**----- v. -----**

**Date of Loss: 09/17/2017**

**Non-Medical Records**

**Deposition of -----, dated November 12, 2020**

The applicant testified that he had not gone back to the store where the injury occurred because every time he passed by the owner would look at him and make fun of him or laugh, trying to cause more drama, so he preferred not to go around there anymore. The accident had been witnessed by vendors, but he did not know any of their names because they preferred to stay anonymous, though he had tried to get their names.

The applicant described the accident. The hook on the gate rail got caught on his shoe and he was unable to hold himself and he fell and dropped his daughter. She landed on her back and head, and everything was so fast that he just spaced out. He saw her on the floor, and she was not reacting well, and he became scared. His daughter was passing out, so he called 911 and kept waiting for the ambulance to arrive. When he fell, he landed first on his right knee, then on the left. He did not ride in the ambulance with his daughter because he felt guilty and as if something worse was going to happen. He could not recall if he was in pain after the accident, because he did not pay attention. He did recall that he did not hit his head or lose consciousness.

The applicant testified that he went to the hospital and got ice but did not seek further treatment because he was there for his daughter. He sought treatment the following day at Downtown Live Chiropractic and went back 25 to 30 times. The chiropractor took x-rays and told him his right knee had fractures. He believed that the chiropractor told him that the discs in his low back had moved. The chiropractor treated him on a lien basis because he had decided to seek legal help after going to the store where the injury occurred and being told to get an attorney because they were not going to help him.

The applicant testified that he was not really having any complaints currently that he attributed to the accident, and hadn’t since March 2020 because he had started exercising.

**Medical Records**

**Initial Chiropractic Report, Health History and Physical Examination, signed by Levon Nalbandyan, DC, dated September 19, 2017**

Subjective: The patient complained of lower back pain and stiffness, radiating pain to his posterior thighs, bilateral knee pain and stiffness, and right ankle pain and stiffness, all constant and at a level of seven on a scale of zero to ten. He reported nervousness and apprehension when walking on uneven surfaces and loss of sleep due to pain and anxiety. His symptoms were aggravated by exertion and reaching overhead and were alleviated to a certain degree by rest. He complained of severe headaches that had been occurring since the accident.

Objective: Dr. Nalbandyan noted that the patient was in moderate-to-severe distress due to pain during the examination and ambulated with a guarded gait. Palpatory findings were as follows: paraspinals – tenderness, hypertonicity, myospasm, and trigger points bilaterally; rhomboids – tenderness and hypertonicity bilaterally and mysospasm and trigger points on the right; pectoralis – negative; trapezius – tenderness, hypertonicity, myospasm, and trigger points bilaterally; latissimus – tenderness, hypertonicity, myospasm, and trigger points on the right; and intercostals – tenderness, hypertonicity, myospasm, and trigger points bilaterally.

Bony palpation revealed tenderness and swelling bilaterally in the costochondral junction, pectoralis, and ribs as well as the sternum. Schepelman’s and Sternal Compression were positive for pain bilaterally and maximum inspiration was positive for discomfort. Range of motion in the lumbar spine was as follows: flexion – 55/90, extension – 12/30, right lateral flexion – 30/40, left lateral flexion – 25/40, right rotation – 20/40, and left rotation – 25/40, all with pain, stiffness, and radiation.

Palpatory findings in the lumbar spine were as follows: paraspinals – tenderness, hypertonicity, myospasm, and trigger points bilaterally; piriformis – tenderness, hypertonicity, myospasm, and trigger points bilaterally; gluteals – tenderness, hypertonicity, myospasm, and trigger points bilaterally; and quadratus lumborum – tenderness, hypertonicity, myospasm, and trigger points bilaterally. Bony palpation of the sacroiliac joints was positive for tenderness on the right and of the sacrum was positive.

Straight leg raise was positive with radiating pain to the posterior thigh at 50º, and Kemp’s, Yeoman’s, and Patrick’s were positive bilaterally with radiating pain to the posterior thigh. Inspection of the right and left femorotibial joints was remarkable for edema, and palpation of the bilateral knees was remarkable for tenderness of the femorotibial joints. McMurray, anterior drawer, posterior drawer, Apley’s compression, Apley’s distraction, Lachmans’ valgus stress, and varus stress revealed local pain bilaterally.

Knee range of motion was as follows: flexion – 110/135 on the left and 115/135 on the right; extension - -4/0 on the left and -5/0; external rotation – 7/10 on the left and 8/10 on the right, and internal rotation – 6/10 on the left and 7/10 on the right, all with pain and stiffness. Inspection of the feet/ankles was remarkable for edema of the right ankle, and palpation of the right ankle was remarkable for tenderness of the anterior tibiotalar joint. Inversion stress, eversion stress, anterior drawer, and posterior drawer were positive for pain on the right. Range of motion was as follows: dorsiflexion – 10/20 on the right and 20/20 on the left; plantar flexion – 30/50 on the right and 50/50 on the left; eversion – 10/20 on the right and 20/20 on the left; and inversion – 20/30 on the right and 30/30 on the left, all with pain and stiffness.

Diagnostic testing: Dr. Nalbandyan obtained lumbar spine x-rays which showed hypolordosis of the normal lumbar curvature and levoscoliosis. Right knee and right ankle x-rays were normal.

History of injury: The patient reported that on September 17, 2017, while walking out of a store, he was involved in a slip-and-fall accident. He stated that he had suddenly tripped and fallen to his knee, causing him to drop his baby. He hit his knees on a railing and his right ankle twisted. He was disoriented, shaken, shocked, scared, and nervous.

Medical history: The patient denied a history of major illness or accidents.

Diagnoses: The diagnoses were of fall on same level from slipping, tripping, and stumbling; dorsalgia; acute traumatic thoracic spine sprain/strain; thoracic subluxation/segmental dysfunction; lumbago; acute traumatic lumbar spine sprain/strain; lumbar subluxation/segmental dysfunction; degeneration of lumbosacral intervertebral disc; sacroiliac subluxation/segmental dysfunction; acute traumatic sacroiliac joint sprain/strain; contusion of bilateral knees; stiffness of bilateral knee joints; bilateral knee sprain/strain; stiffness of ankle/foot, right; acute traumatic foot and ankle sprain/strain, right; contusion of right ankle; stiffness of cervical, thoracic, and lumbar spines; spinal enthesopathy of the cervical spine/thoracic spine/lumbar spine; acute traumatic myofascial pain syndrome; Post-Traumatic Stress Disorder; myospasms; insomnia; and nervousness.

Work status: The patient was released to return to modified work with restrictions of no exertion, bending or twisting at the waist, lifting/carrying/pushing/pulling over ten pounds, working or reaching overhead, prolonged sitting, standing, walking, or driving, walking on uneven surfaces, or stair climbing.

Treatment plan: Dr. Nalbandyan recommended a course of chiropractic manipulative therapy and a multi-modality physiotherapy regimen.

**Daily Soap Notes, signed by Levon Nalbandyan, DC, dated September 19, 2017 – January 29, 2018**

The patient received 36 chiropractic sessions during the time period.

**Letter to unspecified recipients, signed by Levon Nalbandyan, DC, dated September 29, 2017**

The patient was under Dr. Nalbandyan’s chiropractic care due to a motor vehicle accident and needed to be excused for his absences on September 19, September 23, and September 26, 2017.

**Re-Examination Form, signed by Levon Nalbandyan, DC, dated October 16, 2017**

Subjective: The patient reported mild overall improvement but was still experiencing significant lower back pain that radiated to his extremities, left greater than right, at a level of six on a scale of zero to ten; bilateral knee pain, right greater than left, at a level of five to six on a scale of zero to ten with a feeling that the knees were unstable; right ankle pain and swelling at a level of seven on a scale of zero to ten; and difficulty with weightbearing and walking for prolonged periods. He felt that his lower back pain was becoming worse due to his altered gait.

Objective: Dr. Nalbandyan noted that the patient had a limping gait favoring his right side. There was mild persistent right ankle swelling and improved bilateral knee edema with mild residual edema. There was hypertonicity and increased tone with tenderness to palpation 2+ in the bilateral thoracic and lumbar paraspinals, left greater than right, QL, and piriformis. Range of motion was mildly improved but movements were still guarded and painful. There was 2+ tenderness to palpation over L4-S1 SPs, bilateral femorotibial joints, and right talotibial joint.

Assessments: The assessments were of bilateral knee and right ankle sprain/strain; contusion of bilateral knees and right ankle/foot; lumbosacral radiculitis; thoracic spine, lumbar spine segmental dysfunction; thoracic spine, lumbar spine, S1 sprain/strain; and myofascial pain syndrome.

Treatment plan: Dr. Nalbandyan recommended continuation of treatment and referred the patient to orthopedics for concerns of right ankle and bilateral knee internal derangement due to persistent pain and swelling. He ordered a lumbosacral MRI to rule out significant disc injury given the patient’s persistent radicular symptoms, and MRIs of the bilateral knees and right ankle due to persistent swelling/edema and pain.

**Progress Notes, illegible chiropractor’s signature, dated October 16, 2017**

Subjective: The patient reported mild overall improvement, but he was still having significant lower back pain at a level of six on a scale of zero to ten that radiated to his extremities, left greater than right. He complained of bilateral knee pain at a level of five to six on a scale of zero to ten, right greater than left, and continued right ankle pain and swelling at a level of seven on a scale of zero to ten. He had difficulty with weightbearing and walking for prolonged periods. He felt that his lower back pain was getting worse due to his altered gait.

Objective: Physical examination revealed an altered gait favoring the right side. There was mild persistent swelling in the right ankle. Bilateral knee edema had improved and was currently mild. Hypertonicity and increased tone were present with tenderness to palpation 2+ in the bilateral thoracic and lumbar paraspinals, left greater than right. Range of motion was mildly improved but movement was still guarded and painful. There was tenderness to palpation 2+ over L4-S1 SPs, bilateral femorotibial joints, and right talotibial joint.

Assessments: The assessments were of bilateral knee and right ankle sprain/strain; contusion of bilateral knees and right ankle/foot; lumbosacral radiculitis; thoracic spine, lumbar spine segmental dysfunction; thoracic spine, lumbar spine sprain/strain; and myofascial pain syndrome.

Treatment plan: Continuation of the current treatment plan was recommended. The patient was referred to orthopedics for concerns of right ankle and bilateral knee internal derangement due to persistent pain and swelling. An MRI of the lumbar spine was ordered as well as an MRI of the bilateral knees and right ankle.

**Comprehensive Initial Orthopedic Consultation, signed by A. Michael Moheimani, MD, dated November 13, 2017**

Subjective: The patient reported pain in his lower back that radiated to his knees and ankles. He noted burning pain in his lower back, knees, and ankles as well as numbness of the ankles. He had been experiencing fatigue as a result of the accident. He noted trouble with bending, lifting, and sitting due to pain in his lower back and knees. Squatting increased the knee pain. He complained of pain in his lower back, knees, and ankles with walking and standing. He noted swelling of the knees and ankles and weakness of the knees.

Objective: Physical examination revealed the following: lower extremity measurements were thighs – right 59, left 60, and calves - right 8, left 49. Range of motion of the thoracolumbar spine was flexion - 45, extension – 15, right lateral bending – 25, left lateral bending – 25, and right and left rotation – 30. The patient had pain with flexion, extension, and bilateral rotation of the lumbar spine. He ambulated with a mild limp.

Range of motion of the knees was flexion – 120 on the right, 20 on the left, and extension – 0 bilaterally. Patellar crepitus was positive bilaterally. There was joint line tenderness at the bilateral medial and lateral joint lines. McMurray’s was painful bilaterally. There was mild swelling of the ankles. Range of motion was dorsiflexion – 10 bilaterally, plantar flexion – 50 bilaterally, inversion – 30 bilaterally, and eversion – 15 bilaterally.

History of injury: The patient reported that on September 17, 2017 he was walking “of a store” when he tripped over the gate rail that was on the ground and had a piece of metal sticking out of it. He fell forward and felt immediate pain in his lower back. He later developed pain in his knees and ankles. He reported that when he fell forward, he dropped his infant, who was transported via ambulance to a hospital in downtown Los Angeles. He was provided an icepack there but was not examined. He initially sought medical attention two days later with Dr. Nalbandyan, who provided him with several sessions of chiropractic which helped the pain.

Medical history: The patient was diagnosed with scoliosis in 2010 but without back pain. He denied prior knee or ankle problems.

Diagnoses: The diagnoses were of lumbosacral sprain; lumbar facet syndrome; bilateral knee contusion and sprain; and bilateral ankle sprain.

Causation: Dr. Moheimani opined that the patient’s injuries were the direct result of the accident of September 17, 2017.

Work status: The patient was working.

Treatment plan: Dr. Moheimani noted that the patient had improved with chiropractic care and needed to continue with such until he reached maximum medical improvement. As he’d had appropriate conservative management but remained symptomatic nearly two months post injury, he would need an MRI of the lumbosacral spine to evaluate for disc herniation and neural impingement. As the evaluation of his knee joints was consistent with a possible meniscal tear as a result of the accident, MRIs of the knees were also recommended, as were MRIs of both ankle joints. Dr. Moheimani prescribed Flexeril and meloxicam.

**Re-Evaluation Form, signed by Levon Nalbandyan, DC, dated November 17, 2017**

Subjective: The patient reported mild improvement in mobility, swelling, and pain. He continued to experience lower back pain that radiated to his extremities, left greater than right, at a level of five to six on a scale of zero to ten. He complained of bilateral knee pain, right greater than left, at a level of five on a scale of zero to ten with instability and weakness. He continued to report right ankle pain at a level of seven on a scale of zero to ten with improved swelling. He had difficulty with weightbearing and walking for prolonged periods and felt that his lower back pain was becoming worse due to his altered gait.

Objective: Dr. Nalbandyan noted that the patient had an antalgic gait favoring his right side. Mild right ankle swelling persisted, though it was improved from the prior exam. Bilateral knee edema had resolved. There was hypertonicity with spasm with 2+ tenderness to palpation in the bilateral thoracic and lumbar paraspinals, left greater than right, and bilateral piriformis muscles bilaterally. Range of motion was improving but the patient’s movements were still guarded and painful. There was 2+ tenderness to palpation over L4-S1 SPs and R SI joint, bilateral femorotibial joints, and right talotibial joint.

Assessments: The assessments were of bilateral knee and right ankle sprain/strain; contusion of bilateral knees and right ankle/foot; lumbosacral radiculitis; thoracic spine, lumbar spine segmental dysfunction; thoracic spine, lumbar spine, sacroiliac sprain/strain; and myofascial pain syndrome.

Treatment plan: Dr. Nalbandyan recommended continuation of treatment and repeated his request for MRIs of the lumbar spine, bilateral knees, and right ankle.

**MRI of the Lumbar Spine, signed by George Elias, MD, dated November 29, 2017**

The impressions were of 4-mm midline disc protrusion at L4-L5 resulting in abutment of the descending L5 nerve roots bilaterally with a mild degree of central canal narrowing and a 3-mm midline disc protrusion at L5-S1 possibly resulting in abutment of the descending S1 nerve roots bilaterally. Dr. Elias noted that the examination was limited.

**MRI of the Left Knee, signed by George Elias, MD, dated November 29, 2017**

The impressions were of lateral patellar tilt and subluxation with mild chondromalacia of the patella, and small joint effusion. No meniscal tear, fracture, or contusion was seen.

**MRI of the Left Knee, signed by George Elias, MD, dated November 29, 2017**

The impressions were of small joint effusion and lateral patellar tilt and subluxation with mild chondromalacia of the patella. Subcutaneous soft tissue edema was noted anteriorly.

**Progress Report, signed by A. Michael Moheimani, MD, dated December 11, 2017**

Subjective: The patient complained of low back pain with radiation to the bilateral lower extremities as well as bilateral knee and ankle pain.

Diagnoses: The diagnoses were of moderate disc herniations at L4-L5 and L5-S1 with nerve root impingement; bilateral knee lateral subluxation of the patella with chondromalacia patella; and bilateral ankle sprain.

Work status: The patient was released to return to modified work with the restriction of avoidance of heavy lifting.

Treatment plan: Dr. Moheimani recommended a lumbar epidural injection at L4-L5 for improvement in low back pain and radicular symptoms. The approximate global cost for the procedure would be $11,000 per injection. He also recommended a right knee PRP injection for improvement in pain and function at a cost of $1,500. He continued to recommend a right ankle MRI to further evaluate the injury.

**Re-Examination Form, signed by Levon Nalbandyan, DC, dated December 13, 2017**

Subjective: The patient was feeling better overall. He reported lower back pain with occasional radiation to the lower extremities, left greater than right, at a level of four on a scale of zero to ten. He complained of bilateral knee pain, right greater than left, at a level of three to four on a scale of zero to ten and continued right ankle pain at a level of five on a scale of zero to ten. He still experienced mild difficulty with increased pain with weightbearing and walking for extended periods.

Objective: The patient ambulated with a mild antalgic gait. The right ankle swelling and bilateral knee edema had resolved. There was hypertonicity and spasm with tenderness to palpation 1+ in the bilateral thoracic and lumbar paraspinals, left greater than right, and bilateral piriformis muscles bilaterally. Range of motion was still improving but the patient’s movements were still guarded and painful. There was tenderness to palpation 1+ over the L4-S1 SPs and right sacroiliac joint, left femorotibial joint, and right talotibial joint.

Assessments: The assessments were of bilateral knee and right ankle sprain/strain; contusion of bilateral knees and right ankle/foot; lumbar spine radiculitis; thoracic spine, lumbar spine segmental dysfunction; thoracic spine, lumbar spine sacroiliac sprain/strain; myofascial pain syndrome; multiple lumbar spine disc herniations per MRI; bilateral subluxation of patella with chondromalacia per MRI; and tendinosis and edema of right ankle per MRI.

Treatment plan: Dr. Nalbandyan recommended continuation of chiropractic treatment and follow up with orthopedic treatment.

**MRI of the Left Knee, Second Opinion, signed by Martin Wieler, MD, dated January 7, 2018**

The impressions were of subcutaneous edema anterior to the patellar tendon with the possibility of bruising edema to the area being given a consideration, and mild lateral subluxation of the patella related to a shallow trochlear groove of the femur with laxity of the medial retinacular fiber. Cruciate ligaments were intact, and no meniscal tears were seen.

**MRI of the Right Ankle, signed by Saeed Yadegar, MD, dated January 24, 2018**

This was an unremarkable exam.

**Final Chiropractic Report, Discharge Examination and Recommendations, signed by Levon Nalbandyan, DC, dated January 29, 2018**

Record review: Dr. Nalbandyan reviewed records from A. Michael Moheimani, MD as well as multiple MRIs.

Subjective: During the course of treatment the patient had reported gradual and steady symptomatic improvement with the occurrences of flare-ups and exacerbations noted. He complained of mild intermittent lumbar spine pain at a level of one to three on a scale of zero to ten with stiffness aggravated by activities of daily living, 90% improved. He reported mid and upper back pain and stiffness, radiating pain to the posterior thighs, and bilateral knee pain and stiffness, all improved. He complained of nervousness and apprehension when walking on uneven surfaces and loss of sleep due to pain and anxiety.

Objective: Lumbar spine extension was 20/30, lumbar left lateral flexion was 30/40, and lumbar right rotation was 30/40. There was hypertonicity/spasm of the thoracolumbar paraspinal muscles upon palpation and tenderness of the spinous processes of L2-L5. Kemps was positive for local lower back pain.

Activities of daily living: The patient continued to endorse difficulty with traveling (prolonged sitting or driving) and lifting/carrying over 15 pounds at or above shoulder level.

Diagnoses: The diagnoses were of fall on same level from slipping, tripping, and stumbling; dorsalgia; acute traumatic thoracic spine sprain/strain; thoracic subluxation/segmental dysfunction; lumbago; acute traumatic lumbar spine sprain/strain; lumbar subluxation/segmental dysfunction; degeneration of lumbosacral intervertebral disc; multiple lumbar spine intervertebral disc protrusions (L4-L5: 4 mm; L5-S1: 3 mm) resulting in abutment of the descending nerve roots bilaterally with a mild degree of central canal narrowing; sacroiliac subluxation/segmental dysfunction; acute traumatic sacroiliac joint sprain/strain; contusion of bilateral knees; stiffness of bilateral knee joints; bilateral joint effusion of knees per MRI; stiffness of bilateral knee joints; chondromalacia of the bilateral patella per MRI; bilateral knee sprain/strain; stiffness of right foot/ankle; acute traumatic right foot and ankle sprain/strain; contusion of right ankle; stiffness of cervical, thoracic, and lumbar spines; spinal enthesopathy of the cervical spine/thoracic spine/lumbar spine; acute traumatic myofascial pain syndrome; Post-Traumatic Anxiety Syndrome; Post-Traumatic Stress Disorder; myospasms; insomnia; and nervousness.

Causation: Dr. Nalbandyan opined that it was apparent that the patient’s injuries were the direct result of the accident of September 19, 2017.

Whole person impairment rating: Dr. Nalbandyan rated the patient’s lumbar spine impairment at 6% whole person impairment.

Treatment plan: Dr. Nalbandyan noted that the patient would continue to have residuals and that his prognosis remained guarded. He recommended that provisions be made for regular chiropractic care, physiotherapy, medical consultations, and diagnostic studies such as follow up x-rays or MRIs for flare-ups.

**MRI of the Right Ankle, Second Opinion, signed by Martin Wieler, MD, dated February 4, 2018**

The impressions were of fluid abutting against the posterior tibial tendon – a post-traumatic tendinosis was suspected, and mild tibiotalar joint effusion. No fractures were seen.

**Progress Report, signed by A Michael Moheimani, MD, dated March 5, 2018**

Record review: Dr. Moheimani reviewed the right ankle MRI read by Dr. Saeed Yadegar on January 24, 2018 and the right ankle MRI second opinion reading by Dr. Martin Wieler.

Subjective: The patient reported that his low back, bilateral knee, and bilateral ankle pain was improving with home exercise. His pain was worsened with prolonged standing and walking.

Objective: Range of motion examination of the thoracolumbar spine revealed the following: flexion – 45/70, extension – 15/30, right lateral bending – 25/25, left lateral bending – 25/25, right rotation – 30/30, and left rotation – 30/30. Range of motion in the knees was right 120/120 and left 120/120 in flexion and right 0/0 and left 0/0 in extension. Range of motion examination of the ankles revealed the following: dorsiflexion – 15/20 bilaterally, plantar flexion – 40/40 bilaterally, inversion 30/30 bilaterally, and eversion - 25/20 bilaterally.

Diagnoses: The diagnoses were of moderate disc herniations at L4-L5 and L5-S1 with nerve root impingement; bilateral knees lateral subluxation of the patella with chondromalacia patella; bilateral ankle sprains; and right ankle posterior tibial tendinosis with joint effusion.

Work status: The patient was released to return to modified work with the restriction of avoidance of heavy lifting and deep knee bending.

Treatment plan: Dr. Moheimani recommended a lumbar epidural injection at L4-L5 should the patient’s low back pain worsen; a right knee PRP injection should his pain worsen in this area; and home exercises in terms of walking on a treadmill, warm water swimming, and use of a stationary bicycle should his right ankle pain worsen. It was expected that he would have flare-ups that would require a short course of chiropractic therapy and physical therapy episodically. The estimated average global cost of this treatment was $1,000 - $2,000 annually for as long as the patient remained symptomatic. He recommended the use of Tylenol and ibuprofen as needed.

**Progress Report, signed by A Michael Moheimani, MD, dated April 16, 2018**

Record review: Dr. Moheimani reviewed a lumbar spine MRI by Dr. George Elias dated November 29, 2017.

Subjective: The patient was seen for assessment prior to a lumbar epidural injection with PRP at L4-L5 with a right knee PR injection scheduled for May 4, 2018. He complained of low back pain that was worsened with prolonged sitting and right knee pain that was worsened with walking.

Objective: Range of motion examination of the lumbar spine was as follows: flexion – 40/70 with pain, extension – 15/30, right lateral bending – 20/25, left lateral bending – 20/25, right rotation – 25/30, and left rotation – 25/30. Range of motion in the knees was flexion – 130/150 bilaterally, and extension – 0/0 bilaterally. McMurray’s was painful in the right knee.

Diagnoses: The diagnoses were of moderate disc herniations at L4-L5 and L5-S1 with nerve root impingement; bilateral knee lateral subluxation of the patella with chondromalacia patella; bilateral ankle sprains; and right ankle posterior tibial tendon tendinosis with joint effusion.

Work status: The patient was released to return to modified work with the restriction of avoidance of heavy lifting and deep knee bending.

Treatment plan: Dr. Moheimani recommended proceeding with the injections as planned. He advised the patient to refrain from strenuous activities and from taking anti-inflammatory medication for six weeks to allow for the PRP solution to provide maximum healing process. He suggested Tylenol for significant pain.

**Operative Report, signed by Michael Moheimani, MD, dated May 4, 2018**

The pre- and post-operative diagnoses were of moderate disc herniations at L4-L5 and L5-S1 with nerve root impingement and right knee injury with MRI evidence of chondromalacia patella and lateral subluxation. Right knee lumbar epidural at L4-L5, epidurography of lumbar spine with radiographic interpretation, and right knee intraarticular PRP injection with ultrasound guidance were performed.

**Progress Report, signed by A Michael Moheimani, MD, dated May 14, 2018**

Subjective: The patient reported improvement in low back pain from five on a scale of zero to ten to two on a scale of zero to ten and improvement in right knee pain from six on a scale of zero to ten to one on a scale of zero to ten following the injections.

Objective: Range of motion examination of the lumbar spine revealed the following: flexion – 50/70, extension – 20/30, right and left lateral bending – 25/25, and right and left rotation – 30/30. Range of motion examination of the knees revealed flexion of 130/150 bilaterally and extension of 0/0 bilaterally.

Diagnoses: The diagnoses were of moderate disc herniations at L4-L5 and L5-S1 with nerve root impingement; bilateral knee lateral subluxation of the patella with chondromalacia patella; bilateral ankle sprains; and right ankle posterior tibial tendon tendinosis with joint effusion.

Work status: The patient was released to return to modified work with the restriction of avoidance of heavy lifting and deep knee bending.

Treatment plan: Dr. Moheimani advised the patient to refrain from strenuous activities and from taking ant-inflammatory medication for six weeks to allow the PRP solution to provide maximum healing process. He could use Tylenol for significant pain.

**Progress Report, signed by A. Michael Moheimani, MD, dated June 14, 201**

Subjective: The patient reported further improvement in his low back pain since the previous visit, rating the pain there as well as in his right knee at a level of one on a scale of zero to ten. He reported some difficulty with prolonged walking but his ability to walk was significantly improved following the injections.

Objective: Range of motion examination of the lumbar spine revealed the following: flexion – 45/70, extension – 20/30, right and left lateral bending – 25/25, and right and left rotation – 30/30. Range of motion examination of the knees revealed flexion at 130/130 bilaterally and extension at 0/0 bilaterally.

Diagnoses: The diagnoses were of moderate disc herniations at L4-L5 and L5-S1 with nerve root impingement; bilateral knee lateral subluxation of the patella with chondromalacia patella; bilateral ankle sprains; and right ankle posterior tibial tendon tendinosis with joint effusion.

Work status: The patient was released to return to modified work with the restriction of avoidance of heavy lifting and deep knee bending.

Treatment plan: Dr. Moheimani recommended repeat injections to the patient’s lumbar spine and right knee should his pain worsen. He also recommended a home exercise program in terms of walking on a treadmill, warm water swimming, and use of a stationary bicycle for further functional improvement. It was expected that he would have flare-ups which would require a short course of chiropractic care and physical therapy episodically. The estimated cost of this treatment would be $1,000 - $2,000 annually for as long as the patient remained symptomatic.

End ROR.