pain secondary to a head on motor vehicle accident (MVA) involving a cement truck and another commercial vehicle. It was noted Mr. XXX was entrapped taking 25 minutes to extricate with heavy equipment and air medical was requested to decrease transport time to closest trauma center to 18 minutes by air as opposed to 103 minute by ground with morning traffic. Examination revealed Glasgow Coma Scale (GCS) score was 15, abrasions to face, neck immobilized with cervical collar, sinus tachycardia on monitored rhythm, tenderness over bilateral upper and lower quadrants of abdomen, and pain to left upper back with abrasion noted and had thoracic pain with movement. Mr. XXX was provided impression of unspecified injury of lung. Mr. XXX was provided treatment including cervical collar, back board and was transported to the Emergency Department of ZZZ Hospital. **(Sample pdf-page 11-25)**

Upon arrival to the Emergency Department of ZZZ Medical Center, Mr. XXX was noted to have involved in motor vehicle collision (MVC). Examination revealed right anterior chest wall ecchymosis, left axillary laceration with abrasion 2 (2 x 2 lacerations), and abdomen with moderate and generalized tenderness, abrasions and ecchymosis. An ECG (Electrocardiogram) revealed sinus tachycardia, inferior Q, no ST elevation or depression, no inverted T's. X-rays of the chest revealed poor inspiratory effort; overall increased density in the left hemithorax might be related to layering pleural fluid, focal pleural thickening at the mid lateral hemithorax representing pleural hematoma, no pneumothorax, multiple left-sided rib fractures, and subcutaneous emphysema in the left chest. X-rays of the pelvis revealed no pelvic ring fracture. X-rays of the left elbow revealed some dorsal soft tissue swelling with punctate opaque foreign bodies and no acute fracture, dislocation or joint effusion**.** A CT of the head revealed no evidence of mass, mass effect, edema, midline shift, intracranial hemorrhage, or extra-axial fluid collection, an acute cortical infarction was not apparent, normal ventricles, sulci and cisterns, unremarkable osseous structures in appearance, visualized portions of the paranasal sinuses, orbits and mastoid air cells. A CT of the cervical spine revealed no fracture or suspicious lesion, normal vertebral heights and cervical spinal alignment, unremarkable craniocervical junction

region, narrowing of the C6-7 and C7-T1 disc spaces, endplate spurring was noted, prominent degenerative facet changes were seen at multiple levels, the combination of findings resulted in neural foraminal narrowing at multiple levels, fractures of the posterior left 2nd and 3rd ribs, a small left pneumothorax was visible, subcutaneous gas in the soft tissues of the posterior chest, and no prevertebral soft tissue swelling. A CT of the thoracic spine revealed multiple left rib fractures, better visualized fractures of the 3rd through eighth posterior ribs, degenerative changes in the lower cervical and thoracic spine however no definite fracture line. A CT of the chest revealed small pneumothorax, subcutaneous air in the left chest, the 2nd anterior lateral, 3rd, 4th, 5th, 6th, 7th, 8th ribs were fractured and offset, the posterior ribs were also fractured in that region, some blood in the pleural space and consolidation in the left lower lobe most likely atelectasis, the right lung did not demonstrate a pneumothorax, mild interstitial prominence and some minimal basilar volume loss, intact right ribs, some irregularity at the left sternoclavicular joint favored to be degenerative, a definite clavicular fracture was not identified, no significant mediastinal hematoma, the aorta was tortuous, irregularity to the proximal aorta most likely pulsation artifact as that was not a CTA, the lack of mediastinal hematoma makes an aortic injury unlikely, a hiatal hernia was present, and numerous lymph nodes. A CT of the abdomen/pelvis revealed fatty infiltration in the liver, splenic granulomata, a small amount of blood near the tip of the spleen extending into the left paracolic gutter, the adrenal glands, pancreas and kidneys did not demonstrate a lesion, patent celiac, superior mesenteric artery (SMA) and renal arteries, atherosclerotic changes, the pelvis did not reveal a bladder injury or significant hematoma, on bone windows there was a lucent lesion in the left ischium which was present in 2013 the left L2 transverse process showed a subtle lucency and curvature which was new suggesting a fracture. A CT of the lumbar spine revealed left parapelvic cyst in the kidney and small cortical hypodensity mast likely a cyst, the celiac, SMA, renal arteries and inferior mesenteric artery (IMA) were patent, atherosclerotic changes, the L2 left transverse processes fracture, the L3 left transverse process was fractured, protruding disc at L5-S1, the superior endplate of L5 showed sclerosis and defect, anterior osteophytes at all levels, endplate irregularity along the superior and inferior aspect of L3 favored to be degenerative/chronic, a fracture line within the vertebral bodies was not visualized, intact spinous processes and posterior elements. Mr. XXX was provided impressions of pneumothorax on left, MVC, laceration of left upper arm, abrasion of left knee, abrasion of chest wall, closed fracture of transverse process of lumbar vertebra, closed fracture of seven ribs of left side, and left hemothorax. Mr. XXX was medically cleared and admitted in Surgical Intensive Care Unit (SICU) in improved condition and indicated that chest tube placed by Trauma team. **(Sample pdf-page 59-62/Sample pdf-page 32-33/page 38-39/page 31/page 25-26/page 26-27/page 28/page 23-25/page 27)**

TTT, M.D. issued an addendum note indicating Mr. XXX was status post MVC. Examination revealed tachycardia, obese and guarding abdomen, left chest mid-axillary with laceration and tenderness, and left forearm with laceration. Dr. HHH recommended admitting to Intensive Care Unit (ICU) with trauma service. **(Sample pdf-page 62)**

Mr. XXX underwent a Trauma History and Physical examination by **HHH, M.D.,** who noted Mr. XXX was complaining of back pain and left shoulder/left-sided chest pain secondary to a MVC. Dr. HHH noted Mr. XXX was on nasal cannula (NC) so he was taken to the CT scanner after a negative focused assessment with sonography for trauma (FAST) and x-rays of the pelvis.

Examination revealed Mr. XXX appeared in moderate distress, cervical collar in place, and abrasion and small superficial laceration over left chest wall. Dr. HHH reviewed x-rays and a CT of the chest. Dr. HHH recommended admitting to ICU, using cervical collar and provided spine precautions until CT reads were back, indicated would call anesthesia for epidural if no spine fracture, pain control by Robaxin, Toradol, Norco, Dilaudid, and Lyrica, nothing by mouth (NPO) diet, would start Lovenox after CT reads were back and an epidural was placed. **(Sample pdf-page 73-76)**

Mr. XXX underwent left-sided chest tube placement performed by Dr. HHH without complications. **(Sample pdf-page 89-91)**

X-rays of the chest revealed a left chest tube with the tip medially in the left mid-lung field, a pneumothorax was not apparent, multiple left rib fractures with adjacent chest wall air, and minimal atelectasis at the left base. **(Sample pdf-page 33)**

HHH, M.D. issued an addendum note indicating Mr. XXX was status post MVC, presented with 2-8th left rib fractures, hemithorax, pneumothorax with decompression into subsequent and significant subsequent emphysema and left L2-L3 transverse process (TP) fractures. Dr. HHH noted Mr. XXX's CT of the head, cervical spine, and thoracic spine were negative, possible spleen laceration versus retroperitoneal bleed versus left subdiaphragmatic bleed secondary to left chest trauma. Dr. HHH noted Mr. XXX had chest tube placed in Emergency Department (ED) in sterile fashion. Dr. FFF recommended admitting to ICU for respiratory monitoring, rib fracture protocol and consult CAA for epidural placement, and indicated would consult Dr. FFF for possible rib plating, and 3D reconstruction of thorax pending. **(Sample pdf-page 76)**

JJJ, M.D. issued an addendum note indicating Mr. XXX's CTs and x-rays viewed with Dr. HHH. Dr. CCC recommended admitting to ICU for pain control and pulmonary care. **(Sample pdf-page 76)**

X-rays of the left shoulder revealed no fracture or dislocation of the left shoulder, the acromioclavicular and coracoclavicular distance was maintained, left lung infiltrate, left rib fractures, subcutaneous edema overlying the left chest, a small radiopaque density in the soft tissues of the proximal left arm. **(Sample pdf-page 39)**

X-rays of the left ankle revealed non-displaced fracture of the distal left fibula at the level of the tibial plafond, associated soft tissue swelling, the medial clear space was maintained, normal visualized base of the 5th metatarsal, and vascular calcifications. **(Sample pdf-page 31)**

Mr. XXX underwent a CAA consultation and was noted that he was involved in a MVC with cement rock (prolonged extrication). Mr. XXX's x-rays of the chest, FAST exam, CT's of the head, cervical and thoracic spine were reviewed. Mr. XXX was provided assessments of status post MVC with multiple rib fractures on left. **(Sample pdf-page 179) (Handwritten/partially illegible - only what could be read is reported)**

Mr. XXX underwent an Orthopedic consultation with **TTTT, D.O.** for left ankle pain and non-displaced lateral malleolar fracture found on x-ray. Dr. AAA noted that Mr. XXX was brought

to Emergency Department with back pain, left shoulder and chest pain, and left ankle pain secondary to a MVC with cement truck and had prolonged extrication at scene where he was pinned inside for approximately 30 minutes, and found to have left 2-8 rib fractures, left pneumothorax, L2 and L3 transverse process fracture. Dr. AAA noted that Ortho consulted due to non-displaced lateral malleolar fracture found on x-ray. Examination revealed Mr. XXX appeared in mild distress, left-sided chest tube in place with dressing, ecchymosis present in left upper chest, tachycardic heart rate with 110-120, some ecchymosis at left shoulder, superficial abrasions at proximal lower leg, and lateral malleolus tenderness to palpation. Dr. AAA reviewed CT's of the cervical spine, thoracic spine, lumbar spine, chest/abdomen/pelvis, and head, x-rays of left shoulder, left ankle, chest, elbow, and pelvis. Dr. AAA provided impression of lateral malleolus fracture status post MVC. Dr. AAA indicated short leg posterior splint placed in SICU, non-weight-bearing (NWB) left lower extremity (LLE), elevate LLE, and recommended non-operative management. **(Sample pdf-page 78-83)**

Records indicate Mr. XXX was seen for Oxygen Therapy and was last seen for therapy on December 12, 2015. **(Sample pdf-page 84-85/page 98-99)**

Records indicate Mr. XXX was seen for wound care and was last seen for wound care on December 12, 2015. **(Sample pdf-page 7/page 17)**

November 29, 2015: Mr. XXX underwent a Physical Therapy evaluation and provided a treatment plan, which included therapy daily for 1 week with short term goals of Mr. XXX would perform bed mobility without features with modified independence to be achieved by December 3, 2015, would perform functional transfer with 2-wheeled walker (2WW), LLE, NWB, modified independence, would ambulate 50 feet with 2WW, LLE NWB, supervision, and would negotiate 1 step with 2WW, LLE NWB, supervision to be achieved by December 6, 2015 and a long term goal of Mr. XXX would ambulate 300 feet with 2WW, LLE, NWB, modified independent to be achieved by December 27, 2015. **(Sample pdf-page 48-53)**

Mr. XXX underwent an Occupational Therapy evaluation and provided a treatment plan, which included therapy daily Monday to Friday for one week with short term goals of Mr. XXX would complete upper body (UB) dressing with minimal assistance, would complete simple grooming at sink with minimal assistance, and would complete toilet transfer with caregiver assistance (CGA) to be achieved by December 6, 2015 and a long term goal Mr. XXX would complete all activities of daily living (ADLs) with modified independence to be achieved by January 29, 2015. **(Sample pdf-page 8-14)**

Records indicate Mr. XXX was seen for Respiratory Therapy and was last seen for therapy on December 12, 2015. **(Sample pdf-page 108/page 115-116)**

November 30, 2015: X-rays of the chest revealed left chest tube remained, pleural thickening adjacent to multiple left rib fractures was again apparent, some chest wall air, and some dependent atelectasis. **(Sample pdf-page 33-34)**

December 1, 2015: X-rays of the chest revealed left chest tube remained, probably a tiny left apical pneumothorax, pleural thickening adjacent multiple left rib fractures, and chest wall air. **(Sample pdf-page 34-35)**

X-rays of the chest revealed left chest tube had been removed, left apical pneumothorax was slightly larger, pleural thickening adjacent to multiple left rib fractures was apparent, some dependent atelectasis, and left chest wall air. **(Sample pdf-page 35)**

X-rays of the chest revealed the left pneumothorax was similar in size, persistent left lateral pleural thickening, persistent left lung infiltrate, multiple left-sided rib fractures, stable amount of subcutaneous emphysema in the left chest and neck. **(Sample pdf-page 36)**

An ECG revealed sinus tachycardia, minimal voltage criteria for left ventricular hypertrophy (LVH), might be normal variant, inferior infarct, age undetermined, abnormal ECG, and compared to ECG on November 30, 2015 there was no significant changes. **(Sample pdf-page 107)**

December 3, 2015: X-rays of the chest and abdomen revealed left pneumothorax was again identified and patchy consolidation in the left lung, and multiple left-sided rib fractures and dilated loops of small bowel were identified consistent with an ileus or obstruction. **(Sample pdf-page 30-31)**

A CT of the abdomen and pelvis revealed an enlarging left-sided pneumothorax, with associated left base atelectasis, and perhaps a trace amount of left pleural effusion, the right lung base showed minimal right base atelectasis, calcified granuloma in spleen, numerous loops of distended small bowel, containing both air and fluid, however also air and fluid distention of the majority of the colon, transition from a slightly prominent more proximal colon to a non-distended portion of the colon in the distal descending colon region, suspected the findings were more likely related to ileus, minimal calcific arteriosclerosis of the abdominal aorta without evidence of aneurysmal dilatation, multiple displaced lower left lateral rib fractures, and subcutaneous air along the left lateral chest wall. **(Sample pdf-page 21-22)**

Mr. XXX underwent chest tube insertion performed by **NNN, M.D. (Sample pdf-page 89)**

X-rays of the chest revealed left-sided chest tube was in place and subcutaneous emphysema was identified, multiple left-sided rib fractures, and dilated loops of small bowel were identified consistent with obstruction or ileus. **(Sample pdf-page 36-37)**

December 4, 2015: Mr. XXX underwent an Orthopedic consultation with **KKK, M.D.** for the non-displaced lateral malleolus fracture on the left ankle from an x-ray. Examination revealed tender and swollen left ankle, mainly laterally, minimally tender medially. Dr. GGG provided impression of left lateral malleolus fracture, non-displaced. Dr. GGG recommended continuing non-operative care, especially in light of all the other medical issues he was going on and indicated Mr. XXX was going to follow up as an outpatient. **(Sample pdf-page 77-78)**

December 5, 2015: X-rays of the abdomen revealed left chest tube, multiple left-sided rib fractures, nasogastric tube tip at the distal stomach, air-filled dilated small and large bowel loops. **(Sample pdf-page 29)**

Mr. XXX underwent a Nutrition assessment at University Medical Center and was recommended initiating PO diet as medically feasible and advance as tolerated towards regular diet, would monitor for need and provide as needed. **(Sample pdf-page 184/Sample pdf-page 2)**

December 6, 2015: X-rays of the abdomen revealed continued air-filled distended small and large bowel loops, left-sided rib fractures, and nasogastric tube tip was in the stomach. **(Sample pdf-page 29-30)**

December 8, 2015: Mr. XXX underwent a Nutrition re-assessment at University Medical Center and was recommended advance diet as tolerated to regular diet, would monitor for need and provide as needed. **(Sample pdf-page 2-4)**

X-rays of the left wrist revealed no acute fracture and carpal cysts were seen in multiple carpal bones consistent with degenerative change. **(Sample pdf-page 40)**

December 9, 2015: X-rays of the chest revealed multiple left rib fractures associated with left pleural thickening, probably some atelectasis or contusion in the left lung base, and a wire superimposed over the left upper chest, although wondered if it was outside Mr. XXX **(Sample pdf-page 37)**

December 10, 2015: A CTA of the chest revealed the thoracic aorta was of normal caliber with no evidence of aneurysm or dissection, unremarkable visualized portions of the brachiocephalic, right subclavian, right carotid, left carotid and left subclavian arteries, unremarkable and patent visualized portions of the pulmonary arteries, patent pulmonary veins, no evidence for pulmonary embolic disease, atelectasis in the lower lungs, small left hydropneumothorax was similar in size when compared to the prior exam from December 3, 2015, the pneumothorax was larger on that day than it was on the initial presentation CT from November 28, 2015, multiple small areas of loculated fluid were present within the left hemithorax, coronary artery calcification, heart size was mildly enlarged, no pericardial effusion, mild thickening of the distal esophagus, and no mass, and correlate for esophagitis or reflux. **(Sample pdf-page 22-23)**

December 12, 2015: X-rays of the left ankle revealed non-displaced fracture of the fibula in unchanged alignment, bony remodeling at the fracture site, periosteal new bone formation, the ankle mortise was maintained, and spur formation was demonstrated at the attachment site of the plantar fascia to the calcaneus. **(Sample pdf-page 31-32)**

Mr. XXX was discharged from Occupational Therapy as goals met and was indicated Mr. XXX requiring assistance with basic activities of daily living (BADLs) so recommended using 2 wheeled walker. **(Sample pdf-page 36-41)**

Mr. XXX was discharged from Physical Therapy as goals met and was recommended requiring supervision with mobility and 2 wheeled walker**. (Sample pdf-page 95-99)**

Mr. XXX was discharged by **PPP, M.D.** to home and provided discharge diagnoses of abrasion of chest wall and left knee, closed fracture of transverse process of lumbar vertebra, closed fracture of seven ribs of left side, left hemothorax, laceration of left upper arm, MVC, and left pneumothorax. Dr. MMM prescribed Lyrica 100 mg, Acetaminophen-Hydrocodone 325 mg-10 mg, Ciprofloxacin 500 mg, Cyclobenzaprine 10 mg, recommended activity as tolerated, wearing boot when ambulating and out of bed, fine to remove for hygiene and range of motion exercises, weight-bearing as tolerated to left leg, keep foot elevated higher than hip to reduce swelling, move hip and knee often to reduce stiffness, home routine diet, might shower on that day, advised not to soak in bath tub or pool, keep wounds clean and dry, and to follow up in Cast Clinic in 2 weeks, SSS Clinic, and Physician. **(Sample pdf-page 7-11/page 13-37)**

December 14, 2015: Mr. XXX underwent an initial skilled assessment at HHHH **Care** and was recommended skilled nursing services for improving range of motion to 100%, increasing endurance, ambulation with steady gait without pain during daily activities of daily livings, taking pain medication as prescribed, changing position regularly for comfort out of bed (OOB) to chair, avoid slippery surfaces, drinking plenty of fluids and a high fiber diet. **(Sample pdf-page 3-8)**

Mr. XXX underwent a Physical Therapy evaluation at HHHH Care and was provided a treatment plan, which included therapy 3 times a week for 1 week then 2 times a week for 1 week with long term goals of Mr. XXX would ambulate 450 feet with rolling walker (RW)/single tip cane (STC)/L and stand by assistance (SBA) in home/outside on even/uneven terrain allowing him to walk safely to Doctor of Medicine (MD) appointments, to increase standing balance to good to decrease risk of falls Tinetti score to improve to 25/28, to increase 2 mm grade in left ankle/foot, 1 mm grade in bilateral hips and knees to improve ADLs, transfers, and mobility, to monitor Mr. XXX's chronic rib pain, and to be independent with home exercise program (HEP) to be achieved in 2 weeks. Records indicate Mr. XXX was last seen for therapy on December 23, 2015. **(Sample pdf-page 35-37/page 41)**

December 17, 2015: Mr. XXX underwent an Occupational Therapy re-evaluation at HHHH Care and provided a treatment plan, which included therapy 2 times a week for 3 weeks with short term goals of Mr. XXX to perform upper body dressing with SBA, to perform lower body dressing with SBA, to increase standing dynamic balance to F+ to ensure safe functional, to increase strength of bilateral upper extremities (BUE) to/by 4/5 in order to be independent assist to achieve independence with ADLs, and to tolerate greater than 20 minutes activity prior to fatigue, to be met within 1 week and long term goals Mr. XXX to perform upper body dressing with independence assist, to perform lower body dressing with independence assist, to increase standing dynamic balance to G to ensure safe functional, to increase strength of BUE to/by 5/5 in order to be independent assist to achieve independence with ADLs, and to tolerate greater than 30 minutes activity prior to fatigue, and would recall 100% of HEP to achieve functional outcome, to be met within 1 week. Records indicate Mr. XXX was last seen for therapy on December 30, 2015. **(Sample pdf-page 55-56/page 33-34)**

December 19, 2015: Mr. XXX was discharged by Dr. MMM to home in stable condition and was recommended Norco 10 mg, activity as tolerated, no restrictions, and advised to follow up with Orthopedics and YYY Surgery. **(Sample pdf-page 6-7)**

December 28, 2015: Mr. XXX had an office visit with **DDD, F.N.P.** for new work place injury. Mr. XXX reported that he was involved in MVA and was taken to ZZZ Hospital, told it was a head on collision, hospitalized in ICU for 2 weeks, had a chest tube placed due to a left side pneumothorax, discharged on December 12, 2015 with Hydrocodone and Flexeril and was told to follow up with a worker's compensation provider and Cast Foot Clinic. Mr. XXX reported left anterior and posterior displaced rib fractures, had pain 10/10 at that time, had shortness of breath due to pain while breathing, his last dose of Hydrocodone was 3 days ago, had been taking them as scheduled due to severe pain and was using the incentive spirometer. Mr. XXX stated the pain was constant and had been using the recliner while sleeping because it was more comfortable than lying down. Mr. XXX's wife stated a thoracic surgeon seen Mr. XXX in the hospital and spoke with her several times about possibly placing a metal brace for his ribs, however was eventually told it was "too late" for the surgery. Mr. XXX reported left distal fibula fracture, at that time he had minimal pain, had a boot and he was told to wear it during the day and had a leg cast to sleep in at night, he had not followed up with a provider for his fracture, had physical therapy (PT) that comes to his home and had been seen 8 times for therapy and stated it was going well, had some tenderness while walking, and his range of motion (ROM) was good. Mr. XXX indicated having left shoulder strain, had some pain moving arm, however he could not differentiate if it was shoulder pain or rib cage pain, had some ROM issues due to pain and mild weakness. Ms. JJJ noted Mr. XXX had L2 and L3 vertebra fracture, had some ROM issues to lower back, and had more pain to his thoracic area and rib cage posterior and anterior. Mr. XXX reported ankle injury occurred at work more than 1 week ago, the pain was present in the left ankle at a severity of 2/10, mild, intermittent since onset, associated symptoms included an inability to bear weight (mild) and muscle weakness, the symptoms were aggravated by movement, had tried non-weight-bearing and immobilization for the symptoms, and the treatment provided moderate relief. Mr. XXX reported arm injury occurred more than 1 week ago at work, the injury mechanism was a vehicle accident, pain was present in the left shoulder, described as aching, at a severity of 2/10, mild, the pain had been fluctuating since the incident, associated symptoms included muscle weakness, and the treatment provided moderate relief. Mr. XXX stated that back pain started 1 to 4 weeks ago, the problem occurred constantly, unchanged, the pain was present in the thoracic spine (rib cage area), the quality described as aching and stabbing, at a severity of 10/10, severe, the pain was the same all the time, the symptoms were aggravated by bending, coughing, lying down, position, standing and twisting, associated symptoms included weakness (left shoulder), had tried muscle relaxant and analgesics for the symptoms, and the treatment provided mild relief. Examination revealed tenderness and bony tenderness in anterior and posterior left rib cage and swelling in anterior lower left rib cage, decreased range of motion and strength in left shoulder, swelling and mild tenderness in left ankle, decreased range of motion, tenderness, bony tenderness, and pain in thoracic back, decreased range of motion in lumbar back, pain and spasms noted, gait guarded, and boot to left foot present. Ms. JJJ provided assessments of closed fracture of multiple ribs of left side, left shoulder strain, fibula fracture, other closed fracture of 2nd lumbar vertebra, and other closed fracture of 3rd lumbar vertebra. Ms. JJJ prescribed Norco 10-325 mg, recommended ambulatory referral to Pain Clinic, Cardiothoracic surgery, Podiatry, and Orthopedic Surgery, advised to use

incentive spirometry 10 times at least every hour, using a pillow to support rib area, might have to use recliner to sleep up right if needed, and report if fever, cough with sputum, increased shortness of breath or any other worsening symptoms. Ms. JJJ recommended performing ROM exercises and stretches, use ice and heat to area, continue using boot until seen by Podiatry, physical therapy as tolerated, ROM exercises and advised to follow up on October 14, 2015 or sooner if needed. **(Sample pdf-page 7-11)**

December 20, 2015: Mr. XXX underwent an Orthopedic Spine Surgery consultation with **VVV, M.D.** for lumbar transverse process fracture secondary to a motor vehicle accident on November 21, 2015. Mr. XXX stated that he was transported by helicopter from the accident scene to Breckenridge Medical Center. Mr. XXX reported that he was there for 2 weeks and stated that he sustained multiple rib fractures as well as a left ankle fracture, those were being addressed by other providers, and incidentally, that he was found to have left-sided transverse process fractures at L2 and L3. Mr. XXX stated that his back was almost entirely asymptomatic at that point. Mr. XXX reported minimal low back pain on the left side and rated as 2/10 and apportions the pain as 100% in the back and 0% in the leg. Examination revealed mild tenderness to the paraspinous muscles on the left (mild). Dr. ABC reviewing CT of the cervical, thoracic, and lumbar spine performed at Brackenridge Medical Center on November 28, 2015. Dr. ABC provided assessment of lumbar transverse process fracture, closed. Dr. ABC discussed that the usual treatment was for protected activity for about the 1st 4 weeks and then activity as tolerated and advised to follow up on an as needed basis however not anticipated any further care would be needed for his spine and advised him to contact immediately for any neurological deterioration or acute deficits. **(Sample pdf-page 21-24)**

January 6, 2015: Mr. XXX had an office visit with **Dr. JJJ, D.P.M.** for left fracture care. Mr. XXX reported having left lateral ankle pain with an intensity of 3/10 secondary to a MVC. Mr. XXX reported that he went to the Emergency Room/Urgent Care, fracture boot and non-weight-bearing status. Examination revealed minimal left foot/ankle edema, mild and palpation within the distal fibula and left ankle, and had restricted ambulation. Ms. FFF reviewed x-rays of the left ankle. Ms. FFF provided an assessment of left distal fibular fracture, stable. Ms. FFF recommended using fracture boot, guarded weight-bearing with protective device, risk of displacement of fracture without use of protective device and/or gait assistive devices reviewed, driving restriction reviewed, discussed healing times of fractures, compression wrapping, and rest, ice, compression and elevation (RICE) therapy, dispensed ACE wrap, pre-clinic x-rays ordered for next visit and advised to follow up in 4 weeks, possible advancement to an ankle brace at that time. **(Sample pdf-page 39-42/Sample pdf-page 518-520)**

X-rays of the left ankle revealed oblique fracture of the distal fracture with callus formation; ankle mortise was maintained, soft tissue swelling, plantar calcaneal enthesophyte and degenerative changes of the hindfoot and midfoot. **(Sample pdf-page 30-31)**

January 9, 2015: Mr. XXX underwent a Cardiothoracic Surgery consultation with **NNN, M.D.** for fractured ribs secondary to MVA. Mr. XXX reported that apparently, he was unconscious and was treated at AAA Hospital for over 2 weeks, and was discharged, he had multiple injuries at that time, had fractured ribs, fractured spine, fractured ankle and left shoulder strain. Mr. XXX reported that he continued to have chest pain, rated as around 8/10 and stated that he felt

better with Norco. Mr. XXX indicated that he had history of shortness of breath, seen by Thoracic Surgeon and recommended internal fixation with a metal plate; however, it was not done, at that time Dr. LLL thought it was too late to have anything done and especially when there was no chest wall instability, and did not recommend any surgical intervention. Examination revealed chest wall tenderness over the left chest, both posteriorly both at the apex as well as at the base. Dr. LLL reviewed CT's of the spine. Dr. LLL ordered chest x-rays and a CT to evaluate rib fractures, recommended to continue taking the pain medications, and advised to follow up for further recommendations. **(Sample pdf-page 51-53)**

January 13, 2015: Mr. XXX had a follow up visit with Ms. JJJ for left side multiple rib fracture, left shoulder strain, left ankle fracture, and lumbar fracture. Mr. XXX reported that he had foot injury, the pain had been intermittent since onset, associated with a loss of motion (mild), the symptoms were aggravated by palpation, had tried immobilization and ice for the symptoms and the treatment provided moderate relief. Mr. XXX reported he was breathing better and only had pain to his rib area with certain movements. Mr. XXX stated that he was trying to stop taking Norco as much, inquiring if he could take over-the-counter medications, had been having some nausea when taking the medication, had an appointment with the cardiac thoracic surgeon, and a CT was ordered, and it was awaiting approval through worker's compensation (WC). Mr. XXX stated that overall he felt much better and was moving better, left shoulder had improved, and range of motion had improved. Ms. JJJ indicated Mr. XXX saw Ms. FFF, Podiatry, for his left ankle fracture, the treatment would consist of a boot and RICE and then later possible ankle brace. Mr. XXX reported that he had ankle pain only intermittently; at that time he did not have pain, and had been using a walker to assist him when ambulating. Ms. JJJ noted that Mr. XXX had a follow up with Ms. FFF at the end of the month and seen Orthopedics for his lumbar fracture and had not been working due to the injuries. Ms. JJJ provided additional assessments of closed left ankle fracture and lumbar transverse process fracture, closed. Ms. JJJ recommended continuing to use a pillow for support to rib area when coughing, reporting fever, cough with sputum, increased shortness of breath or any other worsening symptoms, and indicated Mr. XXX was fine to use over-the-counter medication for pain if needed, and educated Mr. XXX and his wife to be careful not to double dose with Acetaminophen and Norco, Norco had acetaminophen. Ms. JJJ recommended to continue to perform range of motion exercises and stretches, might use heat to area before exercises, continue to follow orders as indicated by Podiatry, reporting any increase in pain, it was important to remain active and knowing limits, and advised to follow up with Pain Clinic as needed and with Podiatry as indicated and to return to clinic on May 15, 2015 or sooner if needed. **(Sample pdf-page 59-61)**

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