5-20-11

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)
James B. Shaw, M.D.
MD Pain Specialists

[X] Periodic Report (required 45 days after last report) [ ] Change in treatment plan [ ] Released from care

[ ] Change in work status [ ] Need for referral or consultation [ ] Response to request for information

[ ] Change in patient's condition [ ] Need for surgery or hospitalization [X] Request for authorization

[ ] Other:

Patient:

Last: Anderson First: Tiffany MI: Sex: Female
Address: 2 N. Avena Avenue City: Lodi State: CA Zip: 95240
DOI: 06/19/2008 DOB: 08/22/1970
Occupation: Mosquito Control Technician SSN: 549-23-5133 Phone: 209-329-9523

Claims Administrator:

Name: McKenzie Dawson, AIMS Claim Number: VE0700184
Address: P.O. Box 28100 City: Fresno State: CA Zip: 93729
Phone: 916-563-1900 x 242 Fax: 916-563-1919

Employer name: San Joaquin County Mosquito and Vector Control District

Subjective Complaints:

Tiffany Anderson is a 40-year-old, right-handed, female with an industrial knee injury, and she has less than a satisfactory outcome from her surgery.

The patient treated with Dr. Murata on June 19, 2008, with an arthroscopic lateral meniscectomy. Dr. Murata performed surgery for a tear of the anterior horn of the lateral meniscus, and it was found to have complex radial and lateral tears. There was also chondromalacia of the medial femoral condyle which was trimmed. At the time of that surgery, he resected 30% of the meniscus down to a stable base.

The patient had a second MRI that showed a horizontal cleavage tear which was nearly circumferential, and there was an old Baker Cysts 6x7 cm of the posterolateral aspect of the knee. The patient continued to experience lateral knee, patellofemoral, and lateral joint line pain that continues. The pain has continued to have significant pain despite the last two surgeries by Dr. Murata, March 9, 2010. She was found to have grade IV chondromalacia of the medial femoral condyle, a recurrent lateral meniscus tear, had a microfracture of the condyle, and a partial menisectomy.

The patient saw a Qualified Medical Evaluator and future medical care with analgesics, and anti-inflammatories was recommended. The patient has wanted an independent gym membership, and asked that we request authorization. The patient's long term management admittedly are better with the patient taking a proactive role in their care.

Current Symptoms:

The patient has drawn her symptoms on a diagram outlining the human body. The body parts reported are the knees.

The patient was asked to describe his pain based on the McGill Pain Questionnaire short form. The character of the pain is described as ache.

The patient's present pain intensity on a numeric rating scale (NMRS) is 3-7/10. The patient does not have visibly disabling pain.

From the patient's perspective the cause of pain is from the original injury. Aggravating factors include general activities and normal work. Palliative measures include rest.

The patient has taken a proactive approach to their condition, and is actively engaged in moving forward with a self directed management program.

The impact of the pain is problematic because the persistent symptoms have affected the quality of life (QOL) and activities of daily living. He is much more limited in social and recreational activities, and it has affected his outlook and mood.

Objective Findings: *(include significant physical examination, laboratory, imaging, or other diagnostic findings)*

GENERAL APPEARANCE:
The patient is well-developed, well-nourished, and in no distress. The patient is alert, and oriented x3.

HEENT:
Normocephalic, atraumatic. Palpatory examination normal. Pupils are equal, round, and reactive to light. Extraocular muscles are intact. Sclerae are non-icteric. Conjunctiva are pink, non-icteric.

NECK:
There is no significant lymphadenopathy or mass. Trachea is mid-line. The thyroid is without enlargement or palpable nodule. There is no evidence of jugular vein distention.

CARDIOVASCULAR:
The heart has a regular rate and rhythm. Pulses are normal.

RESPIRATORY:
Lungs are clear.

LUMBAR SPINE:
Gait is normal.
Normal Lumbar flexion.
Straight leg raise is negative.
Spasm and guarding is noted lumbar spine mild soreness/ no spasm/ guarding.

FABER TEST Negative.

Patrick Test Negative.

Gaenslen's Test Negative.

MUSCULOSKELETAL:
Right knee has palpatory tenderness over the joint line, and Gerdy's tubercle. No fluid today. No erythema. ROM-extension 0 degrees, flexion 130 degrees. There is no evidence of bony tenderness, joint effusion, enlargement or abnormal motion. No muscle fasciculations, atrophy, muscle weakness, asymmetry or reduced range of motion is noted.

NEUROLOGIC:
Cranial nerves II-XII grossly intact. Strength 5/5 in all muscle groups. Sensation intact to light touch and pinprick. Reflexes are equal and symmetric bilaterally in the upper- 2+/2+ and lower extremities- 2+/2+. Babinski is negative. Cerebellar function grossly intact. Finger-to-nose testing within normal limits. Gait normal.

Diagnosis:
1. 717.9 INT DERANGEMENT KNEE NOS
2. 716.96 ARTHROPATHY NOS-L/LEG
3. 729.1 MYALGIA AND MYOSITIS NOS

Treatment Plan: *(include treatment rendered to date. List methods, frequency and duration of planned treatments(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?*

Based on the clinical history, examination, and diagnostic testing there seems evident a linear cause and effect relationship. The patient had been seen by Dr. Murata, M.D., Orthopedics post surgically, and he does not feel any further specific treatment, or therapy is indicated. He recommended that the Norco be discontinued.

The patient is utilizing scheduled pain medications from another physician.

She is very somatically focused that the knee is not better.

The conceptual model of pain and its management requires the formulation of treatment plans, and careful dynamic assessment of the patient and outcomes based on appropriate goals.

The patient is a candidate for pain medications supported by ACOEM/MTUS Guidelines. The justification for medication therapy is based on a dynamic assessment for risk/benefit analysis in conjunction with a functional assessment. The patient takes oral NSAID's, Motrin, and she is complaining about a residual swelling patella.

Her examination suggest she has a small pre-patellar bursa. She is a candidate for a trial of Voltaren Gel, and I have provided her a prescription. She has been informed that supportive data is mixed, and its use may need UR approval. Request authorization for topical medication.

She is not to use oral Motrin, and topical Voltaren Gel at the same time.

At the patient's last visit, she requested that we inquire with her carrier whether her gym membership for her left knee can be covered by her carrier. We await hearing back from the carrier concerning.

Work Status: This patient has been instructed to: Modifed work is recommended.The patient is precluded from jumping and running as per QME Supplemental Report.

[ ] Remain off-work until _____

[ ] Return to modified work on _____ **with the following limitations**
(List all specific restrictions re: standing, sitting, bending, use of hands etc.)

[ ] Return to full duty on _____ **with no limitations.**

Primary Treating Physician: *(original signature, do not stamp)*Date of Exam: May 20, 2011
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3

Signature: James Shaw MD CA License# A45657
Executed at: 2027 Grand Canal Blvd., Ste 29 Stockton, CA 95207 Date: May 20, 2011
Name: James B. Shaw, M.D. Specialty: Pain Management
Address: 5637 N Pershing Ave, Suite H-9 Stockton, CA 95207 Phone: 760-734-1800