IPM MEDICAL GROUP INC.
treating pain, restoring life

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FACSIMILE COVER SHEET

TO: Bill Review / AnthonyCamblin	FROM: Adrian Bucad
COMPANY: Hartford	DATE: 05/15/2018 08:18 AM
FAX NUMBER: 877-536-1529 / 888-459-1621	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER: 800-327-3636 / 866-401-9222 x 2304008	SENDER'S PHONE NUMBER: (925)691-9806
RE: Alan Eger CL#: YMQC43423C	SENDER'S FAX NUMBER: (925)407-8412

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Please note that the attached progress note is for billing and/or record purposes only. Any requests for authorization will be submitted under separate cover. **THIS IS NOT AN RFA**. Thank you.

cc: NataliaFoley310-626-9632

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May 14, 2018

Hartford
PO Box 14475
Lexington, KY 40512
Adjuster: Camblin, Anthony

PATIENT NAME:	**Eger, Alan**
SOCIAL SECURITY NUMBER:	**548-41-4004**
DATE OF BIRTH:	**09/18/1962**
DATE OF INJURY:	**02/01/2015**
EMPLOYER:	**Triace Bicycle/Bridgeway International**
CLAIM NUMBER:	**YMQC43423C**
FILE NUMBER:	**PT00058748**
DATE OF EVALUATION:	**May 14, 2018**

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT PR-2 / TREATMENT AUTHORIZATION REQUESTED

To Whom It May Concern,

I, Jacob Rosenberg, MD, am the primary treating physician on the above noted patient. The patient was seen in my SANTA ANA, CA office for the purpose of primary treating physician's follow-up evaluation and report. The visit required a review of the patient's medical records, decision making, and any necessary treatment recommendations.

TIME SPENT:

35 min was spent face to face with the patient. More than half of the time was spent in education and counseling the patient.

Time was spent on patient education related to:
- Alternative treatments and options.

DFR, PR-2,3,4

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT PR-2.

CHIEF COMPLAINT

-Back pain going down the leg, Lower backache, Bilateral Knee pain, Left Ankle pain and Left Foot pain.
-Increased Lower back, Bilateral Knee, Left Ankle and Left Foot pain.

SUBJECTIVE COMPLAINTS:

Pain level has increased since last visit. Patient rates his pain with medications as 10 on a scale of 1 to 10. Patient rates his pain without medications as 10 on a scale of 1 to 10. The level of sleep for the patient has stayed the same. Quality of sleep is poor. Patient sleeps 3 hours per day interrupted.

-R sided low back pain with radiation down the back of the R leg crossing the knee and terminating at the lateral aspect of the R ankle. Pain is described as sharp shooting pain better with elevation of the R leg and rest, worse with standing and walking. Pt notes numbness over the lateral aspect of the R ankle but denies weakness.

-Pt also notes that becuase he is unable to work he is feeling depressed and is having difficulty sleeping. Pt denies SI. Pt notes that depression has been worsening over the past month.

CURRENT MEDICATIONS:

Self:
1 Celebrex 100 Mg Capsule SIG: Take 1 every 12 hours

PAST MEDICAL HISTORY:

The patient denies having any previous problems with the body parts injured prior to his current pain complaint. He denies being involved in any previous work-related, motor vehicle, or sports-related accidents with resulting injuries.

The patient's past medical history is noncontributory. He reports no serious medical illness or any previous illness that led to hospitalization. He has no history of diabetes mellitus, heart disease, hypertension, gastritis, ulcer, seizures, thyroid disease, glaucoma, abdominal hernia, malignancy, bleeding disorder, kidney disease, stroke (transient ischemic attack), asthma, chronic cough, arthritis, seizure or epilepsy, bleeding, cancer, HIV/AIDS, hepatitis, and hyperlipidemia.

PRIOR SURGERIES: The patient's past surgical history is significant for clavicle surgery, performed in 2009.

MEDICATION ALLERGIES: The patient reports that he is allergic to ASPIRIN. He denies any previous problem with anesthesia and sedation. He reports having burning sensation in his stomach when taking NSAIDs or anti-inflammatory medications.

NON-DRUG ALLERGIES: The patient has no known non-drug allergies.

SOCIAL HISTORY:

Smoking Use: Never smoked or used tobacco products.
Alcohol use: Denies alcohol use

The patient is married and currently lives with his spouse in Anaheim, California. He has some college education. He does not drink alcoholic beverages. He denies the use of illicit or recreational drugs. He denies any history of alcohol abuse. He also denies any history of drug abuse. He states that he has not been to Alcoholics Anonymous. He does not smoke cigarettes or use other tobacco products. He states that he does not exercise on a regular basis.

EMPLOYMENT HISTORY AND CURRENT WORK STATUS

The patient was working as a research and development director for Triace Bicycle Company/Bridgeway International when he sustained his current injury. He is currently not working. He states that he has not worked since February 2015. He states that his employment status has been affected by his present pain condition. He states that he is yet to have his claim settled. He has been placed on permanent and stationary status. He states that he had an AME evaluation. He is not receiving any disability benefits.

FAMILY HISTORY:

The patient's family history is noncontributory.

REVIEW OF SYSTEMS:

General: (-) anorexia, (-) change in appetite, (-) chills, (+) eat too much/little, (+) good exercise tolerance, (-) fatigue, (-) fever, (-) malaise, (-) night sweats, (+) poor energy, (-) poor sleep, (+) unhappy, (-) weakness, (-) weight changes.
Neurological: (-) numbness, (-) tingling, (-) tremors, (-) seizures, (-) vertigo, (-) dizziness, (-) memory loss, (-) any focal or diffuse neurological deficits.
Psychiatric: (-) anxiety, (-) depression, (-) sleep disturbance, (-) irritability, (-) mood swings, (-) suicidal thoughts or ideations.
Skin: (-) acne, (-) changes in hair or nails, (-) dry skin, (-) easy bruising, (-) excessive sweating, (-) urticaria (-) hyperpigmentation, (-) hypopigmentation, (-) infection, (-) itching (-) jaundice, (-) lesions or sores, (+) loss of hairs, (-) lumps, (-) changes in mole(s), (-) new mole(s), (-) nail ridging, pitting, (-) rash (-) vitiligo.
Gastrointestinal: (-) abdominal pain, (-) heartburn, (-) constipation, (-) diarrhea, (-) nausea, (-) vomiting, (-) hematochezia, (-) melena, (-) change in bowel habits.
HEENT: (-) visual changes, (-) eye pain, (-) double or blurred vision, (-) glaucoma, (-) cataracts, (-) hearing changes, (-) tinnitus, (-) vertigo, (-) dizziness, (-) earache, (-) use of hearing aids, (-) frequent colds, (-) nosebleeds, (-) runny nose, (-) toothache, (-) hoarseness, (-) dentures use.
Neck: (+) neck pain, (+) stiffness.
Respiratory: (-) cough, (-) hemoptysis, (-) shortness of breath, (-) wheezing, (-) nocturnal choking or gasping, (-) TB exposure.
Cardiac: (-) arrthythmia, (-) chest pain, (-) dyspnea on exertion, (-) edema, (-) edema, (-) high blood pressure, (-) irregular heartbeat, (+) leg swelling, (-) murmur, (-) orthopnea, (-)

palpitations, (-) paroxysmal nocturnal dyspnea, (-) shortness of breath.
Urinary: (-) dysuria, (-) frequency, (-) urgency, (-) hesitancy, (-) hematuria, (-) urinary incontinence, (-) flank pain, (-) change in urinary habits.
Genito-Reproductive: (-) sexual difficulties.
Peripheral Vascular: (-) intermittent claudication, (-) cramps, (-) varicose veins, (-) thrombophlebitis.
Endocrine: (-) heat or cold intolerance, (-) excessive sweating, (-) diabetes, (-) excessive urination.
Allergy: (-) dermatitis, (-) hayfever, (-) migraine, (-) sensitivity to pollen.
Hematologic/Lymphatic: (-) anemia, (-) easy bruising, (-) excessive bleeding, (-) history of blood transfusions. All aspects of ROS re-reviewed and there has been no new changes.

VITAL SIGNS:

Weight: 158 lbs, **Height:** 6' 1", **BMI:** 20.84, **BSA:** 1.92, **BP:** 121/69, **Pulse:** 46

EXAMINATION:

General Appearance: The patient appears to be in mild distress.
Spine:
LUMBAR SPINE: Lumbar facet loading is positive on both sides. Straight leg raising test is positive on both the sides in supine position at degrees. Kemps Test is positive.
Neurologic:
SENSORY EXAMINATION: On sensory examination, light touch sensation is decreased over lateral foot and lateral calf on the right side.
Respiratory: Lungs are clear to auscultation and percussion. No wheezes, rales, rubs or rhonchi are noted.
Cardiovascular: Normal sinus rhythm with normal S1 and S2 without audible click, murmur or rub.
Gastrointestinal: The abdomen is soft, non-tender without rebound or guarding. No visible scars, hernias are seen.
Eyes: Pupils equal, reactive to light, Visual field testing deferred.
Integumentary: Gross inspection of skin demonstrates no evidence of abnormality. Hair and nails are also normal. Skin is warm and dry.
Other: Best of three range of motion:
Cervical spine:
flexion was 60 degrees,
extension 40 degrees with pain
40 degrees of left tilt
30 degrees of right tilt
70degrees of left rotation
55 degrees of right rotation.

Lumbar spine range of motion
25 degrees of true flexion
5 degrees of extension.

Straight leg raising in the sitting and supine position were congruent with primarily back and buttock

pain. Internal and external rotation of the hips do not produce any significant discomfort. There is modest pain over the greater trochanter over the right buttock.

DTR R/L
L4 2+/2+
S1 1+/1+

His left fifth toe was rotated metatarsophalangeal joint and deviated medially in the DIP joint. There is limited extension of the fifth toe on the left foot normal on the right foot.

He is able to stand on his right foot without difficulty. He was able to do a single toe raise on the right foot. On the left foot, he was unable to toe raises, and able to stand on the left foot no more than few minutes.

There is a full range of motion in bilateral knees 0-120 degrees of flexion, mild crepitus with flexion and extension, negative McMurray's on right but positive on right, normal stability. No obvious swelling.

There is moderate pain with palpation at the fifth metatarsal head in the left side. The palpation was slightly more prominent than on the right with reduced fat pad on both sides,again more prominent in the left.

In the left shoulder, there is reduced range of flexion to 115 degrees, abduction to 150 degrees, positive impingement findings and rotator cuff weakness versus the right.

RECORD/DIAGNOSTIC REVIEW:

MRI on reveals the following findings.

MRI of the lumbar spine from 08/22/2017 was available for review. At T12-L1, L1-L2, L2-L3, there is mild disc desiccation without evidence of herniation or stenosis. At L3-L4, there is mild disc desiccation bulges minimally into the caudal aspect of the left foramen without neural compression. Schmorl's nodes are seen. L4-L5 mild disc desiccation. No evidence of herniation or stenosis. L5-S1 chronic bilateral pars fracture with grade 1 spondylolisthesis, disc degeneration with vacuum phenomenon type 1 and type 2 endplate changes. There is severe bilateral neural foraminal stenosis due to marginal osseous ridging and the spondylolisthesis. Note is made of a small facet joint synovial cyst on the left dissecting anteriorly, but not causing neural compression. MRI of the left foot from 08/22/2017 was also available for review.

IMPRESSION:
1. Mild amorphous bone edema at the third metatarsal head without adjacent orthosis, adjacent capsuloligamentous pathologyor demonstrable fracturing. Disc height represent mild stress response.
2. Moderate ostearthritis of the far dorsal aspect of the third tarsometatarsal joint with mild subchondral cystic changes at the lateral cuneiform.
3. Mild osteoarthritis of the dorsal aspect of the middle naviculocuneiform joint for normal regional muscles and tendon.
4. No evidence of Morton's neuroma.
5. MRI of the left knee from 08/21/2017 was available for review and this shows minor degenerative changes without meniscus or ligamentous tear.

DIAGNOSES:

M54.10 Radiculopathy, site unspecified
M43.16 Spondylolisthesis, lumbar region
M25.561 Pain in right knee
M25.562 Pain in left knee

TREATMENT PLAN:

Summary:

Mr. Alan Eger presents today with complaints of pain in his upper back, mid back, lower back, bilateral knees, left ankle, and left foot over the past two years and five months. He reports that he sustained work-related cumulative trauma injuries which manifested on February 1, 2015 while working as a research and development director for Triace Bicycle Company/Bridgeway International. Essentially his job was to work in China going to test bikes in a variety of mountain bike races. He described a number of crashes in particular on May 14, 2014, where he fractured his left foot, probably a Jones fracture. He stayed off the foot for a while, but returned to work in August 2014. Subsequent to that, he continued to work until February 2015 when he could no longer continue because of significant pain in the neck, lower back, and bilateral knees. His left foot for some reasons is not an accepted body part. He described that there are a significant number of crashes, and he does not say that any one crash where he had significant discomfort but gradually he had increasingly severe pain in the lower back and bilateral knees, and some pain in the neck as well.

He was prescribed pain and anti-inflammatory medications. He states that he underwent previous diagnostic work-ups including MRI scans of the lumbar spine, ankles and foot in 2015. He also underwent x-rays of the lumbar spine, ankles and foot. Conservative treatments were initiated, including physical therapy, chiropractic treatment, and psychotherapy. He also used a TENS unit.

Previous Treatments
-PT: for the L spine 02-04/17 approximately 20 sessions - no help
-Chiro: 02-04/17 approximately 10 sessions - no help
-acu: no
-Injections: none
-Sugeries: none

Meds: ibuprofen OTC PRN

Imaging:
-8/22/17 - MRI L spine - severe b/l NFN @ L5/S1

THE PATIENT'S HISTORY AND PHYSICAL EXAMINATION IS CONSISTENT WITH:

1. Spondylolisthesis, lumbar region.

2. Pain in left knee.

3. Pain in right knee.

4. Lumbar Radiculopathy

Discussion
-LESI and psych denied
-still with right sided lbp with radiation to the right leg
-taking ibuprofen 800mg TID
-has court date set for 7/2/18

Treatment plan
-At this point I am unsure as to why RFA for LESI is being denied. The pt clearly meets criteria for an LESI and in the denial letter it states that previous treatments were not adequatly summarized and proper imaging reports were not provided. This is clearly stated in the note I have provided.
-await court date on 7/2/18 for further clarifaction of how to move foward with case.

The risks and the benefits of the procedure were fully explained to the patient. The risks include pain, bleeding, infection, nerve root damage, spinal cord damage or paralysis. The patient understands all the risks explained and would like to proceed with the planned procedure.

NSAIDs to always be taken with food, held for any burning stomach pain, black stools, bleeding or high blood pressure.
Patient warned in detail regarding NSAIDs such as relafen, Motrin, ibuprofen, naprosyn, diclofenac etc. Discussed the risk of NSAID associated ulcers, including silent ulcers that could be life threatening. also Renal failure, and HTN leading to stroke or MI.
Patient Understood these risks.

General Preventative Discussion: 15 minutes was spent counseling the patient on a specific preventive care plan, including: the health consequences and effects of drug interactions; reviewing family history and providing specific actions to prevent potential hereditary issues; discussing the benefits of other preventive wellness measures such as physical activity, proper movement and posture, and cognitive functioning. This was performed as a completely seperate service to the EM service.

Greater than 50% of the time was spent on patient education related to:
- Alternative treatments and options.
- A detailed discussion of the patient's medications and side effects.
- Anatomy and differential diagnosis.
- The demonstration of appropriate exercises.
- Procedure outcome and long term expectations.
- Procedure risks and benefits.
- Short and long term steroid risks and benefits.
- A detailed discussion of the patient's work restrictions.

WORK STATUS:

Temporarily Totally Disabled (TTD): Patient is Temporarily Totally Disabled until the next appointment.

WORK RESTRICTIONS:

-No repetitive work.
No heavy work.
So far light duties have not been allowed so he is TTD.

Sincerely,

Jacob Rosenberg, MD

I declare under penalty of perjury that the information accurately described the information provided to me and except as noted herein that I believe it to be true. I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient, the preparation of the report or the dictation of any procedure.

I am this patient's primary treating physician. Pursuant to Article 5.3 of the Official Medical Fee Schedule, I am required by law to submit this PR-2 as a separately reimbursable report with code WC002.§9789.14. Treatment Reports That Are Separately Reimbursable: "(1) Primary Treating Physician's Progress Report (Form PR-2), issued in accordance with section 9785(f), using DWC form PR-2, its narrative equivalent, or letter format where allowed by section 9785. Use Code WC002." Per section 9785(f), cause for this report could be a response to additional information requested, release from care, a change in the patient's condition, treatment plan, or work status, or continuing medical treatment no greater than 45 days since submission of the prior report. Pursuant to section (8): " when continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.

PROOF OF SERVICE
1013a(3) CCP

STATE OF CALIFORNIA, COUNTY OF CONTRA COSTA

I am employed in the County of Contra Costa, State of California. I am over the age of 18 and not a party to the within action. My business address is IPM Medical Group, Inc., 450 North Wiget Lane, Walnut Creek, CA 94598.

I served the foregoing document(s) described below on 05/15/2018

on the interested parties in this action by placing the original, or true copies thereof, in sealed envelopes addressed as follows:

Foley, Natalia
8306 Wilshire Blvd Ste 115
Beverly Hills, CA 90211

AnthonyCamblin
Hartford
PO Box 14475
Lexington, KY 40512

I am "readily familiar" with my employer's practice of collection and processing correspondence for mailing. Under that practice, it would be deposited with U.S. Postal Service on that same day with postage thereon fully prepaid at Walnut Creek, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after deposit for mailing affidavit.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.
Executed at Walnut Creek, California on 05/15/2018

Daniel Rosenberg

Printed Name

Signature