State of California

DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name: **ALAN EGER** *(employee name)* v **Triace Bicycle / Bridgeway International** *(claims administrator name, or if none employer)*

Claim No.: **SIF9876653**

EAMS or WCAB Case No. *(if any)*: **ADJ9876653; ADJ11358589**

I, **BRISEIDA CHAVEZ**, declare:
(Print Name)

1. I am over the age of 18 and not a party to this action.
2. My business address is: **1680 PLUM LANE, REDLANDS, CA 92374**
3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, enter A – E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
A	01/08/21	Subsequent Injury Benefit Trust Fund-SENT ELECTRONICALLY
A	01/08/21	WORKERS DEFENDERS LAW GROUP 8018 East Santa Ana Canyon, Suite 100-215 Anaheim Hills, California 92808
A		

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 01/08/2021

Briseida Chavez
(signature of declarant)

BRISEIDA CHAVEZ
(print name)

QME Form 122
Rev. February 2009

Lawrence M. Richman, M.D.

Mailing Address:
1680 Plum Lane
Redlands, California 92374
(909) 335-2323

December 14, 2020

DEPARTMENT OF INDUSTRIAL RELATIONS
Subsequent Injury Benefit Trust Fund
160 Promenade Circle, Suite 350
Sacramento, California 95834-2962
Attention: Joanna Arizabal, Workers' Compensation Consultant

WORKERS DEFENDERS LAW GROUP
8018 East Santa Ana Canyon, Suite 100-215
Anaheim Hills, California 92808
Attention: Natalia Foley, Esquire

EMPLOYEE	:	**ALAN EGER**
EMPLOYER	:	Triace Bicycle / Bridgeway International
DATE OF INJURY	:	CT March 1, 2011 – February 1, 2015; April 14, 2014
SIBTF NO.	:	SIF9876653
WCAB NO.	:	ADJ9876653; ADJ11358589
DATE OF BIRTH	:	September 18, 1962
EXAM DATE	:	December 14, 2020

COMPREHENSIVE INDEPENDENT MEDICAL EVALUATION IN NEUROLOGY
SIBTF EVALUATION REPORT:

Gentlepersons:

This examination was performed in the county of Los Angeles at 2760 East Florence Avenue, Huntington Park, California 90255 on December 14, 2020.

ML104 -95

Causation is addressed per written request
Apportionment between multiple injuries is addressed

Face-to-face time	2 hours
Review of medical records (280 pages)	2 hours and 30 minutes
Review of deposition (38 pages)	45 minutes
Report preparation and review	5 hours
Report editing	1 hours and 45 minutes

THE TIME REQUIRED FOR THIS PHYSICIAN TO ISSUE THE REPORT: 12 hours.

Thank you for asking me to perform an Independent Medical Evaluation on Mr. Eger in order to determine disability for the Subsequent Injury Benefits Trust Fund, pursuant to Labor Code 4751. I have personally evaluated this patient and prepared this report.

The focus of this report is to address the applicant's pre-existing impairment / disability of different body regions, other than the industrial injury and to note the effects of the following injuries. This evaluation was performed in my office in Huntington Park, California on December 14, 2020. The combination of the above complexity factors total 4.

This report is billed as a ML104 with Regulation 9795.

Per Labor Code 4751: If an employee, who is permanently and partially disabled receives a subsequent compensable injury resulting in additional permanent / partial disability, so that the degree of disability caused by the combination of both disabilities is greater than that which would have resulted from the subsequent injury alone, on the combined effect of the last injury on the previous disability or impairment, is a permanent disability equal to 70% or more of the total, he/she shall be paid in addition to the compensation due under the code for the permanent disability caused by the last injury, compensation of the remainder of the combined permanent disability existing up to the last injury, as provided in this article: provided, that either (a) the previous disability or impairment affected a hand, an arm, a foot, a leg or an eye, on the permanent disability resulting from the subsequent injury affects the opposite and corresponding member, and such allowed permanent disability, when considered alone and without regard to, or adjustment for, the occupation or age of the employee, is equal to 5% or more of the total, or (b) the permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or the age of the employee, is equal to 35% or more of the total.

INITIAL SIBTF SUMMARY:

1. **Did the worker have an industrial injury?**
   Answer - Yes. The applicant sustained an industrial injury on April 14, 2014 and continuous trauma from March 1, 2011 through February 1, 2015. Injured body parts included the bilateral shoulders, low back, bilateral knees, bilateral ankles, stress, nervous system and psyche.

2. **Did the industrial injury rate to a 35% disability without modification for age and occupation?**
   Answer – Not known.

3. **Did the worker have a pre-existing labor-disabling permanent disability?**
   Answer – Yes. The patient sustained a traumatic brain injury in his twenties, as a result of a motor vehicle versus bicycle accident sustaining a scalp laceration and loss of consciousness. He was evaluated in an emergency department and hospitalized for one

month. He had problems with memory and concentration that has persisted to the present. He was treated at Anaheim Memorial Medical Center and then transferred to another facility.

He sustained another traumatic brain injury two years later when a car struck his bicycle. He sustained a concussion with loss of consciousness, an injury to the left hand and fracture of the left hand that did not require surgery. He has experienced specific numbness of the left hand to the present.

He sustained another bicycle accident in 2004 with a fracture of the cervical spine at the C2-3 level that did not require halo stabilization. From that same accident he sustained fractures of the left elbow and right hip. He was hospitalized at Cedars-Sinai Medical Center for five days. He sustained a concussion. He did not require surgery.

In 2005, he crashed a bicycle. No car was involved. He has amnesia for this event, consistent with a concussion. He sustained a fracture of the left shoulder / clavicle, five rib fractures and he underwent surgery for the clavicle fracture.

The patient adds that he has had approximately fifty bicycle crashes, as a result of being a professional bicycle racer. He reports having sustained a fracture of the left elbow on three separate occasions. He reports having sustained a fracture of the left ankle in the early 2000's. He reports experiencing the onset of vertigo two years ago associated with diminished auditory acuity and tinnitus. He has experienced prior difficulty with voiding resulting from one of his earlier bicycle accidents. He reports, as a result of his prior bicycle accidents, he has had difficulty with memory and concentration. He responds affirmatively to the Clinical Dementia Rating Scale from Table 13-5 of the AMA Guides Fifth Edition. The patient reports that he forgets what to purchase at a store, has to keep a list of objects to purchase, forgets where he places personal belongings, loses direction easily and forgets things that he should know. He has difficulty keeping track of time and time-relationships. He reports disequilibrium, hearing loss in both ears and tinnitus in both ears.

4. **Did the pre-existing disability affect an upper or lower extremity or eye?**
Answer – Yes. See response to question number three.

5. **Did the industrial permanent disability affect the opposite or corresponding body part?**
Answer – The patient's prior orthopedic injuries were on the left side. Concussions tend to be bilateral.

6. **Is the total disability equal to or greater than 70% after modification?**
Answer – Unknown at this time.

7. **Is the employee 100% disabled or unemployable from other pre-existing disability and work duties together?**
Answer – The patient is not 100% disabled from other pre-existing disabilities or work injuries together, based on the current information available.

8. **Is the employee 100% disabled from the industrial injury?**
Answer – No.

9. **Additional records reviewed?**
Answer – Yes. See Record Summary below.

10. **Are evaluations or diagnostics needed?**
Answer – Yes. It is my recommendation that the patient undergo either positive Trimonition tomography of the brain or a functional MRI scan of the brain, as well as neuropsychological testing by a board certified clinical neuropsychologist.

SUMMARY OF SURGICAL AND MEDICAL PROBLEMS:

Mr. Eger is a 58-year-old left-handed male, who is involved in research and development of bicycle manufacturing. He has been employed by Triace Bicycle / Bridgeway International for five years through February 28, 2015.

The patient's job required eight hours of standing and walking. He did continuous bending, stooping, squatting, balancing, pulling and pushing. He did frequent lifting of 74 pounds. He had repetitive use of both hands. He used a computer keyboard, worked at unprotected heights and worked on moving equipment. He was exposed to dust, fumes and walked on uneven surfaces.

He has filed a claim for continuous trauma from March 1, 2011 through February 1, 2015, as well as a specific injury of April 14, 2014. The specific injury involved the left foot, at which time he sustained fracture of the foot. His claim of continuous trauma involve multiple orthopedic complaints of the spine and limbs, which I will defer to an orthopedic examiner, as relates his prior industrial claim.

PRE-EXISTING MEDICAL OR SURGICAL PROBLEMS:

The patient reports that prior to this date of hire by Triace Bicycle / Bridgeway International in approximately 2010, he sustained multiple injuries from riding a bicycle while competing as a professional bicyclist.

He sustained a cerebral concussion at the age of 20 and was hospitalized for one month. He experiences difficulty with memory and concentration which has been persistent to the present. He received occupational physical therapy at Anaheim Memorial Hospital and/or other hospitals.

He sustained another head injury two years later, along with an injury to the left hand.

He sustained an injury in 2004 from a bicycle crash, unrelated to a motor vehicle, associated with a concussion, a well as a cervical fracture, fracture of the left elbow and fracture of the right hip. He was admitted to Cedars-Sinai Hospital for five days.

He had another bicycle crash in 2005. He has amnesia for the accident due to a concussion, left shoulder and clavicle fracture requiring surgery, as well as multiple rib fractures.

He reports having sustained multiple crashes throughout his course of being a professional bicyclist preceding his date of hire. He reports a total of three left elbow fractures.

His orthopedic injuries should be addressed by a board certified orthopedic surgeon, as this is outside my expertise.

Although the patient reports having an onset of tinnitus, hearing loss and vertigo over the last two years, it is known that cerebral concussions can, over time, cause the development of progressive Ménière's disease, which should be addressed by a board certified otolaryngologist. He will require audiological testing and possibly a VENG.

The patient has reported persistent headaches since his prior head injuries involving both sides of the scalp, having a throbbing and tension quality, as well as difficulty with memory and concentration.

He does respond affirmatively to the Conventional Rating Scale qualifying for an impairment rating within Table 13-6.

PAST MEDICAL HISTORY:

The past medical history is unremarkable.

CHIEF COMPLAINTS:

The patient reports ongoing difficulty with memory and concentration. He has dizziness, hearing loss in both ears and tinnitus in both ears. The patient reports hyperesthesia and discomfort of the perineum area below the waist, likely representing irritation of the perineum nerves from sitting on a bicycle seat.

He has constant migraine and tension headaches rated as an 8 (out of 10). He has constant cervical spine pain described as an 8. He has constant pain in the shoulders rated as an 8. He has constant pain in the bilateral upper limbs rated as a 6. He has frequent pain in the left hand rated as a 6. He has frequent pain in the upper back described as a 6. He has constant pain in the low back rated as an 8. He has constant pain in the feet described asa 7.

He reports numbness and tingling in the left foot, left elbow, tingling in the bilateral knees, cervical spine and left hand.

CURRENT MEDICATIONS:

The patient is currently taking ibuprofen.

SOCIAL HISTORY:

HABITS:	Tobacco:	The patient does not smoke cigarettes.
	Alcohol:	The patient does not drink alcohol.

ACTIVITIES OF DAILY LIVING:

The patient complains of constipation, difficulty swallowing, grasping, lifting, urinary dribbling, cycling and driving.

The patient reports impaired sleep due to pain, anxiety and depression, which was present prior to his date of hire, but increased after his date of hire, averaging four or five hours of sleep per night.

He reports difficulty maintaining an erection and has difficulty with sexual function due to pain.

His headache complaints are described as follows.

Table 18-4:
I – A1, B10, C7, D10 and E8.
II – A8, B9, C9, D10, E8, F10, G10, H8, I10, J8, K8, L6, M7, N4, O10 and P3.
III – A8, B7, C7, D7 and E10.

NEUROLOGICAL EXAMINATION:

CRANIAL NERVE EXAMINATION:

Cranial nerves II-XII are serially tested and are within normal limits. Dix-Hallpike maneuver was negative.

MOTOR EXAMINATION:

The patient showed full (5/5) motor force of the upper and lower limbs without evidence of wasting, weakness or fasciculations.

SENSORY EXAMINATION:

The patient has an altered sensation of the left upper limb with hyperesthesia in the C7 distribution.

DEEP TENDON REFLEXES:

All reflexes are 1+.

COORDINATION:

Finger-to-nose testing was normal.

PATHOLOGIC REFLEXES:

Babinskis are absent.

GAIT AND STATION:

The patient has a mildly broad-based gait. His tandem gait is unstable. Romberg tests are negative. Concern is raised for cervical myelopathy because of the patient's unstable gait. He should undergo an MRI scan of the cervical spine.

CERVICAL SPINE EXAMINATION:

There is straightening of cervical lordosis with spasm and tenderness. The left trapezius muscle group exhibits spasm and tenderness.

REVIEW OF MEDICAL RECORDS:

Compromise and Release dated 06/18/18 w/DOI: CT: 03/01/11-02/01/15; 04/14/14. Back, B/L shoulders, B/L knees, B/L ankles, B/L feet, nervous system- stress, nervous system-psych; unclassified. Settlement amount of $30,000. Employed by Triace Bicycle Bridgeway International as a Director of Development.

04/23/14 - X-ray of L Foot interpreted by Lawrence Isaac Harrison, MD Findings/Impression: There is a comminuted fx of proximal to mid-portion of the fifth metatarsal. A transverse fracture line is seen at the base the fifth metatarsal, but multiple other fx lines are seen extending longitudinally to the midportion of the mid fifth metatarsal shaft. These additional fracture lines are best seen the AP view, Overall, no significant displacement or angulation of the fracture fragments noted. No other focal osseous abnormality noted.

05/06/14 – X-ray of L Foot by Kathryn Shouyee Yung, MD.
Findings/Impression: Sub-acute comminuted fracture of the proximal L fifth metatarsal. No significant angulation or displacement. The joint alignment is normal. Bones are mildly osteopenic. No significant soft tissue abnormality is seen.

05/27/14 - X-ray of L Foot interpreted by Young Kim, MD.
Findings/Impression: Healing fx demonstrated, showing no significant change in alignment from prior study.

06/17/14 - X-Ray of L Foot by Kathryn Shouyee Yung, MD at First Hope Medical Clinic.
Findings/Impression: Subacute healing fx of the proximal fifth metatarsal. The alignment is normal. The bones are osteopenic, which may be related to disuse. No new fractures are seen. There is no significant soft tissue abnormality.

04/23/1 - Dr's 1st Rpt by Hao Thai, MD (Family Medicine)/Albert Lai, MD (Pain Medicine) at Centers of Rehab and Pain Medicine. DOI: 04/18/14; CT 03/01/11- 02/01/15. Pt states, on 04/18/14 while he was working/riding for Triace in China at a Ride Event on top of mountain in Phjiang China. He won that event and was asked to have pictures at the finish line. At that time, around 11 a.m., a bike fan jumped on his foot with a special shoe made for bike cleats/pedals and broke the #5 bone in L foot. He went back to the hotel where he fell down trying to walk to the bed and found his foot turn black. Since he could not speak any Chinese and could not get any help and had no one to take him to the hospital. Around 5 am he finally called the Sales person from Triace, and with this Sales Person help he arrived to the Pujiang hospital around 8am and had an X-ray showed his L foot broken. He was then transferred to ER in Shanghai Hospital where he was confirmed his broken foot and had it casted. Patient got a flight back to USA 2 days later being immobile in bed and on crutches with foot elevated. CC: L foot has always been hurting painfully and swollen since accident in Apr/2014. Also c/o R foot pain, but L>R side VAS 6-8/10. The pain is localized with dull, aching in character, limit with standing and walking more than 5 mins. Pain decreased by rest, Naproxen 500 mg and Ibuprofen 800 mg x3/day VAS 4-6/10. C/o both knee pain for 2 years. Constant daily pain. Vas 7-8/10 pain, generalized. Dull, aching in character. L knee does give out on rare occasion, but no locking of the knees. Some swelling. Also c/o LBP for 1 year. Constant daily pain VAS 5-7/10. The pain is localized with dull, aching in character. Pain is increasing with bending the back, walking, and standing. C/o L clavicle pain from 2006, constant daily pain VAS 4-6/10 The pain is associated with radiating to LUE with N/T and dull, aching in character. Also c/o depression > 50%, since lay off. Acute stress disorder. Prior treatments have consisted of physical therapy, Ibuprofen and Naproxen, which have provided temporary relief of symptoms. PMH: L clavicle surgery in 2006 with pins and screw. Previous Accident: Foot broken in 04/2014. Current Meds: Naproxen 500 mg, Ibuprofen 800 mg. BP 129/80, Wt 153 lbs. PE: Negative ortho tests. Negative Lachman, McMurray and stress test. Sensation (light touch/pinprick) in C4, C5, C6, C7, C8/T1 intact B/L. Motor 5/5 in deltoids, biceps, triceps, wrist flexors, wrist extensors, triceps (C7). Sensation (light touch/pinprick) in L1/2, L2, L3, L4, L5, S1 intact B/L. Motor 5/5 in hip flexors, quadriceps, EHL

(Dorsiflexors), plantarflexors. Reflexes, B/L Patellar (L4) and Achilles(S1) 2+. Valgus/varus stress test, anterior drawer, posterior drawer, McMurray's, Apley's test negative. Anterior drawer and Thompson test negative. Dx: 1) Knee joint pain. 2) Foot/ Ankle pain joint. 3) Lumbar s/s. 4) M&M. 5) Depression. 6) Clavicle pain. 7) Acute stress disorder. 8) Myalgia & Myositis. Plan: Dispensed Naproxen 550 mg, Cyclobenzaprine 7.5 mg, Omeprazole 20 mg. Requested PT and MRI L/S, B/L Knee & L Foot. Consider Psych referral. TTD.

05/22/15 - MRI of L Foot/Ankle interpreted by Brenda Safranko, MD at Top Imaging Ctr. Positive Findings: There is a small amount of fluid in the tibialis posterior tendon sheath, which is physiologic in quantity. The Achilles tendon is normal low signal intensity. However, edema is seen in Kager's fat pad approximately 5 cm from the calcaneal insertion. There is fluid signal at the plantar fascia calcaneal insertion. Intraosseous ligament is visualized in sinus tarsi. Impression: 1) Edema in Kager's fat pad indicating Achilles tendon inflammatory change. 2) Plantar fasciitis.

06/23/15 - PR2 by Hao Thai, MD/Albert Lai, MD. Pt c/o constant B/L knee pain and associated with swelling, N/T, weakness. Pain remains about the same since last visit at average of 6-7/10 and 8/10 at worst. C/o of persistent chronic L foot/ankle pain associated with swelling, N/T with pain at 6-7/10 average and 8/10 at worst. LBP is improving. Pain is intermittent and associated with N/T with pain at average of 2-3/10 and 4/10 at worst. Vitals: BP 131/86. PE: Pt is oriented, ambulates slowly and in moderate distress. Dx: 1) Lumbar disc with radiculopathy. 2) Lumbar radiculopathy. 3) B/L knee internal derangement, lateral meniscal tear. 4) Knee joint effusion. 5) L Achilles tendinitis/bursitis. Plan: Dispensed/refilled Naproxen 550mg, Cyclobenzaprine 7.5 mg, Omeprazole 20mg. Pt declines cortisone injection. Requested multi stim unit, PT to the affected areas of knee, L/S, L foot/ankle. Requested MRI of Knee and L/S and Podiatrist consultation. RFA for Flurbiprofen 10%, Lidocaine 10%, Gabapentin 6%. Instructed pt not to ride bike more than 5 min at a time. Off work.

07/24/15 - MRI of R Knee interpreted by Alan Todd Turner, MD at Top Imaging Ctr. Positive Findings: The articular cartilage of the patellar femoral condyle is thinned. Signal is seen in the anterior and posterior horn of the lateral meniscus. The articular cartilage of femoral condyle and tibial plateau is thinned. There is minimal amount of fluid in the joint space on T2-weighted images.
Impression: 1) Minimal effusion. 2) Grade II signal in the anterior and posterior horn of the lateral meniscus.

07/24/15 - MRI of L/S interpreted by Alan Todd Turner, MD at Top Imaging Ctr.
Positive Findings: There is straightening of the L/S with loss of normal lordotic curvature. There is anterior displacement of L5-Sl vertebral body. The disc spaces reveal loss of height at L5-S1 disc level. Anterior disc bulge measuring 3-4 mm is seen at L5/-S1 disc level. L5-S1 disc level reveals a posterior disc bulge, 4-5 mm. There is displacement of the posterior longitudinal ligament. There is minimal narrowing of the spinal canal. The neural foramina are narrowed.

Impression: 1) Spondylolisthesis at L5-S1 vertebral body. 2) Posterior disc bulge. 4-5 mm at L5-S1 disc level. 3) Spasm. 4) Degenerative disc at L5-S1 disc level. 5) Anterior disc bulge, 3-4 mm at L5-S1 disc level.

07/24/15 - MRI of L Knee interpreted by Alan Todd Turner, MD at Top Imaging Ctr. Positive Findings: Axial images reveal a moderate amount of fluid in the joint space on T2-weighted images. The articular cartilage of the patellar femoral condyle is thinned. Signal is seen in the anterior and posterior horn of the lateral meniscus. The articular cartilage of femoral condyle and tibial plateau is thinned. There is minimal amount of fluid in the joint space on T2-weighted images.
Impression: 1) Moderate effusion. 2) Grade II signal in the anterior and posterior horn of the lateral meniscus.

08/18/15 - PR2 by Hao Thai, MD/Albert Lai, MD. Constant B/L knee pain and associated with swelling, N/T, weakness. Pain remains about the same since his last visit on average of 6/10 and 8/10 at worst. Pt also requests to have MRI review, more medication and Voltaren gel. L Foot/Ankle pain associated with swelling, N/T with pain on average of 7/10 and 8/10 at worst. LBP is mildly worsening since his last visit on 06/23/15. Pain is intermittent and associated with N/T, radiates down to LE. Vitals: BP 113/66. PE: Pt presents with normal mood and is confused. Dx remains unchanged. Rx: Voltaren Gel. Plan: Dispensed /refilled Naproxen 550 mg, Cyclobenzaprine 7.5 mg, Omeprazole 20 mg. Consider injection to knee and foot. Re-ordered pain cream Flurbiprofen 10% Lidocaine 10% Gabapentin 6%. Off work until 10/01/15.

09/08/15 – PR2 by Hao Thai, MD / Albert Lai, MD. Constant B/L knee pain with L>R associated with swelling, which is moderately worse since the last visit. Pain on average of 6-7/10 and 9/10 at worst. C/o constant chronic L foot/ankle pain associated with swelling, which worsens moderately. Pain on average of 6-7/10 and 9/10 at worst. Constant LBP associated with weakness and swelling, which is moderately worse since last visit. Pain on average of 6/10 and 8/10 at worst. Vitals: BP 138/86. PE: Pt is oriented, anxious with antalgic gait and ambulated slowly. Presents in moderate distress. UE: Sensory: Sensation to light-touch and pinprick in the dermatomes of C4, C5, C6, C7, and C8 is intact B/L. Motor: Motor strength in deltoid, biceps, triceps, wrist flexors, and wrist extensors is 5/5 B/L. Reflexes: Reflexes in biceps, brachioradialis, and triceps are 2+ B/L. LE: Sensation to light touch and pinprick in the dermatomes of L1, L2, L3, L4, L5, and S1 is intact B/L. Motor: Motor strength in hip flexors, quadriceps, EHL (dorsi flexors), and plantar flexors is 5/5 B/L. Reflexes: Reflexes in patellar and Achilles are 2+ B/L. Orthopedic Tests: Negative Valgus/Varus stress test, anterior/posterior drawer test, McMurray test, and Apley test B/L. Negative anterior drawer test and Thompson test B/L. Dx: 1) Lumbar s/s. 2) Myalgia and myositis. 3) Knee joint effusion. Plan: Dispensed Cyclobenzaprine 7.5 mg. Continue Naproxen and Flexeril that he still has. Declines knee injection does not want steroid. Awaiting RFA for physical therapy with regard to L/S, B/L knees and foot. Requested for knee brace, knee sleeve and back support brace RFA to request for pain cream Flurbiprofen 10% Lidocaine 10% Gabapentin 6% Off work.

10/26/15 - Ortho PQME by Todd H. Katzman, MD. DOI: CT 3/1/11 to 2/1/15; 4/14/14. Pt is an avid racing bicyclist and his job involved testing and riding bicycles, as well as promoting the bicycles in China. He tested bikes and rode bikes at multiple mountain bike racing events. During the course of his employment, he suffered multiple injuries. On 04/14/14, while at a racing event in China, somebody jumped up and landed on his L foot. He experienced immediate pain and he was seen at a hospital in China where x-rays were obtained. Diagnosed with a fracture and a cast was applied. Then returned to US and was seen at Kaiser. The cast was removed and a special shoe was applied, which he used for six to eight weeks. Underwent a course of PT. Eventually, he returned to China and he continued working until he was laid off from work in 2015. During the course of his employment, he injured his knees. Sometime in 2013, he was involved in a bicycle accident and injured both knees at that time. In addition, he states that as a result of riding bicycles seven to eight hours per day and as a result of limping following his L foot injury, he noted the onset of low back pain. In addition, he states that in 2005, he suffered a fractured L clavicle. Because of persistent pain, especially in his L foot, knees and low back, he was seen by Dr. Thai. Following his examination, x-rays and MRI scans were obtained. He was treated with a course of physical therapy. He states that he has been seeing Dr. Thai on a monthly basis. Because of his persistent pain in his L foot, knees and low back, he now presents for an orthopedic evaluation. CC: L foot pain, B/L knee pain and LBP. Feels weak when riding a bicycle. ROS: Denies fever, weakness, fatigue or appetite loss. No significant weight loss or gain. Denies epilepsy or convulsions. Denies other neurologic problems with the exception of those associated with this injury. Wt 155 lbs. PE: B/L shoulders: Impingement Test, Apprehension Test, Abduction Resistance Tests are negative B/L. L/S: SLR is negative to 90 degrees in sitting and reclined positions. Lasègue's test negative B/L. Anterior Drawer, Lachman, Patella Apprehension, Patella Inhibition, McMurray, Pivot Shift tests are negative B/L. B/L Ankles/Feet: Anterior drawer test is negative B/L. Neurologic: Normal with regard to strength and sensation. DTRs are 2+ and symmetrical. Dx: 1) L fifth metatarsal fx. 2) B/L knee strain. 3) Musculoligamentous strain, lumbosacral spine. 4) S/p L clavicle fx. Discussion: Examiner opines that the injury is industrially related. He gives a reliable accounting of the nature of his symptoms. Pt did sustain a specific injury to L foot and his other areas of pain appear to be due to the nature of his work activities. Exam today reveals mild discomfort in L/S, B/L knees and L foot. It is noted that his L foot fx, which occurred in April of 2014, has healed and he requires no specific treatment for his foot at this time. With respect to B/L knees, he has been L with lingering pain. It is noted that the MRI scan reveals no evidence of meniscal tear and therefore, he does not require surgical intervention. He would benefit from a course of formal PT in order to strengthen his knees so that he can resume cycling. With respect to L/S, it is noted that there are mild degenerative changes but there is no evidence of a disc herniation or neural impingement. Recommend that he be allowed to undergo a short course of PT in order to strengthen his lumbar musculature so that he will be able to resume cycling. It is noted that he was able to perform his usual and customary work duties until February of 2015 when he was laid off from work. Because he was able to perform his regular work duties until he was laid off, it is opined that he has not required prolonged TTD and there is no reason he would not be able to continue performing his regular work duties at this time, especially in light of the fact that the MRI scans of the knees and L foot are normal. He should be able to return to work while

undergoing treatment if work is made available to him. Therefore, he is able to seek new employment. In summary, pt has sustained industrially related injuries in this case and he requires further treatment. The treatment course should include formal physical therapy focusing on range of motion and strengthening exercises for both knees and the lumbar spine two times a week for four to six weeks followed by a home exercise program. He is allowed to cycle, train and seek new employment. Because he has not yet reached the maximum benefit of medical treatment, he is not yet P&S. Disability Status: Pt is allowed to seek new employment at this time. He has no work restrictions. He is not yet permanent and stationary, as he requires further treatment. Causation: Industrially related. Functional Capacity: Pt is allowed to perform all activities required of him and he may seek new employment at this time. Future Medical Care: Pt undergoes a course of formal PT and a HEP. He may also benefit from the use of nonsteroidal anti-inflammatory medication. He does not require surgical intervention.

11/05/15 - PR2 by Hao Thai, MD/Albert Lai, MD. Constant B/L knee pain improved for about 3 weeks by applying pain cream. Pain on average of 6/10. Constant chronic L foot/ankle pain that improved for few weeks then recurred. Pain on average of 6/10. LBP is about the same since his last visit. Dx remains unchanged. Plan: Dispensed Naproxen 550 mg, Cyclobenzaprine 7.5 mg, Omeprazole 20 mg. Requested PT with regard to L/S, B/L knees and foot. Requested for refill of pain cream Flurbiprofen 10% Lidocaine 10% Gabapentin 6%. Off work.

07/11/16 - P&S Rpt by Brent Pratley, MD – First Hope Medical Clinic. DOI: CT: 03/01/11-02/01/15. Pt has continued LBP and B/L knee pain. PE: L/S: SLR to 80 degrees was positive B/L. DTR and Achilles reflexes were +2 B/L. Coordination, able to walk on his toes and heels Unable to squat. Sensory testing with the Wartenberg's wheel revealed no sensory changes over the dermatomes of L/S or BLE. LE: McMurray & Lachman were positive. Dx: 1) L/S strain. 2) Grade II tear, B/L knee. 3) L/S spondylolisthesis L5-S. 4) Anterior disc bulge 34mm, L5-S1per MRI. 5) L/S radiculopathy. Impairment Rating: L/S: 10% WPI secondary to spondylolisthesis. L ankle: 3% WPI. Ankles: 3% for R knee and 3% for L knee. Combining L/S, L ankle 3%, R knee 3%, L knee 3% and adding 1% for ADLs equals 20% whole person disability. Work Restrictions: No long standing and no heavy lifting over 20 lbs. Vocational rehabilitation: Suggested since he cannot return to his prior occupation as a bicyclist. Causation: Work-related trauma. Discussion/Plan: Pt was initially referred for a spine surgery consult, which was denied. He hoped to return to his previous occupation as a bicyclist which is not realistic. He completed a course chiropractic care and this provider continued to prescribe Tramadol, Prilosec, and Naprosyn to assist in alleviating some of his symptoms. Future Medical Care: Consist of orthopedic evaluations, possible spine surgery, and short course of chiropractic /PT.

09/12/16 - Ortho QME Rpt by Todd H. Katzman, MD. DOI: CT 03/01/11- 02/01/15; 04/14/14. Interim Hx: Since pt's last evaluation, he was under the care of Dr. Pratley. His treatment course included home exercises and PT. He was declared P&S in July of 2016. There has been no new injury. CC: LBP and B/L knee pain. ROS: Denies fever, weakness, fatigue or appetite loss. No significant weight loss or gain. Denies frequent or severe HAs. Denies epilepsy or convulsions. Denies other neurologic problems with the exception of those associated with this injury. PE:

Impingement, Apprehension, Abduction Resistance Tests negative B/L. B/L Elbow: Tinel's test is negative. SLR negative to 90 degrees in the sitting and reclined positions. Lasègue's test is negative B/L. Anterior Drawer, Lachman, Patellar Apprehension, Patellar Inhibition, McMurray, Pivot Shift are negative B/L. Anterior drawer test is negative B/L. Neuro exam is normal with regard to strength and sensation. DTRs are 2+ and symmetrical. Dx: 1) Hx of L fifth metatarsal fx, healed. 2) B/L knee strain. 3) Musculoligamentous strain, lumbosacral spine. 4) Hx of L clavicle fx. In 2001. Discussion: Examiner opines that the injuries are industrially related. Treatment he has received has been appropriate. At this time, it was believed that he has reached the maximum benefit of medical treatment. This provider disagree with the conclusions drawn by Dr. Pratley in his P&S report of 07/31/16 notes that the patient fits into ORE Category II with respect to the L/S and gives the pt 10% WPI. However, pt has no significant structural abnormalities, he has normal L/S motion with his fingertips reaching the floor during flexion, and there is no evidence of neural impingement. Therefore, he is not considered a lumbar GRE Category II. Rather, he is considered to fit into lumbar category I. Furthermore, with respect to the ankles, it should be noted that he did not sustain an injury to his ankles as far as known, and his ankle examination is normal. He did suffer a fx of L foot fifth metatarsal, which eventually resolved, and therefore, he has no WPI related to ankles or feet. With respect to his knees, he has tendinitis. Dr. Pratley has given the patient Impairment as if he had a meniscal injury that required surgical intervention. However, pt did not sustain this type of injury to his knees. Disability status: P&S from the CT injuries that occurred from March 2011 to 02/01/15, and from the specific injury of 04/14/14. Impairment Rating: L foot, fx has healed and pt has been L with no impairment. B/L knees, no structure injury and he has normal, motion with no other abnormalities, However, because of the lingering pain caused by tendinitis, he has 3% WPI. With respect to L/S, he sustained a strain of the lumbar musculature. There has been no structural damage to L/S. Therefore, he is considered a 0% WPI. Therefore, his total WPI is 3%. Causation: Industrially related. Functional Capacity: Able to perform his usual and customary work duties. Future Medical care: Continue with home exercises. He may require the occasional use of an OTC non-steroidal anti-inflammatory med. With persistent pain, he could require further orthopedic consultation, the use of pain medication and/or a possible cortisone injection to the area of inflammation. He is not surgical candidate.

10/28/16 – Supplemental Rpt by Brent Pratley, MD. Comment: Pt was declared P&S on 07/11/16. Examiner agrees with the revised lumbar category II calculated at 8% WPI. In regards to B/L knees, requested x-rays were approved and taken at this facility on 10/19/16. B/L knee exams indicated mild knee effusion. No atrophy. Therefore there can be no rating for the torn lateral meniscus if there is indeed one. Pt has 3% WPI, 1.5% for R knee and 1.5% for L knee.

01/17/17 - PR2 by Brent Pratley, MD. Pt's treatment has finished. He continues with LBP along with B/L knee pain. Dx: 1) L/S strain. 2) B/L knee sprain. 3) L/S spondylolisthesis, L5-S1. Rx: Tramadol 50 mg, Motrin 800mg. Plan: He will need pain management for continued medication. Off work.

01/17/17 – Supplemental Rpt by Brent Pratley, MD. Pt was declared P&S on 07/11/16. This office received a letter indicating a discrepancy between work restrictions suggested by Dr. Katzman and this provider. Pt is asymptomatic until he was involved in the heavy physical activity of bicycling after working for Bridgeway International Inc. for approximately 5 years. This provider has given him 8% WPI for lumbar category II. There is no ratable lesion for the knees; there is no atrophy of the gastroc. Table 18-4 indicates 3% whole person disability, 15% for R knee and 1.5% for L knee, At this point, it is this provider's opinion he unable to return to his job at Bridgeway International inc. doing the bicycling he did before. He is a qualified injured worker and in need of a vocational rehabilitation or some type of work change of no heavy lifting, no repetitive bending or twisting, etc. In the absence of any prior injury, apportionment does not apply.

07/28/17 – PTP's Initial Eval by Jacob Rosenberg, MD - IPM Med Grp. DOI: 02/01/15. Pt rates the pain as 8 /10. Pain intensity as 9/10. Level of sleep for the pt has decreased due to difficulty in falling asleep. Quality of sleep is poor due to difficulty in staying asleep. Pt described a cumulative trauma on 02/01/15 while working for Triace Bicycle Company. He is still in the research and development, doing testing and development of carbon fiber high-end bicycles for five years preceding 02/01/2015. Essentially the job was to work in China going to test bikes in a variety of mountain bike races. He flies off from his base approximately 20 days per month to different events where he is always pitted against local contestants. He was expected to win races. He would race typically on a hike, but he would have to carry a case on the plane with him then reassemble at the test site. Typically, there is a handler to work with him sometimes to help carry the bike, sometimes to help with assembling. The bikes usually had sensors on them that allow other technicians to see how the bikes were working or qualify to be able to approve the quality of the bike. All the bicycles that he rode were preproduction models. He described a number of crashes in particular a 05/14/20 14 crash where he fractured his L foot probably a Jones fracture. He stayed off the foot for a while, but returned to work in 08/2014. Subsequent to that he continued to work until 02/2015 when he could no longer continue because of significant low back, cervical spine and B/L knee pain. L foot for some reasons is not an accepted body part. He described that there are a significant number of crashes, and be does not say that any one crash where he had significant discomfort but gradually he had increasingly severe pain in the knees, low back and some pain in the cervical spine as well, L shoulder was injured many years ago in a prior bicycle injury, non-industrial with a clavicle fx. Currently, despite primarily low back and L knee pain along with some pain in sole of L foot. He described swelling in the foot, and some swelling in the B/L knees. When he stands and walks for more than 15-20 minutes, he developed severe B/L knee pain. When he stands or sits or walks for more than 15 minutes, he developed significant low back pain. Occasionally the low back pain radiates to the R buttock, R posterior thigh down to R foot, lateral foot, multiple times per day, and there is radiation primarily in the SI nerve root distribution in R side to the little toe. The only medication is ibuprofen 800 mg tablets per day and Prilosec because of drastic irritation with ibuprofen. He has had a course of physical therapy in the past, but no injections, no acupuncture. Dr. Pratley's has MRI scans, which he believes showed a significant pathology. Besides the radiation to the lumbar spine down to R, bra he also has a constant L foot pain primarily at the 4th and 5th

metatarsal heads with significant pain on the foot with standing and walking. CC: C/o pain in his upper back, mid back, lower back, B/L knees, L ankle, and L foot over the past two years and five months. He reports that he sustained work-related CT injuries which manifested on 02/01/15. Currently, despite primarily lower back and L knee pain along with some pain in the sole of L foot. He described swelling in the foot, and some swelling in the B/L knees. When he stands and walks for more than 15 to 20 min, he developed severe B/L knee pain. When he stands or sits or walks for more than 15 minutes, he developed significant LBP. Occasionally the LBP radiates to R buttock, R posterior thigh down to R foot, lateral foot, multiple times per day, and there is radiation primarily in the SI nerve root distribution in R side to the little toe. The only medication is ibuprofen 800 mg tablets per day and Prilosec because of drastic irritation with Ibuprofen. He has had a course of PT in the past, but no injections, or acupuncture. Dr. Pratley's has MRI scans, which he believes showed a significant pathology Besides the radiation to from the lumbar spine down to R, but lie also has a constant L foot pain primarily at the 40i and 5th metatarsal heads with significant pain on the foot with standing and walking. Present Complaint: Currently, pt c/o pain in the mid-back, lower back, B/L knees, L ankle, and L foot. His LBP radiates down to his BLE. The pain is associated with N/T and weakness in B/L legs and L foot. The pain is constant in frequency and severe in intensity. Rates the severity of the pain as 8, but as 8 at its best and 10 at its worst. He describes the pain as sharp, cutting, throbbing, shooting, and electric-like with muscle pain and pins-and-needles sensation. The pain is aggravated by prolonged walking, prolonged standing, prolonged sitting, kneeling, and stooping. He further states that he can only lift or carry items weighing less than 10 lbs. The pain is relieved with taking medication and elevating the affected area. He states that he experiences relief of back pain when leaning on something for support. He does not use any assistive device for walking. He reports having constipation. The patient states that his symptoms have been worsening since the injury. He states that his lower back pain is worse when bending forward. He can sit for 10 minutes at one time and stand for 5 minutes at one time. ROS: Negative for N/T, tremors, seizures, vertigo, dizziness, memory loss, any focal or diffuse neurological deficits. Vitals: Weight: 158 lbs. BP: 138/83. PE: SLR in the sitting and supine position were congruent with primarily back and buttock pain. Internal and external rotation of the hips do not produce any significant discomfort. There is modest pain over the greater trochanter over R buttock. Sensory evaluation showed decreased sensation primarily in the 2.83 Semmes-Weinstein monofilament in L S1 gross sural nerve distribution. His L fifth toe was rotated metatarsophalangeal joint and deviated medially in the DIP joint. There is limited extension of the fifth toe on L foot, normal on R foot. His gait was normal. He is able to stand on his R foot without difficulty. He was able to do a single toe raise on R foot. On L foot, he was unable to toe raises, and able to stand on the L foot no more than few minutes. Negative McMurray's. L shoulder, positive impingement findings and rotator cuff weakness versus R. Dx: 1) Spondylolisthesis, lumbar region. 2) Pain in L knee. 3) Pain in R knee. Oswestry Index: Total: 62 % disability. Pt appears to be experiencing mild to moderate symptoms of depression by his CES-D score of 27. Epworth sleepiness scale: 10. Plan: Obtain Dr. Pratley's MRI scans. Requested one visit of PT to help him with providing a transition to home exercise program and active range of motion. A trial of H-wave in conjunction with PT physical therapy would be appropriate to see if we can reduce his pain to allow him to participate more vigorously a the

home exercise program. He does not have significant relief, there is no need to continue the H-wave twice. Prescribed Celebrex 100 mg to replace Ibuprofen. Alternatively, would place him on naproxen and supplemented with a proton pump inhibitor type drug to control his gastric irritation. A med-legal evaluation for L foot would be appropriate. Requested MRI scans of the L/S, B/L knees, L foot. Explained to him that it was unlikely for him to return to the competitive-type racing environment that he was, but depending upon the imaging studies he may well be able to return to bike riding and performing the similar evaluation test of preproduction models.

08/21/17 – PR2 by Jacob Rosenberg, MD. Pt c/o pain at 8/10, pain intensity as 9/10. The level of sleep for pt has decreased due to difficulty in falling asleep. Quality of sleep is poor. Due to difficulty in staying asleep pain level has increased since last visit. Pt rates his pain with medications as 8/10 and without medications as 10/10. Level of sleep for pt has decreased due to difficulty in falling asleep due to difficulty in staying asleep. Quality of sleep is poor. Pt sleeps 6 hours per day interrupted. Currently, despite primarily low hack and L knee pain along with some pain in the sole of L foot. He described swelling in the foot, and some swelling in the B/L knees. When he stands and walks for more than 15-20 minutes, he developed severe B/L knee pain. When he stands or sits or walks for more than 15 minutes, he developed significant low back pain. Occasionally the low back pain radiates to R buttock, R posterior thigh down to R foot, lateral foot, multiple times per day, and there is radiation primarily in the S1 nerve root distribution in R side to the little toe. Besides the radiation to the lumbar spine down to R, but he also has a constant L fool pain primarily at the 4th and 5th metatarsal heads with significant pain on the foot with standing and walking. Conservative treatments were initiated, including physical therapy, chiropractic treatment, and psychotherapy. He also used a TENS unit. Apparently nothing else was authorized as he was eventually released from the previous PTP. ROS: Positive for poor energy. Negative for sleep, weakness, weight changes, N/T, tremors, seizures, vertigo, dizziness, memory loss, any focal or diffuse neurological deficits. Vitals: Weight: 157 lbs, BP: 135/77. PE: SLR in the sitting and supine position were congruent with primarily back and buttock pain. Internal and external rotation of hips did not produce any significant discomfort. There is modest pain over the greater trochanter over the R buttock. Sensory evaluation showed decreased sensation primarily in the 2.83 Semmes-Weinstein monofilament in L S1 gross sural nerve distribution. His L fifth toe was rotated metatarsophalangeal joint and deviated medially in the DIP joint. There is limited extension of the fifth toe on L foot normal on R foot. His gait was normal. He is able to stand on his R foot without difficulty. He was able to do a single toe raise on R foot. On L foot, he was unable to toe raises, and able to stand on L foot no more than few minutes. Negative McMurray's on R but positive on right, normal stability. Dx remains unchanged. Plan: Finish the 4 sessions of PT. Apparently only 4 sessions were authorized. H-wave was approved but he has not received the machine. Modified Duty with no repetitive or heavy work. Light duties are not allowed so he essentially remains TTD.

09/13/17 – PR-2 by Jacob Rosenberg, MD. Pain level has increased since last visit with 7/10 Pain without meds 9/10. Level of sleep for the pt has decreased due to difficulty in falling asleep due to difficulty in staying asleep. Quality of sleep is fair. Sleeps 5 hours per day interrupted. Pain level seemed to have increased since last visit, but he has not had any interim injuries,

accidents, or illness. The primary pain is still in the lumbar spine radiating to BLE. Vitals: Wt 155 lbs, BP 125/77. PE: Lumbar facet loading is positive on both sides. SLR is positive on both the sides in supine position at degrees. Kemps Test is positive. SLR in the sitting and supine position were congruent with primarily back and buttock pain. Sensory evaluation showed decreased sensation primarily in the 2.83 Semmes-Weinstein monofilament in L S1 nerve distribution. DTR R/L L4 2+/2+. S1 1+/1+. Negative McMurray's on R but positive on R, normal stability. Positive impingement findings and rotator cuff weakness versus R. MRI of L/S from 08/22/17 was available for review. At T12-L1. L1-L2, L2-L3, there is mild disc desiccation without evidence of herniation or stenosis. At L3-L4, there is mild disc desiccation bulges minimally into the caudal aspect of L foramen without neural compression. Schmorl's nodes are seen. L4-L5 mild disc desiccation. No evidence of herniation or stenosis. L5-S1 chronic B/L pars fracture with grade I spondylolisthesis, disc degeneration with vacuum phenomenon type I and type 2 endplate changes. There is severe B/L neural foraminal stenosis due to marginal osseous ridging and the spondylolisthesis. Note is made of a small facet joint synovial cyst on the L dissecting anteriorly, but not causing neural compression. MRI of L foot from 08/22/17 was also available for review with impression of mild amorphous bone edema at the third metatarsal head without adjacent orthosis, adjacent capsuloligamentous pathology or demonstrable fracturing. Disc height represents mild stress response. Moderate OA of the far dorsal aspect of the third tarsometatarsal joint with mild subchondral cystic changes at the lateral cuneiform. Mild OA of the dorsal aspect of the middle naviculocuneiform joint for normal regional muscles and tendon. No evidence of Morton's neuroma. MRI of L knee from 08/21/17 was available for review and this shows minor degenerative changes without meniscus or ligamentous tear. Dx: 1) Spondylolisthesis, lumbar region. 2) Pain in L knee. 3) Pain in R knee. Plan: Requested for a podiatry consult, acupuncture therapy, PT for L/S and both knees. Also requested Lumbar ESI. Modified duty with no repetitive work. No heavy work. So far light duties have not been allowed so he is TTD.

10/04/17 – PR2 by Jacob Rosenberg, MD. Pain level has increased since last visit. Pain with medications 7/10, without medications 9/10. Also c/o back pain and low back feels better with PT. Felt better with Celebrex and asking for refill. Less pain and stiffness, easier to exercise. Primary pain is still in L/S radiating to BLE. Vitals: Weight: 154 lbs, BP: 123/79. PE: Lumbar facet loading is positive on both sides. SLR is positive on both sides in supine position at degrees. Kemps Test is positive. SLR in the sitting and supine position were congruent with primarily back and buttock pain. Sensory evaluation showed decreased sensation primarily in the 2.83 Semmes-Weinstein monofilament in the L S1 nerve distribution. DTR R/L L4 2+/2+. S1 1+/1+. Able to do a single toe raise on R foot. On L foot, he was unable to toe raises, and able to stand on L foot no more than few minutes. Negative McMurray's on R but positive on right, normal stability. L shoulder, positive impingement findings and rotator cuff weakness versus R. Dx remains unchanged. Rx: Celebrex 100 mg. Plan: Podiatry evaluation on 10/16/17 Dr. Burke. Second request for acupuncture and PT. Third request for L/S epidural. TTD.

11/07/17 – PR2 by Jacob Rosenberg, MD. Pain with medications as 8/10 and without medications as 10/10. Level of sleep for the patient has decreased due to difficulty in falling

asleep due to difficulty in staying asleep. Quality of sleep is poor. Pt sleeps 4 hours per day interrupted. Spoke with adjustor who states that they do not know the status of the ESI request at this time but will work get back. Pt has been using Celebrex which is not helping his pain and causes him GI upset. Today pt c/o 8/10 R side LBP with radiation down the back of R leg crossing the knee and terminating at the lateral aspect of R ankle. Pain is described as sharp shooting pain better with elevation of the R leg and rest, worse with standing and walking. Pt notes numbness over the lateral aspect of R ankle but denies weakness. Pt also notes that because he is unable to work he is feeling depressed and is having difficulty sleeping. Depression has been worsening over the past month. Wt: 154 lbs, BP: 120/74. PE: Lumbar facet loading is positive on both sides. SLR is positive (degrees not given) on both the sides in supine position at degrees. Kemps Test is positive. DTR R/L, L4 2+/2+. S1 1+/1+. Able to stand on his R foot without difficulty. He was able to do a single toe raise on R foot. On L foot he was unable to toe raises, and able to stand on L foot no more than few minutes. Negative McMurray's on R but positive on R, normal stability. L shoulder, positive impingement findings and rotator cuff weakness versus R. Dx: Radiculopathy, site unspecified. Plan: Re-requested acupuncture and PT. Discontinue Celebrex. Referral to Dr. Dorsey for psych evaluation and optimization of depression. TTD.

01/04/18 – PR2 by Jacob Rosenberg, MD. Pain level has decreased since last visit. Pain with meds 8/10 and without meds as 10/10. Level of sleep for pt has stayed the same. Quality of sleep is poor. Sleeps 4 hours per day interrupted. R-sided LBP with radiation down the back of R leg crossing the knee and terminating at the lateral aspect of the R ankle. Pain is described as sharp shooting pain. Notes numbness over the lateral aspect of R ankle but denies weakness. Pt has completed multiple rounds of PT with minimal benefits. Vitals: Weight: 156 lbs, BP 123/71. PE: Lumbar facet loading is positive on both sides. SLR is positive on both the sides in supine position at degrees. Kemps Test is positive. Light touch sensation is decreased over lateral foot and lateral calf on R side. SLR in sitting and supine position were congruent with primarily back and buttock pain. DTR R/L, L4 2+/2+, S1 1+/1+. Limited extension of fifth toe on L foot normal on R foot. He is able to stand on his R foot without difficulty. He was able to do a single toe raise on R foot. On L foot, he was unable to toe raises, and able to stand on L foot no more than few minutes. Negative McMurray's on R but positive on right, normal stability. L shoulder, positive impingement findings and rotator cuff weakness. Dx: Radiculopathy. Plan: F/u with adjuster regarding ESI. Referred to psych. TTD.

02/15/18 – PR2 by Jacob Rosenberg, MD. Pain level has remained unchanged since last visit. Pain with medications as 8/10, without medications as 10/10. Level of sleep for the patient has stayed the same. Quality of sleep is poor. Pt sleeps 4 hours per day interrupted. R-sided LBP with radiation down back of R leg crossing the knee and terminating at the lateral aspect of the R ankle. Pain is described as sharp shooting pain, better with elevation of the R leg and rest, worse with standing and walking. Pt notes numbness over the lateral aspect of the R ankle but denies weakness. Pt also notes that because he is unable to work he is feeling depressed and is having difficulty sleeping. Pt denies SI. Pt notes that depression has been worsening over the past month. Completed approximately 20 sessions of PT for L/S with no help. Completed

X

approximately 10 sessions of chiro with no help. PE: Lumbar facet loading is positive on both sides. SLR test is positive on both sides in supine position at degrees. Kemps Test is positive. Neurologic: On sensory examination, light touch sensation is decreased over lateral foot and lateral calf on R side. SLR in the sitting and supine position were congruent with primarily back and buttock pain. Internal and external rotation of the hips do not produce any significant discomfort. There is modest pain over the greater trochanter over R buttock. DTR R/L, L4 2+/2+, S1 1+/1+. Able to stand on his R foot without difficulty. He was able to do a single toe raise on R foot. On L foot he was unable to toe raises, and able to stand on L foot no more than few minutes. Negative McMurray's on R but positive on right, normal stability. L shoulder, positive impingement findings and rotator cuff weakness versus R. Plan: Taking Ibuprofen 800mg. Re-submitted auth for LESI. TTD.

05/14/18 - PR2 by Jacob Rosenberg, MD. Pain level has increased since last visit. Pain with meds as 10/10, without medications as 10/10. Level of sleep has stayed the same, Quality of sleep is poor. Pt sleeps 3 hours per day interrupted. Right-sided LBP with radiation down the back of the R leg crossing the knee and terminating at the lateral aspect of the R ankle. Pt notes numbness over the lateral aspect of the R ankle but denies weakness. Pt also notes that because he is unable to work he is feeling depressed and is having difficulty sleeping. Pt notes that depression has been worsening over the past month. LESI and psych denied. ROS: Positive Poor energy. Negative for weakness, weight changes, N/T, tremors, seizures, vertigo, dizziness, memory loss, any focal or diffuse neurological deficits. Vitals: Weight: 158 lbs, BP 121/69. Lumbar facet loading is positive on both sides. SLR is positive on both the sides in supine position at degrees. Kemps is positive. Light touch sensation is decreased over lateral foot and lateral calf on R side. SLR in the sitting and supine position were congruent with primarily back and buttock pain. DTR R/L, L4 2+/2+, S1 1+/1+. He is able to stand on R foot without difficulty. Able to do a single toe raise on R foot. On L foot, he was unable to toe raises, and able to stand on L foot no more than few minutes. Negative McMurray's on R but positive on right, normal stability. In L shoulder, positive impingement findings and rotator cuff weakness versus R. Dx remains unchanged. Plan: Resubmission request for a R L5/S1 interlaminar ESI. Pt has radicular symptoms on H&P including neurological deficits in sensation over the lateral aspect of L calf. Pt has failed 20 sessions of PT for the lumbar spine in 2017. In addition to this he has an MRI from 08/17 showing severe B/L neuroforaminal narrowing correlating with the symptoms on H&P. TTD

02/13/17 - Deposition of Todd Katzman, M.D. (38 Pages).

Page 5: Dr. Todd Katzman had taken deposition before.
Page 6: Doctor had issued two reports in this case, one dated 10/26/15 and next one was on 09/12/16. Doctor testified that he reviewed those reports in preparation for deposition.
Page 7: Doctor mentioned in his report that the patient claimed all injuries during the course of his employment, but was working on regular job the entire time. Doctor stated that the patient's duties were testing of bikes, walking around, riding the bikes, and showing people about bikes. He also admitted that the patient did not take off work.

Page 8: Doctor testified that it is medically probable that the patient's bilateral knee injury is due solely to his summer of 2013 injury.
Page 9: Doctor testified that he prepared both of his reports under the provisions of Labor Code 4628 and those requires an evaluator to take the patient's history and to perform the evaluation.
Page 11: Doctor saw the patient about 6 months ago.
Page 12: Doctor stated that the patient had problems with squatting. Based upon doctor's evaluation, he did not believe that the patient had any specific structural problem with his knee that prevented him from riding a bike.
Page 16: Doctor stated that he examined the patient's foot.
Page 19: As per page number 16 of doctor's report, it indicated that he conducted multiple tests such as testing of motion in the cervical spine and also asked the patient to touch his chin to chest. Doctor stated that shoulder motion is not true and he could barely lift his elbow. Also admitted that the patient could reach his arms above his head on both sides. Doctor performed Tinel's and examined his elbow.
Page 20: While performing Lasegue's test, the patient was sitting on a bed, though they were moving his hips and knees. Doctor revealed that he had no pain with straight leg raise test. He testified the patient could put his hands to the ground. Doctor thought he had full cervical range of motion.
Page 22: Doctor had the opportunity to review Dr. Pratley's 07/11/16 Permanent and Stationary Report. Doctor also admitted that in his Permanent and Stationary Report, under System Review, he noted essentially normal except for the history of present illness.
Page 23: Doctor also had an opportunity to review his 03/23/16 report and on page 4 where Dr. Pratley noted that the patient was able to bring his fingertips to the floor. He felt that would be consistent with his findings and evaluation of the patient. Doctor opined that the patient had a normal exam. Doctor found that the patient had MRI studies, which didn't reveal any meniscal injury. Doctor stated that the patient had a foot fracture, which healed. He had lumbar complaints without any objective findings, and found that there was no reason to say he couldn't ride a bike.
Page 24: Doctor believed that the patient had subjective complaints, but he doesn't really have any objective findings. Doctor stated that during exam, the patient was bending his knees.
Page 26: He felt that based on medical probability, the patient doesn't have a major problem with his knees.
Page 27: Doctor believed that knee concern was not associated with the back pain for this case.

NOTE: Remainder of the record includes superior court house notes, Disability Rating, HICF.

CLINICAL IMPRESSIONS:

1. History of multiple concussions, nonindustrial.
2. Post traumatic head syndrome, nonindustrial.
3. Post traumatic headaches, nonindustrial.
4. Possibly traumatic induced Ménière's disease, nonindustrial, to be addressed by a board certified laryngologist.
5. Compression injury, nonindustrial.

X

6. Bowel and bladder disturbance, nonindustrial.

DISCUSSION AND RECOMMENDATIONS:

I have had an opportunity to evaluate Mr. Alan Eger, who sustained multiple injuries during the course of his employment for Triace Bicycle / Bridgeway International including a left foot fracture in April 2014, as well as continuous trauma between March 1, 2011 through February 1, 2015 to multiple body parts including the back, bilateral shoulders, knees and ankles. There were also claims for the nervous system, stress and psychologic factors.

The patient has a complicated medical history that predates his date of hire primarily associated with multiple blunt head trauma with cerebral concussions and cognitive impairment, post-traumatic headaches and possible Ménière's disease, resulting from blunt head trauma, which should be addressed by a board certified otolaryngologist.

Additionally, he reports discomfort in the saddle of his buttocks region that would support a perineum nerve injury from sitting on a bicycle seat; a common complaint of bicyclists, being professional or nonprofessional.

He has had prior orthopedic injuries, which I will defer to a board certified orthopedist to address.

He should also undergo a formal urologic evaluation to address a perineum nerve injury or irritation, as well as any bowel or bladder complaints resulting from his course of participating in bicycle competitions and training for much of his young life.

Regarding the patient's medical records reviewed by me, I note that there is reference to the patient training for bicycle races, as noted by Dr. Hao Thai on April 23, 2014 at which time he was noted to have sustained a fracture of the left foot while in China, as well as having a history of a stress disturbance, along with depression.

He was reported to have lumbar disc disease and lumbar radiculopathy in 2015.

He underwent an orthopedic evaluation by Panel Qualified Medical Evaluator, Dr. Katezman on October 26, 2015. His orthopedic complaints occurred during a bicycle race in China on April 1, 2014.

Other records in 2017 refer to the patient having trouble with sleep, including insomnia and difficulty staying asleep.

Review of systems obtained by Dr. Rosenberg, primary treating physician on July 28, 2017 made reference to the patient not having vertigo at the time; keeping in mind that Ménière's disease occurs episodically and can have periods of quiescence for months or longer / any given time.

The patient did not report memory loss, although it does not appear that a review of the patient's activities of daily living regarding cognitive functioning (CDR scale) was obtained consistently during his examinations. The medical history does not make reference to the patient's prior numerous concussions.

He continued to treat with Dr. Rosenberg, who commented on the patient having left S1 radiculopathy, as well as poor sleep, averaging four hours of sleep per night.

The patient's deposition of February 13, 2017 was directed to the patient's orthopedic injuries during his course of employment, problems with various postures and difficulty elevating his upper limbs.

With respect to the patient's neurological complaints predating his date of hire, in my opinion, he qualifies for a 16% whole person impairment for cognitive complaints related to multiple concussions that he sustained either from motor vehicular versus bicycle accidents or accidents without any motor vehicle involved with 100% apportionment of permanent disability to pre-existing nonindustrial factors.

For the patient's headache complaints, in my opinion, he qualifies for a 3% whole person impairment with 100% apportionment of permanent disability to pre-existing head injuries, unrelated to his course of employment.

For the patient's complaints of dizziness likely related to longstanding Ménière's disease from cerebral concussions, in my opinion, he qualifies for a 5% whole person impairment from Table 13-13 with 100% apportionment of permanent disability to pre-existing nonindustrial factors.

The patient's final whole person impairment is calculated as follows: Sixteen percent combines with 5% to equal a 20% whole person impairment. Twenty percent combines with 3% for a **22% whole person impairment**.

The patient should undergo audiological testing, neuropsychological testing, PET imaging or functional MRI scan imaging. The patient should undergo orthopedic and urologic evaluations for his multiple pre-existing orthopedic complaints, as well as his urogenital complaints.

If I can be of further assistance regarding this case, please do not hesitate to contact this office.

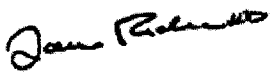
SOURCE OF ALL FACTS AND DISCLOSURE:

The source of all facts was the history given by the examinee and review of the previous examiner's medical reports. I personally interviewed the examinee, performed the physical examination, reviewed the history with the examinee, reviewed the medical records provided, dictated this report and it reflects my professional observations, conclusions and recommendations. Face-to-face time conformed with DWC Guidelines. I declare under penalty of perjury that the information contained in this report and its attachments, if any, are true and correct to the best of my knowledge and belief, except as to the information that I have indicated and received from others. As to this information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true. Labor Code 139.3 was not violated.

Assistance with preparation of this report was provided by Isabel Mendoza, Assistant and Rapid Care, Record Summarizer, each of whom were trained by Arrowhead Evaluation Services, Incorporated. Please note that all times listed reflect physician time spent and not staff time.

Date of Report: December 14, 2020. Signed this 7th day of January, 2021 at San Bernardino County, California.

Yours truly,



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LMR/kdp