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INDEPENDENT MEDICAL EXAMINATION

RECORD / PEER REVIEW REPORT

Prepared in accordance with AMA Guides to the Evaluation of Permanent Impairment, 6th Edition, where applicable

Claimant:	[redacted]
Date of Birth / Age at DOI:	[redacted] / 69 years old
Date of Injury / Loss:	8/23/2025
Date of Report:	8/5/2026
Claim / File Number(s):	Claim No. [redacted] ([redacted]) / [redacted] File #[redacted] / Physician File #[redacted]
Jurisdiction / Line of Coverage:	Oklahoma; automobile / medical payments (No-Fault/med-pay) claim
Referral Source:	[redacted], on behalf of [redacted] (Adjuster: [redacted])
Type of Review:	Records/peer review only — no examinee was seen
Examining/ Reviewing Physician:	Leslie Welch, D.C., CICE, NRCME

Claimant:	[redacted]
Provider(s)/ Treatment Under Review:	[redacted], D.C. — [redacted], [redacted]

Table of Contents

I. Purpose, Scope, and Methodology of Review

This report was prepared at the request of [redacted], on behalf of [redacted], for the purpose of providing an independent, objective medical opinion regarding the reasonableness and medical necessity of the chiropractic care rendered to the claimant, the appropriateness of the specific modalities used (including Alpha-Stim/microcurrent therapy), causation and the causal relationship of the claimed conditions to the 8/23/2025 incident, the contribution of pre-existing/degenerative findings, and the necessity of ongoing chiropractic care. The specific referral questions posed are restated verbatim in Section XI below.

This is a records/peer review only. No examinee was seen; this report is based entirely on the written records identified in Section II.

II. Records Reviewed

The following is an index of all records reviewed, by provider/source, with date range and page references to the source file ([redacted], 177 pages, as provided by [redacted]):

- [redacted] — Trauma Emergency Department. [redacted], MD (Emergency Medicine). DOS: 8/23/2025. After-Visit Summary, full ER chart, imaging reports, medication administration record, discharge instructions/patient education materials. (pp. 1–20)
- [redacted] (claimant's counsel) — correspondence to [redacted]/Adjuster [redacted] re: medical specials demand, dated 6/24/2026, with undated follow-up invoice. (pp. 21, 171)
- [redacted] — [redacted], DC. Billing ledger, all dates of service, CPT codes, and charges, 8/29/2025–12/30/2025. (pp. 22–26)
- [redacted] — [redacted], DC. Initial History and Initial Examination (DOS 8/29/2025) and 34 subsequent Daily Note visit records, DOS 9/2/2025–12/30/2025. (pp. 27–170)
- EMSA (ambulance) — CMS-1500 claim form, DOS 8/23/2025, HCPCS A0427 (ALS emergency transport) plus mileage, billed $1,423.50. (p. 172)
- LexisNexis Risk Solutions / Tulsa Police Department — Oklahoma Official Collision Report #[redacted], including 9/9/2025 amended supplement regarding the at-fault driver's citations; reporting officer [redacted]. (pp. 173–177)

No records were identified in the file from [redacted], MD (the family-medicine follow-up recommended at ER discharge), from any neurologist or allergist (referenced by the claimant at the ER visit as an existing, ongoing work-up for chronic headaches), from any orthopedic or PM&R specialist, or from any imaging beyond the 8/23/2025 ER CT of the head and cervical spine. See Section X regarding these gaps.

III. Case Snapshot / Identifying Information

Date/Mechanism of Injury:	**8/23/2025; rear-end motor vehicle collision at a signalized intersection while claimant's vehicle was slowing for traffic**
Setting/Circumstances:	Motor vehicle collision, [redacted], Tulsa, OK; claimant's 2009 Honda Civic struck from behind by a 2012 Mazda 6; at-fault driver fled the scene (hit and run) and was later cited
Initial Treatment:	EMSA ambulance transport to [redacted] Trauma Emergency; evaluated by [redacted], MD; discharged same day
Course of Treatment at Issue:	[redacted], [redacted], DC; 35 total visits (1 initial exam + 34 treatment visits), 8/29/2025–12/30/2025 (~4 months, 1 week); total billed $5,350.00
Referral Questions (short form):	Reasonableness/necessity of duration and frequency of chiropractic care; appropriateness of modalities including Alpha-Stim/MENS for headache and dizziness; causation and pre-existing-condition analysis; necessity of ongoing care

IV. Chronological Medical Summary

This section is factual and chart-based. Opinion and analysis are reserved for Sections VI–IX.

IV.A — Mechanism of Injury (Per Incident/Police Report)

At approximately 12:45–12:46 PM on Saturday, 8/23/2025, the claimant was driving eastbound on 31st Street in Tulsa, Oklahoma, and was slowing for traffic stopped at a signal when her vehicle was struck from behind by a 2012 Mazda 6 driven by [redacted]. Per the responding officer's original narrative, [redacted] exited his vehicle, approached the claimant's window, then re-entered his vehicle and fled the scene eastbound without exchanging information. The claimant reported head and neck pain at the scene and was transported by EMSA ambulance to [redacted]. Her vehicle remained drivable and was

retrieved by family. A supplemental report dated 9/9/2025 documents that [redacted] later surrendered to police, admitted he had been eating and was not paying attention to traffic, and was cited for Inattentive Driving, Hit & Run, Duty to Report an Injury Collision, and Obstruction of the Accident Investigator (Tulsa PD Report #[redacted]).

The chiropractic intake history records the claimant's self-reported estimate of impact speed as "35–45 mph." The police report does not independently document vehicle speed, EDR data, or accident-reconstruction findings, and the officer's narrative — claimant "slowing for traffic stopped at the light," struck from behind — together with the property-damage narrative describing "minor damage" to both vehicles, is more consistent with a lower-speed, congested-traffic rear-end impact. This discrepancy between the uncorroborated self-reported speed estimate and the objective accident record is addressed further in Section VII.B (Mechanism Plausibility).

IV.B — Emergency/Urgent Care

The claimant was evaluated at [redacted] Trauma Emergency on 8/23/2025 by [redacted], MD (arrival 1332; discharge 1534). Chief complaint: motor vehicle crash, headache, nausea. Vitals were notable for elevated blood pressure (170/94), with pulse 69, temperature 98.2°F, respirations 18, and SpO2 95%. Physical examination was largely benign: no acute distress; normocephalic/atraumatic; neck supple with no midline cervical spine tenderness to palpation; no seatbelt sign on chest or abdomen; abdomen soft and non-tender; neurologically intact with no focal deficit; alert and oriented x3; mood and behavior normal.

CT head without contrast was negative, showing no evidence of acute infarction, hemorrhage, extra-axial fluid collection, or mass effect (impression: no significant intracranial abnormality). CT cervical spine without contrast showed no acute fracture or dislocation and no radiographically significant paraspinous hematoma; however, it identified uncovertebral joint spurring and facet arthrosis producing left-greater-than-right neural foraminal stenosis at C3-4, posterior vertebral body spurring resulting in central canal stenosis at C5-6, and left foraminal stenosis at C6-7 — multilevel degenerative findings that necessarily pre-date the collision. These findings are addressed in the causation analysis at Section VII.C.

In the ER, the claimant received ondansetron (Zofran-ODT) 4 mg PO, ibuprofen (Advil/Motrin) 800 mg PO, and ketorolac tromethamine (Toradol) 30 mg, and was discharged with a new prescription for methocarbamol (Robaxin) 500 mg PO three times daily as needed for muscle spasm, for up to five days. Diagnoses assigned were MVC, initial encounter (V87.7XXA) and headache (R51.9); disposition was discharge home, condition documented as "improved." Follow-up was recommended with [redacted], MD (Family Medicine) in approximately one week (around 8/30/2025), "as needed," and a return to [redacted] if symptoms worsened.

The ER record also documents the claimant's active home medication list at the time of the incident, reproduced below:

Medication	Common Name	Class / Purpose
Methocarbamol 500 mg (new, started at ER discharge)	Robaxin	Muscle relaxant — PRN, up to 5 days
Acyclovir 400 mg	Zovirax	Antiviral
Albuterol HFA 108mcg inhaler	ProAir / Proventil / Ventolin	Bronchodilator
Alendronate 70 mg	Fosamax	Osteoporosis (bisphosphonate)
Aspirin 81 mg	Low-dose aspirin	Cardiac/stroke prophylaxis
Atorvastatin 40 mg	Lipitor	Cholesterol
Estradiol 0.1mg/gm vaginal cream	Estrace	Hormone
Fexofenadine 180 mg	Allegra	Antihistamine/allergy
Fish oil 1000 mg	—	Supplement
Fluticasone-vilanterol 100-25mcg inhaler	Breo Ellipta	Asthma/COPD
Glucosamine Chondroitin Complex	—	Supplement
Lisinopril-hydrochlorothiazide 20-12.5 mg	Prinzide / Zestoretic	Blood pressure
Methylprednisolone 4 mg	Medrol Pak	Steroid
Montelukast 10 mg	Singulair	Asthma/allergy
Paroxetine 20 mg	Paxil	Antidepressant (SSRI)
Phentermine-Topiramate ER 3.75-23 mg	Qsymia	Weight management
Systane Complete 0.6%	—	Ophthalmic (eye drops)
Vitamin D3 25mcg (1000 IU)	Cholecalciferol	Supplement
Zinc 50 mg	—	Supplement

Of particular relevance to causation, the claimant told ER staff that she was "currently working with an outpatient neurology and allergist for determining cause of her chronic

headache symptoms" and declined additional new medication because she did not want it to affect upcoming allergy testing — documenting an active, pre-existing headache work-up independent of the accident. This is independently corroborated by her home medication list above, which includes fexofenadine (Allegra), montelukast (Singulair), and fluticasone-vilanterol (Breo Ellipta) — an allergy/asthma medication cluster consistent with active allergy management. Past surgical history was limited to cesarean section and skin cancer excision; family history was notable for COPD (mother), stroke (father), and dementia (father); social history was negative for tobacco, vaping, alcohol, and drug use. No record in the file documents that the recommended follow-up with Dr. ■■■■■■■■ occurred, and no records from the claimant's pre-existing neurologist or allergist were provided (see Section X).

IV.C — Subsequent/Index Treatment Under Review: ■■■■■■■■■■■■■■■■■■■■■■■■■■■■

The claimant presented for chiropractic evaluation on 8/29/2025, six days after the MVC, and was seen for an Initial History and Initial Examination by ■■■■■■■■■■■■■■■■■, DC, followed by 34 additional "Daily Note" visits through 12/30/2025 — 35 total visits over approximately 4 months and 1 week.

Initial subjective complaints (8/29/2025), all described as occurring 90–100% of the day at moderate intensity:

- Neck pain 7/10; thoracic stiffness 5/10; low back pain 7/10; cervical stiffness 6/10; cervical restriction 6/10; headaches 7/10; dizziness/imbalance 7/10; right hip pain 7/10; left shoulder pain 7/10.

Initial objective findings (8/29/2025):

- Palpatory: spinal asymmetry/fixation C4–C6 (right greater than left) with spasm of the paraspinal muscles, scalenes, SCM, upper/mid trapezius, and rhomboids (bilateral, moderate); spinal asymmetry/fixation L4–L5 (right greater than left) with lumbar paraspinal spasm (bilateral, moderate).
- Cervical ROM: Flexion 30° (60% of normal); Extension 30° (50%); Left lateral flexion 25° (55%); Right lateral flexion 30° (66%); Left rotation 60° (75%); Right rotation 65° (81%).
- Lumbar ROM: Flexion 30° (50%); Extension 15° (60%); Left lateral flexion 20° (80%); Right lateral flexion 15° (60%).
- Positive orthopedic tests: cervical — lateral flexion compression, rotation compression, maximum cervical rotatory compression, cervical distraction; lumbar — Kemp's test, straight leg raise. Upper-extremity reflexes and strength were within normal limits; cognitive screening was normal.

Diagnoses assigned at intake (unchanged verbatim through all 35 visits):

- Segmental/somatic dysfunction, lumbar region (M99.03); Lumbalgia, unspecified (M54.50); Segmental/somatic dysfunction, cervical region (M99.01); Cervicalgia, unspecified (M54.2); Segmental/somatic dysfunction, thoracic region (M99.02); Headache, unspecified (R51.9); Muscle contracture, unspecified site (M62.40); Pain in/around left shoulder joint (M25.512).

Initial treatment plan:

- Chiropractic manipulative treatment (CMT, 98940), myofascial release (97140), muscle stimulation (97014), and ultrasound (97035), rotated across visits; home ice/heat, home NSAID use, and a home exercise program as tolerated.

Visit-by-Visit / Serial Treatment Trend Table

Values marked with were charted using descriptive phrasing (e.g., "greater," "slightly worse") without a re-stated discrete number in that portion of the record; the last clearly charted numeric value is carried forward for trend purposes. Neck = neck pain; Low Back = low back pain; Headache = headache; Dizzy = dizziness/imbalance; Hip = hip pain (charted as right hip only through approximately 10/13/2025, then inconsistently as "Right/Left" hip thereafter — see Section V); Shoulder = left shoulder pain. **Scale is 0–10 as charted by the treating provider.*

Date	Visit Type	Neck	Low Back	Headache	Dizzy	Hip	Shoulder	Modalities Billed
8/29/25	Initial Hx/Exam	7	7	7	7	7 (R hip)	7	CMT, myofascial, muscle stim, US
9/02/25	Daily Note	7	7	7	7	7	7	CMT, myofascial, muscle stim
9/03/25	Daily Note	7	7	6	7	7	7	CMT, US, muscle stim
9/05/25	Daily Note	7	7	6	7	7	7	CMT, myofascial, muscle stim
9/08/25	Daily Note	7	7	5	7	7	6	CMT, US, muscle stim
9/10/25	Daily Note	7	7	4	7	7	6	CMT, US, muscle stim
9/12/25	Daily Note	7	7	4	5	5	6	CMT, US, muscle stim
9/15/25	Daily Note	7	7	4	5	5	6	CMT, myofascial, muscle stim
9/17/25	Daily Note	7	6	4	5	4	6	CMT, myofascial, muscle stim

Date	Visit Type	Neck	Low Back	Headache	Dizzy	Hip	Shoulder	Modalities Billed
9/19/25	Daily Note	7	6	4	5	4	6	CMT, myofascial, muscle stim
9/22/25	Daily Note	7	6	4	5	5	5	CMT, myofascial, muscle stim
9/24/25	Daily Note	7	6	5	6	6	4	CMT, myofascial, muscle stim, US, + Alpha-Stim (NEW)
10/01/25	Daily Note	7	7	6	6	6	4	CMT, myofascial, muscle stim, Alpha-Stim
10/06/25	Daily Note	7	7	6	6	6	4	CMT, myofascial, muscle stim, Alpha-Stim
10/08/25	Daily Note	5	6	5	5	6	4	CMT, myofascial, muscle stim, Alpha-Stim
10/10/25	Daily Note	4	5	5	4	6	3	CMT, US, muscle stim, Alpha-Stim
10/13/25	Daily Note	5	6	5	4	6	3	CMT, myofascial, muscle stim, Alpha-Stim
10/16/25	Daily Note	4	5	4	3	5	3	CMT, myofascial, US, muscle stim, Alpha-Stim
10/20/25	Daily Note	4	5	4	3	5	3	CMT, myofascial, muscle stim, Alpha-Stim
10/23/25	Daily Note	3	4	4	3	4	3	CMT, myofascial, muscle stim, Alpha-Stim
10/27/25	Daily Note	3	4	4	3	4	2	CMT, US, muscle stim, Alpha-Stim
10/30/25	Daily Note	3*	4*	5	3	4	2	CMT, US, muscle stim, Alpha-Stim
11/03/25	Daily Note	3	4*	5	3	4	2	CMT, US, muscle stim, Alpha-Stim
11/06/25	Daily Note	3	4*	5	3	4	2	CMT, US, muscle stim, Alpha-Stim
11/10/25	Daily Note	3	4*	4*	3*	4*	2*	CMT, US, muscle stim, Alpha-Stim
11/12/25	Daily Note	3	4*	4	3	4	2	CMT, US, muscle stim, Alpha-Stim
11/17/25	Daily Note	3	4	3-4	3	4	2	CMT, myofascial, US, muscle stim, Alpha-Stim
11/20/25	Daily Note	3	4*	3-4	2	4	2	CMT, myofascial, muscle stim, Alpha-Stim

Date	Visit Type	Neck	Low Back	Headache	Dizzy	Hip	Shoulder	Modalities Billed
11/24/25	Daily Note	3	4*	3	2	4	2	CMT, US, muscle stim, Alpha-Stim
12/05/25	Daily Note (post-Thanksgiving)	3	4*	3	1-2	4	2	CMT, US, muscle stim, Alpha-Stim
12/09/25	Daily Note	3	4*	3	1-2	3	1-2	CMT, US, muscle stim, Alpha-Stim
12/12/25	Daily Note	3	4*	3	1-2	3	1-2	CMT, US, muscle stim, Alpha-Stim
12/15/25	Daily Note	3*	4*	3	1	3	1-2	CMT, US, muscle stim, Alpha-Stim
12/18/25	Daily Note	3*	4*	3	1	3	1	CMT, US, muscle stim, Alpha-Stim
12/30/25	Daily Note (final visit in file, post-holidays)	3	4	4	1	4	1	CMT, US, muscle stim, Alpha-Stim

Chart Interpretation

- Visits 1–11 (8/29/2025–9/22/2025, approximately 3.5 weeks): Neck, low back, dizziness, hip, and shoulder pain ratings remain at 6–7/10 throughout this period. Headache is the only complaint to decline in this span, from 7/10 to 4/10.
- Visit 11 (9/24/2025): Alpha-Stim/microcurrent therapy is added to the treatment plan. No cervical or lumbar range-of-motion measurements or orthopedic tests are re-administered at this visit or at any subsequent visit in the file.
- Visits 12–20 (10/1/2025–10/23/2025, approximately 4.5 weeks): Pain ratings decline gradually across most complaints — neck pain from 7/10 to 3/10, low back pain from 7/10 to 4/10, dizziness from 6/10 to 3/10, and shoulder pain from 4/10 to 3/10.
- Visits 21–35 (10/27/2025–12/30/2025, approximately 9.5 weeks): Pain ratings fluctuate within a narrow range for the remainder of the file — neck pain at 3/10, low back pain at 3–4/10 (no value below 3/10 is charted in this span), headache at 3–5/10, dizziness at 1–3/10, hip pain at 3–4/10 (no value below 2/10 is charted), and shoulder pain at 1–2/10. Values increase intermittently around 10/30/2025, 11/3/2025, and 12/5/2025 (post-Thanksgiving) and 12/30/2025 (post-December-holiday) before returning to the prior range. No visit in this span, or in the file overall after 8/29/2025, documents a numeric value of 0 for any complaint, and no

cervical or lumbar ROM or orthopedic testing is re-administered at any point after the 8/29/2025 intake.

Notable trend observations:

- Pain ratings were essentially flat (neck, low back, dizziness, hip, and shoulder all at 6–7/10) from the 8/29/2025 intake through approximately 9/22/2025 — the first 11 visits, roughly 3.5 weeks of care — with only headache showing early improvement (7→4/10 by 9/10).
- A modest, generally sustained improvement trend begins around 10/8–10/16/2025 (roughly visits 15–18, approximately 6–7 weeks into care), with neck pain reaching 3–4/10 and most other complaints trending into the 3–5/10 range.
- From approximately 10/23/2025 (visit ~20) through the final charted visit on 12/30/2025 (visit 35), symptom ratings plateau in the 1–4/10 range with intermittent upticks (e.g., after the Thanksgiving and December holidays); no visit documents full resolution, and no visit after 8/29/2025 re-administers objective measures (ROM, orthopedic testing).
- Dizziness and left shoulder pain show the most consistent improvement (7/10 → 1/10 by the final visits); low back pain and hip pain show the least improvement, remaining in the 3–4/10 range through 12/30/2025.

Alpha-Stim microcurrent therapy was first introduced on 9/24/2025 (visit 11 of 35, approximately 4 weeks into care) with the stated purpose "to reduce the headaches and dizziness," and was then documented at every subsequent visit through 12/30/2025 — 24 total visits — without interruption. It does not appear as a separately billed line item on the billing ledger (the ledger reflects only 98940, an alternating 97140/97035, and 97014 at each visit).

IV.D — Other Providers / Interval History

No subsequent provider records, emergency-department returns, specialist consultations, or gaps in treatment beyond the intervals noted above (e.g., the Thanksgiving and December-holiday intervals) appear in the file. The recommended one-week follow-up with ■■■■■■■■■■■■■■■■■■■■■, MD (Family Medicine) is not documented as having occurred, and no records from the claimant's pre-existing outside neurologist or allergist (referenced at the ER visit) were provided. See Section X.

V. Documentation Observations (Factual / Pattern-Level)

The observations below concern documentation and process gaps in the chiropractic record — not the manipulative technique or overall quality of hands-on care, which are addressed separately in Section IX. Chiropractic manipulation was performed at every visit without any noted complication, and the claimant's own charted pain ratings show

measurable improvement through the earlier portion of the treatment course before symptoms plateaued.

- Diagnosis list identical at all 35 visits. The same eight ICD-10 codes appear verbatim in every Initial History, Initial Exam, and all 34 Daily Notes from 8/29/2025 through 12/30/2025, without addition, subtraction, or resolution of any diagnosis over four months of care.
- No re-examination/re-assessment visit is documented anywhere in the file. Cervical and lumbar ROM measurements and orthopedic testing (Kemp's, straight leg raise, compression/distraction tests) were performed and charted only once, at the 8/29/2025 intake, and were never re-measured or re-administered at any of the subsequent 34 visits. Improvement after intake is documented only via subjective pain-scale narrative and general palpatory descriptors, not objective, reproducible measures.
- The Initial Examination note's "PLAN" section identifies the modalities to be used (chiropractic manipulation, myofascial release, ultrasound, muscle stimulation) but does not specify a defined number of visits, a prescribed visit frequency, or an anticipated treatment endpoint. No subsequent note in the file documents such a plan. However, the actual dates of service reflect a discernible, consistent day-of-week pattern: visits occurred on a Monday/Wednesday/Friday (three-times-weekly) schedule from approximately 9/8/2025 through 9/24/2025, then shifted to an approximately Monday/Thursday (twice-weekly) schedule from approximately 10/13/2025 through the remainder of care. No note in the file documents a reassessment, clinical rationale, or objective finding associated with this change in frequency.
- No formal discharge summary, maximum medical improvement (MMI)/plateau determination, or documented discussion of care-plan modification appears anywhere in the file, notwithstanding that symptom ratings plateaued (fluctuating 1–4/10, with intermittent increases) for the final approximately ten weeks of care (roughly 10/23/2025–12/30/2025).
- Hip-pain laterality is inconsistent in the chart. The initial 8/29/2025 exam and early visits document "Right Hip Pain" only; beginning around 10/16/2025 the same complaint is re-labeled "Right/Left Hip Pain" without any interval history explaining a new left-sided onset, trauma, or exacerbating event.
- No referral to any other provider (orthopedics, neurology, PM&R, pain management) is documented at any point in the four-month chiropractic course, notwithstanding persistent headache and dizziness complaints that the claimant had told the ER she was already separately being worked up for by an outside neurologist/allergist prior to the accident.
- No imaging beyond the 8/23/2025 ER CT (head and cervical spine, both without contrast) appears anywhere in the file. No MRI was obtained despite four months of persistent axial complaints and a plateau in symptom improvement.

- The chiropractic record does not reflect that any attempt was made to obtain records or prior imaging from the claimant's pre-existing outside neurology and allergy work-up. Given that this work-up was already underway for chronic headache symptoms at the time of the accident, it is reasonably likely that some form of prior neurological imaging exists from that work-up; no such prior imaging was requested or referenced at any point in the 35-visit chiropractic course.
- No X-rays or any other independent imaging were obtained by the chiropractor at intake or at any point during the 35-visit course. The Initial History note does not cite or reference the actual 8/23/2025 ER CT report; instead, it records the imaging results as relayed verbally by the claimant ("per claimant, no fractures/dislocations"). If the treating chiropractor independently obtained or reviewed the CT report itself, that review is not documented anywhere in the file; the chart as written reflects reliance on the claimant's verbal account alone. Chiropractic manipulation (CMT) was initiated at the first visit, 8/29/2025, on this basis.
- The claimant's home medication list, including alendronate (Fosamax) for osteoporosis, is documented in the ER After-Visit Summary (Section IV.B) but is not referenced, reconciled, or acknowledged anywhere in the 35-visit chiropractic record — notwithstanding its direct relevance to manipulation safety considerations at the cervical and lumbar levels treated.
- The claimant's ER blood pressure was elevated (170/94), and her home medication list includes lisinopril-hydrochlorothiazide for hypertension; this may reflect a situational elevation related to acute pain/trauma, a baseline control issue, or both, and is noted here as part of the complete medication and vital-sign picture rather than as an independent standard-of-care finding.
- Billing/coding discrepancy: the chiropractic billing ledger lists the 8/29/2025 visit as CPT 99202 (new-patient E/M, straightforward), while the narrative "PLAN" section of the Initial Examination note itself states "Consultation, history and examination, 99203" — a discrepancy between the ledger and the clinical note.

VI. Applicable Standards, Guidelines, and Literature

The chiropractic literature and guideline frameworks applicable to duration, frequency, and modality selection for this case's presentation (cervical and lumbar mechanical/soft-tissue pain of traumatic onset, with an adjunctive-modality question specific to headache and dizziness) are identified and fully cited in **Appendix C — Cited Literature**, attached to this report. The governing principle drawn from those sources is set forth below.

Payer/regulatory frameworks (e.g., Oklahoma workers' compensation visit/duration parameters, cited in Section VIII.C) are referenced only as comparators on "typical" visit/duration patterns in a different line of coverage — not as the binding legal or clinical standard governing this Oklahoma automobile/med-pay claim.

Governing Principle

Chiropractic, like other specialties within medicine, has developed evidence-based clinical practice guidelines to govern the appropriate duration, frequency, and selection of care, and this report treats adherence to those guidelines as a reasonable and appropriate expectation for the profession, consistent with the standard other specialties hold themselves to.

The governing principle across the sources above is that the duration and frequency of chiropractic care should be determined by documented clinical response at defined reassessment points, not by a fixed, predetermined number of visits established at intake. A typical therapeutic trial of chiropractic care consists of 6–12 visits over two to four weeks (Globe et al., 2016; Whalen et al., 2019), after which the treating provider is expected to reassess and determine the necessity of continued care based on the patient's documented response; additional trials of care are supported only where clinically meaningful improvement has been demonstrated at that reassessment (Whalen et al., 2019). For neck pain specifically, a 4-week reassessment point is likewise supported as the interval at which continued-care decisions should be clinically driven rather than default (Myhrvold et al., 2023). Where the patient has resolved or reached a plateau at reassessment, further care should be tapered or discontinued; where maximum therapeutic benefit has been reached, a trial of therapeutic withdrawal followed by a final evaluation is the guideline-consistent approach (Globe et al., 2016; Whalen et al., 2019).

One specific guideline framework, however, warrants a caveat: an older, second-edition ACOEM Occupational Medicine Practice Guidelines chapter classified manipulation as "optional" rather than "recommended" despite a "B"-level evidence rating, a classification criticized within the chiropractic profession as inconsistent with the evidentiary support manipulation carries relative to other physical medicine interventions for mechanical spine pain (Dynamic Chiropractic, "The ACOEM Occupational Medicine Practice Guidelines: Biased Against Chiropractic Care," dynamicchiropractic.com/article/50013). It is worth noting that ACOEM's more recent chronic pain guidelines chapter has since shifted to recommend manipulation for chronic low back pain, chronic neck pain, and cervicogenic headache. Given this history, ACOEM's phase-of-care limits are not treated in this report as uncontested consensus, but as one of several guideline frameworks, with the chiropractic-specific guidelines above (Globe et al.; Whalen et al.; Bryans et al.; Bussières et al.) given primary weight for the duration/frequency analysis in Section VIII.

VII. Causation Analysis

Causation is addressed to a reasonable degree of medical probability (greater than 50% likelihood), applying the causation and apportionment framework of the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition and the AMA Guides to the Evaluation of Disease and Injury Causation, as applicable.

VII.A — Temporal Relationship

Onset of neck pain, back pain, headache, dizziness, left shoulder pain, and right hip pain is documented as immediate and same-day, consistent with a traumatic soft-tissue mechanism arising from the rear-end collision. A temporal association alone is not sufficient for causation and is weighed together with mechanism plausibility and objective findings below.

VII.B — Mechanism Plausibility

The claimant's ER examination was largely benign (neck supple, no midline cervical tenderness, no focal neurologic deficit), and CT imaging was negative for fracture, dislocation, or acute intracranial process — findings consistent with a soft-tissue (strain/sprain) mechanism rather than a structural/fracture injury, which is itself unremarkable and expected for a rear-end MVC of this general character. The claimant's self-reported estimate of 35–45 mph impact speed is not corroborated by the police report, which documents no independent speed data and describes the claimant as "slowing for traffic stopped at the light" when struck, with "minor damage" to both vehicles and the claimant's vehicle remaining drivable. To a reasonable degree of medical probability, the objective record (minor property damage, vehicle remained drivable, no fracture/dislocation) is more consistent with a lower-speed impact than the self-reported estimate, though soft-tissue injury of the type and degree documented remains biomechanically plausible even at lower impact speeds and does not depend on the higher estimate to be causally supported.

VII.C — Differential Causation by Body Region

Cervical spine (neck pain/cervicalgia):

The claimant's cervical spine demonstrates pre-existing, chronic degenerative findings on the 8/23/2025 CT (uncovertebral/facet spurring with foraminal stenosis at C3-4, central canal stenosis at C5-6, foraminal stenosis at C6-7) that necessarily predate the collision. Based on the clinical course documented in this file, it is my opinion, to a reasonable degree of medical probability, that the claimant's cervical spine complaint represents an aggravation — a permanent alteration of the natural history of her pre-existing cervical degenerative disease — rather than a temporary exacerbation. This conclusion rests primarily on the plateau pattern reflected in the chart: rather than resolving or returning toward zero, the claimant's cervical symptoms stabilized at a persistent, non-zero level (approximately 3/10) that was sustained, with only minor fluctuation, from late October 2025 through the final documented visit on 12/30/2025, without ever fully resolving.

Thoracic and lumbar spine (thoracic stiffness/lumbalgia):

No pre-existing thoracic or lumbar complaints or degenerative findings are documented in this file. On this record, the thoracic and lumbar complaints are attributable to the 8/23/2025 collision as a new soft-tissue injury, subject to any contrary findings on independent examination.

Left shoulder pain:

No pre-existing shoulder complaints are documented. The left shoulder pain is attributable to the collision as a new soft-tissue injury on this record, and shows the most consistent improvement of any complaint charted (7/10 at intake to 1/10 by the final visit).

Right/left hip pain:

No pre-existing hip complaints are documented, and the hip complaint is attributable to the collision as a new soft-tissue injury on this record. The unexplained shift in the chart from "right hip" to "right/left hip" beginning around 10/16/2025, without any documented interval trauma or new mechanism, is a documentation inconsistency addressed in Section V and should be considered in weighing the reliability of this specific complaint.

Headache:

The claimant's own statement to ER staff — that she was already being evaluated by an outside neurologist and allergist for chronic headaches — is a material pre-existing-condition data point that the chiropractic record never engages with. Without records from that outside work-up, full causal apportionment of the headache complaint (7/10 at intake, fluctuating 3–6/10 through mid-course, 3–4/10 at the final visits) between the MVC and the pre-existing chronic headache condition cannot be completed on this record alone. See Section VII.E.

Dizziness/imbalance:

No vestibular or positional workup (e.g., Dix-Hallpike testing) was ever performed to distinguish a cervicogenic or post-traumatic etiology from other causes of dizziness. Temporal onset is consistent with the collision, but the specific mechanism was never diagnostically characterized in this record.

VII.D — Apportionment

The thoracic, lumbar, left-shoulder, and hip complaints are attributed entirely to the 8/23/2025 incident, absent contrary findings on independent examination or subsequently produced records. The cervical spine complaint is characterized as an aggravation of pre-existing cervical degenerative disease, as set forth in Section VII.C. Upon request from the referral source for a numeric apportionment of the cervical spine complaint, it is my opinion, to a reasonable degree of medical probability, that the claimant's cervical spine symptomatology is apportionable as approximately **65% attributable to the pre-existing cervical degenerative disease** and approximately **35% attributable to the acute cervical soft-tissue injury** sustained in the 8/23/2025 incident. This apportionment is offered as a reasoned clinical estimate based on the record as a whole — including the multilevel degenerative CT findings at C3-4, C5-6, and C6-7, the claimant's age (69 at the time of the incident), and the persistent symptom plateau discussed in Section VIII.A — rather than a precise, measurable calculation; no diagnostic method exists to numerically quantify the relative contribution of a chronic degenerative process versus an acute soft-tissue injury to a single symptom complex, and this

percentage should be understood accordingly. The headache and dizziness complaints cannot be apportioned, numerically or otherwise, on this record alone; see Section VII.E.

With respect to the cervical spine specifically, and consistent with the 65%/35% apportionment set forth above, it is my opinion, to a reasonable degree of medical probability, that the claimant's pre-existing cervical degenerative disease — reflecting the uncovertebral and facet spurring, central canal stenosis at C5-6, and foraminal stenosis at C3-4 and C6-7 identified on the 8/23/2025 CT — necessarily developed over a period of years preceding the collision, and represents the predominant contributor to the claimant's ongoing cervical symptomatology. The acute cervical soft-tissue injury sustained in the collision is layered on top of that pre-existing degenerative foundation; its contribution is real and causally related to the incident, but proportionally smaller than that of the underlying degenerative disease. This relative weighting is consistent with, and lends further support to, the plateau pattern discussed in Section VIII.A: a claimant whose persistent cervical symptoms are substantially rooted in a chronic degenerative process would be expected to reach and sustain a stable, non-zero symptom plateau of the kind reflected in this chart, rather than progress toward full resolution, since the underlying degenerative pathology does not resolve with palliative chiropractic care.

VII.E — Effect of Documentation Gaps on the Causation Opinion

The claimant's pre-existing, outside neurology and allergy work-up for chronic headaches — referenced in her own history to the ER — was not produced in this file. Full causal apportionment of the headache and dizziness complaints cannot be completed on the current record. Records from [redacted], MD, and from the claimant's outside neurologist and allergist, are not part of the current file and would bear materially on this gap if available (see Section X). It is my opinion that, given the claimant's pre-existing, active neurology work-up for chronic headaches, it is reasonably likely that some form of prior neurological imaging (e.g., brain MRI) exists from that work-up; such imaging, if obtained, would have provided a valuable pre-accident baseline against which the 8/23/2025 ER imaging could have been compared, and would materially assist the causation analysis for the headache and dizziness complaints if it becomes available. The interim opinion above is offered on the current record and is subject to revision should those records become available.

VII.F — Causation Conclusion

It is my opinion, to a reasonable degree of medical probability, that:

- The claimant's cervical spine complaint represents an aggravation — a permanent alteration of the natural history of her pre-existing cervical degenerative disease — causally related to the 8/23/2025 incident. The pre-existing degenerative disease, which necessarily developed over a period of years preceding the collision, is apportioned at approximately 65% and represents the predominant contributor to the claimant's ongoing cervical symptomatology; the acute cervical soft-tissue injury sustained in the collision, apportioned at approximately 35%, is layered on top of that pre-existing degenerative foundation and is a real, causally related, but

proportionally smaller contributor (Section VII.D). This is consistent with the claimant's persistent, non-zero cervical symptom plateau documented from late October 2025 through the final visit, for the reasons set forth in Sections VII.C, VII.D, and VIII.A.

- The claimant's thoracic complaint represents a new injury causally related to the 8/23/2025 incident.
- The claimant's lumbar complaint represents a new injury causally related to the 8/23/2025 incident.
- The claimant's left shoulder complaint represents a new injury causally related to the 8/23/2025 incident.
- The claimant's hip complaint represents a new injury causally related to the 8/23/2025 incident, subject to the laterality-documentation inconsistency noted in Section V.
- The claimant's headache and dizziness complaints cannot be causally apportioned between the 8/23/2025 incident and her pre-existing, independently-managed chronic headache condition on the current record; this opinion is offered on an interim basis and is subject to revision upon receipt of the outside neurology/allergy records identified in Section X.

VIII. Reasonableness and Necessity of Duration, Frequency, and Type of Care

VIII.A — Duration & Frequency

Applying the governing principle in Section VI to the chart findings in Section IV: eleven visits had already occurred by 9/24/2025 (approximately four weeks into care) with symptom ratings still largely unchanged from intake (6–7/10 across most complaints) — the point at which the guideline framework calls for reassessment and a plan-modification decision is precisely where no reassessment occurs in this chart, and instead a new modality (Alpha-Stim) was added without any documented re-examination. Objective improvement (ROM, orthopedic findings) was never re-measured after intake, so there is no objectively documented functional basis on which a guideline-consistent reassessment decision could have been made at the 6–12 visit mark, the 2–4 week mark, or at any later point in this record. This is consistent with the visit-frequency pattern identified in Section V: care proceeded on a consistent three-times-weekly schedule through late September 2025 and then shifted to a twice-weekly schedule from mid-October 2025 onward, with no note in the file documenting a reassessment, clinical rationale, or objective finding tied to that change in frequency.

The subjective pain trajectory — flat for approximately four weeks, then declining, then plateauing at 1–4/10 with fluctuation from late October through the December holidays —

is most consistent with the claimant having reached a therapeutically stable plateau by approximately mid-to-late October 2025 (roughly visits 19–20, the 7–8 week mark). It is my opinion, to a reasonable degree of medical probability, that continued chiropractic care beyond approximately visit 20 (10/23/2025) is not supported as reasonable and necessary on this record. This is the point at which the claimant's own charted symptom ratings — as reflected in Section IV.C's visit-by-visit trend table and the Chart Interpretation immediately following it — enter the sustained, non-zero plateau that persists, essentially unchanged, through the final visit on 12/30/2025, without any intervening reassessment, objective re-measurement, or plan modification to justify the further 15 visits and approximately nine and one-half weeks of unmodified care that followed.

The overall pattern — 35 visits over approximately 18 weeks with no documented reassessment, no change in the diagnosis list, and a care plan structurally identical (same modalities, same billing pattern) from visit 2 through visit 35 — is difficult to reconcile with the guideline principle that duration should be driven by documented clinical response rather than a default ongoing-visit pattern — notwithstanding that the manipulative care delivered throughout that period was, in isolation, technically consistent with standard practice.

VIII.B — Referral / Comanagement Threshold

No red-flag findings (progressive neurologic deficit, saddle anesthesia, bowel/bladder involvement, suspected fracture, infection, unexplained weight loss, major trauma beyond the MVC itself) are documented at any point, so an emergent referral was not clinically indicated on this record. However, the failure-to-progress referral threshold — assessed via standardized outcome measures at a therapeutically stable plateau — appears to have been reached by approximately visit 20 (10/23/2025), consistent with the plateau determination in Section VIII.A, and the commonly cited general orthopedic benchmark of a 4–6 week trial before specialist consultation (absent red flags) had already elapsed twice over by that point. No consultation or comanagement referral is documented anywhere in the four-month file, despite the plateau and despite headache/dizziness — the claimant's most neurologically-flavored complaints — being the specific target of prolonged, unmodified adjunctive therapy rather than diagnostic escalation or referral. It is my opinion, to a reasonable degree of medical probability, that upon reaching this plateau at approximately visit 20, chiropractic treatment should have been discontinued or tapered, with referral or comanagement consideration undertaken at that point, rather than continuing the unmodified chiropractic care documented in this file for a further 15 visits through 12/30/2025.

The visit-20 plateau discussed above pertains to the claimant's musculoskeletal complaints as a whole. As set forth in Section IX.B, a separate and earlier referral point applies specifically to the claimant's headache and dizziness complaints, given the absence of any documented differentiation between a cervicogenic mechanism and the claimant's pre-existing neurological/allergy-related condition.

VIII.C — Payer/Regulatory Comparators (Context Only)

Oklahoma workers' compensation guidelines — a different line of coverage, cited here only as a general practice comparator — permit a chiropractor to serve as attending provider for up to 60 days or 18 visits, whichever occurs first, before certain hand-off requirements apply. This claimant's course (35 visits over approximately 140 days) is roughly double that comparator on both metrics. This is offered as context on "typical" practice patterns in a different line of coverage, not as the legal or clinical standard governing this Oklahoma automobile/med-pay claim.

IX. Modality-Specific Analysis

IX.A — Spinal Manipulation / High-Velocity Low-Amplitude (HVLA) Manipulation

HVLA manipulation is a manually applied, high-velocity, low-amplitude thrust directed at a specific spinal segment, intended to restore segmental mobility, reduce mechanical restriction, and produce reflexive neuromuscular and analgesic effects. It is the core, most extensively researched chiropractic intervention and carries the strongest evidentiary support among physical medicine interventions for mechanical spine pain in the literature reviewed. In this case, CMT (98940) was performed at every one of the 35 visits, generally consistent with typical protocol for this modality across an active treatment course. The clinical question in this case is not whether manipulation itself was appropriate as a modality, but whether its continuation at unmodified frequency for the full 35-visit course — without interval reassessment — was reasonable and necessary beyond the point discussed in Section VIII.A.

A separate concern, distinct from the duration/frequency issue above, is the basis on which manipulation was initiated in the first instance. The Initial History note of 8/29/2025 does not cite or reference the actual 8/23/2025 ER CT report; it records the imaging results as relayed verbally by the claimant ("per claimant, no fractures/dislocations"). No X-rays or other independent imaging were obtained by the chiropractor at intake or at any subsequent point in the 35-visit course. If the treating chiropractor independently obtained or reviewed the actual CT report before initiating manipulation, that review is not documented anywhere in the file. This is a genuine concern to me: the ER CT cervical spine had already identified multilevel degenerative findings at C3-4, C5-6, and C6-7 — findings that bear directly on the safety and technique considerations for cervical manipulation at those specific segments — and manipulation was initiated at the first visit without any documented independent review of that report. Reliance on a patient's verbal, secondhand account of imaging results, rather than a documented review of the imaging report itself, prior to initiating high-velocity, low-amplitude cervical manipulation, falls below what I would consider an appropriate standard of documentation and practice under these circumstances.

This concern is heightened by the claimant's documented home medication list (Section IV.B), which includes alendronate (Fosamax), a bisphosphonate prescribed for

osteoporosis. It is my opinion, to a reasonable degree of medical probability, that given the claimant's osteoporosis and the multilevel degenerative cervical findings already identified on CT, chiropractic X-rays of the cervical and lumbar spine should have been taken and reviewed by the treating chiropractor prior to initiating high-velocity, low-amplitude manipulation, in order to properly assess bone density-related fracture risk and segment-specific structural integrity at the levels to be manipulated. No such X-rays were taken at any point in this 35-visit course.

IX.B — Alpha-Stim / MENS (Microcurrent) Therapy

Microcurrent therapy delivers electrical current at sub-sensory intensity, well below the milliampere range used in conventional TENS or interferential current. Its proposed mechanism involves modulation of cellular bioelectric activity and stimulation of ATP production, theorized to support soft-tissue healing and reduce pain perception at the cellular level — a localized, soft-tissue-directed mechanism, not one directed at central or vestibular causes of headache or dizziness.

In this case, Alpha-Stim was introduced on 9/24/2025 (visit 11 of 35) with the stated purpose of reducing the claimant's headaches and dizziness, and was then continued at every visit for the remainder of the course — 24 consecutive sessions — through 12/30/2025. The chart does not document the body region to which Alpha-Stim was actually applied (a cervical paraspinal/suboccipital application would at least be mechanistically plausible as an adjunct for a cervicogenic headache component; the notes do not specify), nor does it document objective findings correlating a cervicogenic mechanism to the claimant's headache pattern. No vestibular or positional workup was performed at any point to support a cervicogenic or otherwise treatable mechanism for the dizziness. Critically, the claimant's own pre-existing, independently-managed chronic headache work-up (with an outside neurologist and allergist) is never acknowledged or addressed anywhere in the chiropractic record, despite headache being one of the two specific complaints Alpha-Stim was directed at treating.

It is my opinion, to a reasonable degree of medical probability, that the claimant's headache and dizziness complaints represent a clinical picture functionally distinct from her musculoskeletal complaints (cervical, thoracic, lumbar, shoulder, and hip), and should have been evaluated and managed as such. Alpha-Stim/MENS, by its mechanism, is capable at most of addressing a cervicogenic contribution to headache and dizziness; it has no mechanism directed at a neurological or allergy-related etiology. The chart, however, never documents any clinical testing or findings distinguishing a cervicogenic component of the claimant's headache and dizziness from a neurological or allergy-related etiology, notwithstanding the claimant's own disclosed, pre-existing, independently-managed work-up for chronic headaches with an outside neurologist and allergist. Absent that differentiation, there is no documented basis to conclude that Alpha-Stim was ever addressing the actual cause of the claimant's headache and dizziness.

It is further my opinion that, because this differentiation was never undertaken, the referral point for the headache and dizziness complaints specifically is not the same as the musculoskeletal plateau point addressed in Sections VIII.A–VIII.B (approximately visit 20,

10/23/2025). Rather, referral back to the claimant's neurologist and allergist should have been considered at or shortly after Alpha-Stim was introduced on 9/24/2025 (visit 11) — the point at which it became necessary to determine whether these complaints were cervicogenic, and therefore potentially responsive to chiropractic care, or attributable to her pre-existing condition, which chiropractic treatment would not be expected to address. On this record, 24 consecutive visits of unmodified Alpha-Stim therapy for headache and dizziness, without that threshold differentiation ever being made, is not supported as reasonable and necessary.

IX.C — Adjunctive Passive Modalities (Myofascial Release, Muscle Stimulation, Ultrasound)

Myofascial release (97140), muscle stimulation (97014), and ultrasound (97035) were rotated across visits throughout the treatment course as adjuncts to manipulation. These are standard, low-risk soft-tissue modalities commonly used in conjunction with spinal manipulation for mechanical spine pain, and their use here — applied to the same regions being manipulated, without indication of duplicative billing on the same visit for competing modalities, and without any documented adverse reaction — is consistent with generally accepted chiropractic practice. Nothing in the record suggests these modalities were used excessively or inappropriately; the concerns identified in this report relate to duration, reassessment, and Alpha-Stim/MENS specifically (Section IX.B), not to this adjunctive-modality selection.

Taken together, the manipulative technique and modality selection used in this case were consistent with accepted chiropractic practice, and the claimant's own charted pain ratings reflect measurable improvement during the earlier, reasonable portion of the treatment course. The concerns identified in this section and in Section V relate to documentation, imaging-review, and reassessment practices — not to a departure from accepted manipulative technique or hands-on treatment quality.

X. Open Items / Limitations of the Current Record

- No records from ■■■■■■■■■■■■■■■■■■■■■■, MD (Family Medicine) — the ER-recommended one-week follow-up — appear in this file, and it is unknown whether that follow-up visit occurred.
- No records from the claimant's pre-existing outside neurologist or allergist (referenced at the ER visit in connection with her chronic headache work-up) appear in this file, including any prior imaging (e.g., brain MRI) that may exist from that work-up.
- It is unknown whether any MRI was ever obtained in connection with the 8/23/2025 accident; none appears in this file.
- The chiropractic billing ledger lists the 8/29/2025 visit as CPT 99202, while the narrative "PLAN" section of the Initial Examination note itself states "Consultation,

history and examination, 99203"; this discrepancy is unresolved on the current record.

- It is unknown to which body region Alpha-Stim/MENS was applied at each visit; the chart does not specify.

XI. Response to Specific Referral Questions

Question 1:

Based on the records from 8/29/2025 through 12/30/2025, was the overall course of chiropractic care medically necessary and appropriate under generally accepted chiropractic standards?

See Section VIII.A for the full analysis. In summary, the overall course of chiropractic care was reasonable and necessary during an initial period consistent with guideline-based therapeutic trial and reassessment expectations, but the record does not support that the full 35-visit, ~18-week course was medically necessary and appropriate in its entirety. It is my opinion that care was reasonable and necessary through approximately visit 20 (10/23/2025), beyond which point continued unmodified care is not supported, for the reasons set forth in Section VIII.

Question 2:

Does the duration and frequency of chiropractic care provided in this case (35 sessions over 4 months) fall within a reasonable range for an auto-related neck/back/soft tissue injury episode, based on current evidence-based guidelines and typical chiropractic practice? If not, at approximately what date or visit range would you say treatment reasonably changed character?

See Section VIII.A. The 35-session/4-month course exceeds the 6–12 visit / 2–4 week guideline benchmark for an initial therapeutic trial, and exceeds (roughly doubles) the Oklahoma workers' compensation 60-day/18-visit comparator cited for context in Section VIII.C. Based on the chart's own symptom-plateau data, treatment reasonably changed in character at approximately visit 20 (10/23/2025), at which point the guideline-consistent approach would have been reassessment, tapering, or referral rather than continued unmodified care.

Question 3:

*Were the chiropractic procedures and modalities utilized (manipulation, modalities, exercises, etc.) appropriate for the documented diagnoses and exam findings, or do any appear excessive, duplicative, or not medically necessary? Please specifically speak to 'Alpha **Stim microcurrent** therapy which was provided to reduce the headaches and dizziness.'*

See Section IX for the full modality-specific analysis. Chiropractic manipulation (98940) was performed consistent with typical protocol throughout. Myofascial release, muscle stimulation, and ultrasound were rotated across visits in a manner generally consistent

with adjunctive soft-tissue modality use. Alpha-Stim/MENS, addressed specifically in Section IX.B, presents the more significant concern: it was continued at 24 consecutive visits for headache and dizziness without documented site of application, objective correlation to a cervicogenic mechanism, interval reassessment, or acknowledgment of the claimant's pre-existing headache work-up. It is my opinion that this continuation was not reasonable and necessary, and that referral back to the claimant's neurologist and allergist should have been considered at or shortly after Alpha-Stim was introduced, for the reasons set forth in Section IX.B.

Question 4:

Please comment on the mechanism of the claimed injury, diagnosis related to this accident, diagnostic findings, including any pre-existing conditions.

See Sections IV.A (mechanism), IV.B (ER diagnostic findings), and VII (causation analysis) for full discussion. In summary: the claimant sustained a rear-end MVC on 8/23/2025; diagnoses assigned were consistent with cervical, thoracic, and lumbar soft-tissue strain/sprain, headache, and left-shoulder/hip pain; ER imaging identified pre-existing multilevel cervical degenerative disease (C3-4, C5-6, C6-7) and the claimant's own history disclosed a pre-existing, independently-managed chronic headache condition under work-up by an outside neurologist and allergist.

Question 5:

Does medical documentation and/or your examination support a causal relationship between the claimed accident and the symptoms presented or injury(s) claimed?

See Section VII for the full causation analysis, addressed by body region. In summary, the documentation supports a causal relationship between the accident and the claimant's cervical, thoracic, lumbar, left-shoulder, and hip complaints, to a reasonable degree of medical probability, subject to the pre-existing degenerative component at the cervical spine, which is apportioned at approximately 65% pre-existing / 35% incident-related (Section VII.D). The documentation does not, on this record alone, support full causal apportionment of the headache and dizziness complaints given the undisclosed pre-existing headache work-up; see Section VII.E.

Question 6:

Is ongoing treatment [Chiropractic] within your specialty reasonable, medically necessary, and causally related to this accident?

See Sections VIII.A–VIII.B. Ongoing chiropractic care is not supported as reasonable, medically necessary, or causally related to this accident on the current record. The claimant's own charted symptom ratings reached a stable plateau by approximately visit 20 (10/23/2025), and no objective finding was re-measured at any point after the 8/29/2025 intake to establish a continuing functional deficit. Accordingly, no ongoing chiropractic treatment beyond what is already reflected in this file is supported.

Question 7:

If treatment [Chiropractic] is reasonable, medically necessary, and causally related to this accident, please provide a medical opinion on the frequency, duration, and expectation to achieve pre-accident status.

As set forth in the response to Question 6, ongoing chiropractic treatment is not supported as reasonable and necessary on this record; accordingly, no opinion is offered on frequency or duration of further chiropractic care. With respect to expectation of return to pre-accident status: the claimant's own charted pain ratings never returned to zero at any point across the 35-visit course, and given the pre-existing cervical degenerative disease and aggravation finding discussed in Section VII.C, a full return to a pre-accident asymptomatic baseline is not an appropriate expectation for the cervical spine specifically. The thoracic, lumbar, shoulder, and hip complaints, representing new soft-tissue injury without documented pre-existing pathology, would be expected to fully resolve within standard soft-tissue healing timeframes.

Question 8:

Please document all medical records reviewed to include provider, specialty, dates of service, and if applicable findings of the physical exam performed.

See Section II for the full records-reviewed index (provider, specialty, and dates of service) and Section IV.C for a summary of the physical examination findings documented at the 8/29/2025 chiropractic intake (the only examination in this file with charted objective findings — range of motion and orthopedic testing — as no re-examination was performed at any subsequent visit, and no independent examination by the undersigned was performed as part of this records-only review).

XII. Impairment Rating (AMA Guides, 6th Edition)

An impairment rating is not undertaken in this report. This is a records/peer review only; no examinee was seen, no treating provider in this file has documented a finding of maximum medical improvement (MMI), and the chiropractic record contains no re-examination or discharge evaluation from which a rating could be derived. Should an impairment rating ultimately be requested and appropriate (e.g., following an in-person examination or upon receipt of an MMI determination from a treating provider), it should be completed as a supplemental report at that time.

XIII. Summary of Opinions

- 1. The claimant's thoracic, lumbar, left-shoulder, and hip complaints represent new soft-tissue injuries causally related to the 8/23/2025 incident. The claimant's cervical spine complaint represents an aggravation — a permanent alteration of the natural history of her pre-existing cervical degenerative disease — causally related to the incident, apportioned at approximately 65% pre-existing / 35% incident-related. (Section VII, VII.D)

- 2. Causal apportionment of the headache and dizziness complaints cannot be completed on the current record, given the claimant's pre-existing, independently-managed outside neurology/allergy work-up for chronic headaches; this opinion is offered on an interim basis. (Section VII.E)
- 3. The course of chiropractic care was reasonable and necessary through approximately visit 20 (10/23/2025), reflecting a guideline-consistent initial therapeutic trial and continued care during a period of documented, if gradual, subjective improvement. (Section VIII.A)
- 4. Continued, unmodified chiropractic care beyond approximately visit 20 (10/23/2025) is difficult to support as reasonable and necessary, in the absence of any documented reassessment, objective re-measurement, plan modification, or referral, notwithstanding a therapeutically stable plateau reflected in the claimant's own charted pain ratings. This opinion concerns duration and the absence of reassessment, not the manipulative technique itself, which was performed consistently with accepted practice throughout. (Sections VIII.A–VIII.B)
- 5. Alpha-Stim/MENS therapy was introduced on 9/24/2025 without any documented differentiation between a cervicogenic mechanism and the claimant's pre-existing neurological/allergy-related headache condition, and its continuation for 24 consecutive visits, without interval reassessment or that threshold differentiation ever being made, is not supported as reasonable and necessary. (Section IX.B)
- 6. Ongoing chiropractic care is not supported as reasonable, medically necessary, or causally related to this accident on the current record; no further chiropractic treatment beyond what is already reflected in this file is indicated. Full return to a pre-accident asymptomatic baseline is not an appropriate expectation for the cervical spine given the pre-existing degenerative disease and aggravation finding addressed in Section VII.C, though the thoracic, lumbar, shoulder, and hip complaints would be expected to fully resolve. (Section XI, Questions 6–7)

XIV. Limitations, Disclosures, and Certification

- I certify that the clinical findings, opinions, and conclusions expressed in this report reflect my own independent professional judgment, based on my training, experience, and personal review of the records identified in Section II. No artificial intelligence tool was used to generate, determine, or formulate my medical opinions.

- The opinions expressed herein represent my professional medical judgment based on the records made available to me as of the date of this report. Should additional records become available — including but not limited to prior neurological or allergy/immunology records, baseline imaging, or other documentation not currently in my possession — I reserve the right to review such records and amend, supplement, or modify my opinions as appropriate.
- I have no financial interest in the outcome of this claim beyond my usual and customary compensation for this record review.
- This report is a records-only peer review; no doctor-patient relationship was established, and I had no direct interaction with the claimant.
- The opinions expressed are the independent opinions of the undersigned, are not influenced by the referral source or the outcome of the claim, and are held to a reasonable degree of medical probability unless otherwise stated.

Leslie Welch, D.C., CICE, NRCME

License number / state: Oklahoma State Board of Chiropractic Examiners, License #3361

Date signed: 8/5/2026

Appendix C — Cited Literature

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- Whalen WM, Hawk C, Farabaugh RJ, Daniels CJ, Taylor DN, Anderson KR, Crivelli LS, Anderson DR, Thomson LM, Sarnat RL. Best Practices for Chiropractic Management of Adult Patients With Mechanical Low Back Pain: A Clinical Practice Guideline for Chiropractors in the United States. J Manipulative Physiol Ther. 2023. doi:10.1016/j.jmpt.2023.04.010. (2023 update to the above.)
- Whalen W, Farabaugh RJ, Hawk C, Minkalis AL, Lauretti W, Crivelli LS, Wyatt L, Sheppard M, Walters SA. Best-Practice Recommendations for Chiropractic Management of Patients With Neck Pain. J Manipulative Physiol Ther. 2019 (epub ahead of print). (Directly on point for this claimant's cervicalgia: recommends an initial trial of 6-12 visits over 2-4 weeks, additional 6-visit trials only with demonstrated clinically meaningful improvement, and describes interim assessment, trials of therapeutic withdrawal, and MMI determination as the

guideline-consistent response once a plateau is reached. Also addresses LLLT and IFC as passive-modality adjuncts.)

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