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July 11, 2022

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Claimant Name:	**ANISA CHANEY**
Social Security No.:	XXXX-XX-6450
Date of Birth:	9/6/1973
Date of Panel QME:	April 22, 2021
Panel Number:	7382307
EAMS Number:	ADJ13521045
Date of Injury:	CT 01/06/2020-06/30/2020; CT 07/06/2019-07/05/2020
Claim #:	2080381794
Employer:	Bold Quail Holdings, LLC

SUPPLEMENTAL TYPE MEDICAL-LEGAL REPORT

State of California Workers' Compensation Program

Dear Concerned Parties:

At your request, the following laboratory results / recently received medical records were reviewed. Causation and other compensability determinations have been discussed below.

BILLING: ML-203-95 + MLPRR is billed. I declare under penalty of perjury that I have received and personally reviewed 544 pages of medical records.

BRIEF CASE REVIEW:

I originally evaluated this examinee on April 22, 2021. At the time she was 47 years old and had been hired as a Nurse Consultant in April 2010. Her last day at work took place on July 6, 2020. She denied a history of chronic medical conditions and was not taking any medications at the time of my evaluation.

The examinee started to complain of left upper extremity, cervical and jaw pain towards the latter part of 2018. She sought medical care through her primary care physician. She continued to work as usual, but started to have trouble sleeping and her left side due to left shoulder pain. She was taking nonsteroidal anti-inflammatories intermittently.

The examinee's symptoms appeared to be stable on the early 2019. The company changed hands, and the examinee had been complaining about supervision difficulties. She had trouble pushing heavy carts, and required assistance but there was none to be had. She felt overworked and rushed. Her new employer initially appeared to be sympathetic, but nothing happened in the long run. The examinee became increasingly concerned over the Covid crisis, and went to her supervisor with her worries. The supervisor was not sympathetic, noting that the patients were not going to be quarantined. After that episode, she was gradually isolated. She was fired after becoming concerned about a patient that had left the facility unsupervised; she wanted to call the police.

During the latter part of 2019 the examinee started to develop episodes of oppressive chest pain. This was associated to the onset of her shift. She also suffered from intermittent diarrhea and frequent stomach cramping. She started to lose weight, going from 136 pounds to 123 pounds. The examinee use OTC medications for her symptoms. After she stopped working her symptoms appeared to improve, and by December 2020 she felt much better. The last episode of chest pain took place on September 2020.

The examinee has a history of seasonal environmental allergy and takes antihistamines sporadically. At one time, she was diagnosed with irritable bowel syndrome, but had no symptoms at the time of my original evaluation. She denied a history of hypertension, but suffered from acute anxiety attacks and her blood pressure was elevated during these episodes.

At the time of my evaluation, all of her current complaints were musculoskeletal in nature. Family history significant for history of hypertension, strokes and a brain aneurysm.

Physical examination showed normal vital signs, no evidence of hypertension (blood pressure = 116/62) and a BMI of 25.2. Oral anatomy was Mallampati 4. Cardiopulmonary examination was unremarkable, and there was no evidence of peripheral edema. Laboratories were ordered.

Medical records were reviewed. They showed a history of stress at home and at work dating back to 2015. The examinee was deposed on November 13, 2020; at that time the examinee testified

had separated from her husband for about two years. At the time her weight was 122 pounds. Blood pressure was normal. The examinee was a current, daily smoker according to her Kaiser Permanente May 2018 medical records. The Examinee saw Dr. Pietruszka for her Worker's Compensation claim, and this provider claims that the Examinee was exposed to chemicals, dusts and vapors during the course of her work as well as excessive noise, heat and cold. She was diagnosed with a long list of musculoskeletal problems, as well as gastritis due to NSAIDs and irritable bowel syndrome. None of these diagnoses were documented objectively. There were deemed to be compensable.

REVIEW OF RECORDS:

"A physician may not bill for review of documents that are not provided with this accompanying required declaration from the document provider. Any documents or records that are sent to the physician without the required declaration and attestation shall not be considered available to the physician or received by the physician for purposes of any regulatory or statutory duty of the physician regarding records and report writing."

Attestation is needed in order to finalize my conclusions ___Yes ___No
Note: A supplemental report will be required to include those records not having an attestation available at the date of production (per date on signed declaration below) of this report.

Attestation has been received and is acknowledged herein _X_ Yes ___No PAGES: 544

Undated Consent to Treatment. Examinee had consented for treatment.

01/27/12 Consent Form for HIV Blood Test. Examinee had consented for HIV blood test.

01/27/12 Quest Diagnostics. Cytology Report.
Pap test. Source: Cervical. Result: Negative for intraepithelial lesion or malignancy

01/27/12 Quest Diagnostics. Laboratory Report.
Lipid Panel. Cholesterol, total: 115.
Basic Metabolic Panel. Glucose: 104.
Hepatic Function Panel. Globulin: 2.0. Albumin/Globulin Ratio: 2.4.
Complete Urinalysis. Squamous Epithelial Cells: 6-10. Moderate mucus threads.
HIV AB, HIV ½, EIA with reflexes. HIV ½ EIA antibody screen: Non-reactive.
RPR (DX) with reflex titer and confirmatory testing: Non-reactive.

Thyroid panel and Complete blood count with differential/platelet were performed and their values were found to be within normal range.

01/27/12 Dr. Valentin Hernandez, Internal Medicine. History and Physical. Examinee complained of having a sore throat with cough, phlegm and green mucous with fevers which were not better

even though she was drinking a lot of fluids. She noted a fungus over the extremities as well as the groin which was quite pruritic and felt like it was on fire. Review of systems was significant for persistent cough with expectoration, sore throat and spreading worsening fungus on the skin. Vitals: BP: 112/64. Height: 5'2". Weight: 140 lbs. Pulse: 64. RR: 20. Temperature: 97.6. General examination revealed Examinee appeared to be in pain. Skin examination revealed it was slightly red. Examination of the neck revealed supple with palpable nodes. Diagnoses: Pharyngitis. Tinea corporis. Plan: Ordered complete blood count, cholesterol panel, SMA-7, liver function tests, thyroid panel, pap smear and urinalysis. Follow up as needed.

02/02/12 Dr. Valentin Hernandez. History and Physical. Examinee felt weak, tired and no matter how much she sleeps, still tired progressively getting worsened over the past few weeks to the point that she was barely able to do most of the work. Even one block of exercise was enough to make her tired. She has not had any rest over the past two weeks as the cough has been getting worse and was associated with phlegm and felt warm and sore throat and pleuritic chest pains associated with dyspnea. She was having worsening and pruritic burning pains all over the toes and feet as well as the groin which was quite red. She was being exhausted with even the most elementary work, tired and also had persistent cough not getting better in spite of medications and kept her awake. Redness and thickness of the skin with pruritus also present. Review of systems was significant for quite tired, not eating well, cough, phlegm, fevers, dyspnea and spreading worsening fungus on the skin. Vitals: BP: 118/64. Height: 5'2". Weight: 134 lbs. Pulse: 62. RR: 14. Temperature: 97.8. General examination revealed Examinee appeared nervous. Skin examination revealed erythematous and papular rash. HEENT examination revealed pharynx has hemorrhages with purulent mucous. Examination of the chest revealed diffuse rhonchi bilaterally. Diagnoses: Anemia, iron deficiency. Bronchitis. Tinea corporis. Rx: B complex qd, Ferrous Sulfate 325 mg qd and Lamisil 250 mg qd. Plan: Prescribed Tinactin cream for 10 days. Work Status: Off work from 02/02/12 to 02/05/12. Able to return to work on 02/06/12. Follow up as needed.

12/18/12 Dr. Valentin Hernandez. History and Physical. Examinee's joint pains were getting worse even with the medicines especially in the mornings, even though she has tried applying warm packs and towels to the joints. She has been having a purulent cough over the past few days not getting any better and has noted difficulties with hoarseness even though she has been doing gargling. Examinee has noted pains in most of the large joints especially over the knees and sore throat with phlegm and cough with a thick phlegm and redness and thickness of the skin with pruritus. Also reported the worsening and pruritic burning pains all over the toes and feet as well as the groin which was quite red. Review of systems was significant for diffuse joint pains, persistent cough with expectoration, sore throat and spreading worsening fungus on the skin. Vitals: BP: 103/59. Height: 5'2". Weight: 143 lbs. Pulse: 66. RR: 19. Temperature: 97.3. Skin examination revealed skin was red and desquamative. HEENT examination revealed nose and turbinates were red and purulent. The throat has white exudate with injection. Examination of the neck revealed to be supple with tender anterior nodes. Has decreased range of motion and was tender bilaterally from C1-C7. Examination of the back revealed limited motion of the lower back with tenderness

over the lumbar spine. Examination of the extremities revealed swelling and tenderness over the knees and ankles with decreased range of motion. Diagnoses: Osteoarthritis. Pharyngitis. Tinea corporis. Rx: B complex, Ferrous Sulfate 325 mg and Tylenol #3 qd. Plan: Prescribed Tinactin cream. Ordered Complete blood count. Follow up as needed.

12/21/12 Dr. Valentin Hernandez. History and Physical. Examinee noticed hot and pruritic redness and a worsening rash over the feet and groin which was not responding to the over-the-counter creams. She has noted an increase in the cough, phlegm, sore throat and headaches over the past week even though she has been taking some over the counter medications. Review of systems remains the same as previous visit. Vitals: BP: 104/62. Height: 5'2". Weight: 143 lbs. Pulse: 82. RR: 18. Temperature: 97.2. General examination revealed Examinee appeared dyspneic and exhausted. Skin examination revealed erythematous and papular rash. HEENT examination revealed tympanic membrane was neither red nor retracted. The nasal mucosa was injected and watery. Pharynx has hemorrhages with purulent mucous. Examination of the neck revealed supple with tender anterior nodes. Diagnoses: Pharyngitis. Tinea corporis. Rx: Nizoral 200 mg qd. Follow up as needed.

05/24/13 Dr. Valentin Hernandez. History and Physical. Examinee complained of having redness over the skin and warmth which has not responded to the antibiotics she was on at this time and came in for change of medication. Examinee developed a white yellow vaginal discharge over the past week which was getting worse on taking the medications. She has not had any rest over the past two weeks as the cough has been getting worse and was associated with phlegm, felt warm, sore throat and pleuritic chest pains associated with dyspnea. Review of systems was significant for infection of the skin which was getting worsened, vaginal discharge and infection, cough, phlegm, fevers, and dyspnea. Vitals: BP: 110/68. Height: 5'2". Weight: 132 lbs. Pulse: 76. RR: 18. Temperature: 97.8. General examination revealed Examinee appeared to be in pain. Skin examination revealed to be slightly red. HEENT examination revealed tympanic membrane was neither red nor retracted. The nose was tender with purulent mucous. Examination of the neck revealed supple with palpable nodes. Examination of the chest revealed rhonchi on auscultation. Examination of the abdomen revealed tenderness over the bladder. Vaginal exudate present. Diagnoses: Cellulitis. Vaginitis. Bronchitis. Rx: Tylenol #3 qid. Plan: Ordered pap smear, complete blood count, SMA-7, cholesterol panel, liver function tests, urinalysis and serum pregnancy test. Follow up as needed.

05/24/13 Quest Diagnostics. Laboratory Report.
Lipid Panel. Cholesterol, total: 105.
Basic Metabolic Panel. Urea Nitrogen (BUN): 6.
Urinalysis. Appearance: Hazy. Leukocyte Esterase: 2+. WBC: 10-20. Squamous Epithelial Cells: 6-10. Bacteria: Moderate.
HCG Total: Negative.

Hepatic function panel and complete blood count with differential/platelet was performed and their values were found to be within normal range.

05/24/13 Quest Diagnostics. Cytology Report.
ThinPrep Test. Result: Negative for intraepithelial lesion or malignancy. Shift in vaginal flora suggestive of bacterial vaginosis.
Molecular Testing. Chlamydia Trachomatis DNA, SDA, PAP Vial: Not detected. Neisseria Gonorrhoeae DNA, SDA, PAP Vial: Not detected.

05/25/13 Dr. Alan Todd Turner, Diagnostic Radiology. United Medical Imaging of Inglewood. Pelvic ultrasound revealed uterus didelphys. Right ovarian cyst.

05/29/13 Dr. Valentin Hernandez. History and Physical. Examinee complained of dysuria and burning on urination for the past week associated with fevers and not getting better with fluids and medications and then had flank pains. Examinee noted an increase in the cough, phlegm, sore throat and headaches over the past week. Pains in the flanks goes down into the groin and also has a purulent greenish cough, with sore throat and headaches. Review of systems was significant for dysuria, burning, fevers, persistent cough with expectoration and sore throat. Vitals: BP: 110/60. Height: 62". Weight: 132 lbs. Pulse: 66. RR: 18. Temperature: 97.9. HEENT examination revealed tympanic membrane was neither red nor retracted. The nasal mucosa was injected and watery. The pharynx was red with pus. Rest of the exam remains the same as previous visit. Diagnoses: Urinary tract infection. Pharyngitis. Rx: Doxycycline 100 mg bid, Diflucan 150 mg qd, Nizoral 200 mg qd, B complex and FeSO4 325 mg qd. Follow up as needed.

06/14/13 Dr. Valentin Hernandez. History and Physical. Examinee complained of pains in the flanks with heat over the bladder on urinating and chills and fevers over the past four days which became worse even on fluids. Examinee does not relate any previous infections of that type. Examinee felt weak and tired and no matter how much sleeps Examinee was still tired, progressively getting worse over the past few weeks to the point that she was barely able to do most of the work. Review of systems was significant for dysuria, burning, fevers, quite tired and not eating well. Vitals: BP: 110/60. Height: 5'2". Weight: 134 lbs. Pulse: 72. RR: 16. Temperature: 98.1. General examination revealed Examinee was worried. Diagnoses: Urinary tract infection. Anemia, iron deficiency. Follow up as needed.

12/29/13 Dr. Valentin Hernandez. Medical Questionnaire and Physical Form. Examinee wears glasses or contact lenses occasionally.

12/30/13 Dr. Valentin Hernandez. History and Physical. Examinee noticed hot and pruritic redness and a worsened rash over the feet and groin which was not responding to the over-the-counter creams. She noted an increase in the cough, thick phlegm, sore throat and headaches over the past week. Review of systems was significant for spreading and worsening fungus on the skin, persistent cough with expectoration and sore throat. Vitals: BP: 110/60. Height: 5'2". Weight: 135 lbs. Pulse: 87. RR: 14. Temperature: 97.6. General examination revealed Examinee was dyspneic and

exhausted. Skin examination revealed erythematous and papular rash. HEENT examination revealed tympanic membrane was neither red nor retracted. The nasal mucosa was injected and watery. Pharynx has hemorrhages with purulent mucous. Examination of the neck revealed supple with tender anterior nodes. Diagnoses: Tinea corporis. Pharyngitis. Rx: Tylenol #3 qid. Plan: Prescribed Lamisil cream bid for 10 days. Follow up as needed.

10/02/15 Dr. Valentin Hernandez. History and Physical. Examinee complained of greenish mucous from a very productive cough which was not altered by cough medicines; pains over the joints and some of them have become swollen. Examinee's cough has been kept her from getting any sleep and every time she coughs the chest hurts and felt like burning inside inspite of trying lozenges and over the counter cough medicines. She has been having a purulent cough over the past few days not getting any better and also noted difficulties with hoarseness even though she has been doing gargling. She has developed a white vaginal discharge over the past week which was getting worsened on taking the medications she had and presenting difficulties to her because of the intense pruritus. She was having difficulties in moving the wrists, closing the hands, and walking because of pains of the ankles and knees and hips, hurting at different times, but getting worse over the past two weeks. Review of systems was significant for cough, phlegm, fevers, dyspnea, persistent cough with expectoration, sore throat, vaginal discharge and infection and diffuse joint pains. Vitals: BP: 118/60. Height: 5'2". Weight: 122 lbs. Pulse: 74. RR: 16. Temperature: 98.1. General examination revealed Examinee was under stress and tired. Skin examination revealed macular and papular rash. HEENT examination revealed nose and turbinates were red and purulent. The pharynx was red with pus. Examination of the neck revealed to be supple with palpable nodes. She has decreased range of motion and was tender bilaterally from C1-C7. Examination of the back revealed decreased range of motion. Examination of the chest revealed diffuse rhonchi bilaterally. Examination of the abdomen revealed white exudate in the vagina. Examination of the extremities revealed swelling and tenderness over the knees and ankles with decreased range of motion. Diagnoses: Bronchitis. Pharyngitis. Vaginitis. Osteoarthritis. Rx: Doxycycline 100 mg bid and Diflucan 150 mg qd. Plan: Prescribed Clotrimazole cream for 10 days. Ordered complete blood count, SMA-7, liver function tests, thyroid panel, HIV test, urinalysis and mammogram. Follow up as needed

10/02/15 Consent Form for HIV Blood Test. Examinee had consented for HIV blood test.

10/02/15 Quest Diagnostics. Laboratory Report.
Lipid Panel with reflex to direct LDL. Cholesterol, total: 115.
Hepatic Function Panel. Total Bilirubin: 1.6. Direct Bilirubin: 0.4.
Complete Urinalysis. Leukocyte Esterase: Trace.

Chlamydia/N. Gonorrhoeae: Chlamydia Trachomatis: Not detected. Neisseria Gonorrhoeae: Not detected.

RPR (monitor) with Reflex Titer: Non-reactive.

Infectious Diseases. HIV ½ antigen/antibody, fourth generation with reflex: Non-reactive.

Basic metabolic panel, thyroid panel and complete blood count includes differential/platelet were performed and their values were found to be within normal range.

10/12/15 Dr. Arash Tehranzadeh, Radiology. ICM Medical. Pelvic transvaginal ultrasound revealed anterior myometrial uterine body fibroid measuring 1.1 x 0.9 x 1.6 cm.

10/15/15 Dr. Valentin Hernandez. History and Physical. Examinee complained of progressively and worsening weakness over the past month and ran out of breath with almost any work not being able to complete most things able to be done in the past. She has noted an increase in the cough, phlegm, sore throat, hoarseness and headaches over the past week even though she has been taking some over-the-counter medications. Review of systems was significant for quite tired and was not eating well, persistent cough with expectoration and sore throat. Vitals: BP: 120/70. Height: 62". Weight: 124 lbs. Pulse: 82. RR: 14. Temperature: 97.2. General examination revealed Examinee appeared to be in pain. HEENT examination revealed the tympanic membrane was neither red nor retracted. The nasal mucosa was injected and watery. The pharynx was red with pus. Diagnoses: Anemia, iron deficiency. Pharyngitis. Rx: B complex qd, FeSO4 325 mg and Lamisil 250 mg qd. Plan: Ordered pap smear. Follow up as needed

10/15/15 Quest Diagnostics. Laboratory Report.
Pap Test. Result: Negative for intraepithelial lesion or malignancy.
Molecular Test. HPV mRNA E6/E7: Not detected. Chlamydia Trachomatis RNA, TMA: Not detected. Neisseria Gonorrhoeae RNA, TMA: Not detected.

04/13/16 Dr. Valentin Hernandez. History and Physical. Examinee felt weak and tired and felt no matter how much sleeps, she was still tired progressively getting worse over the past few weeks to the point now that barely able to do most of the work. Even one block of exercise was enough to make her tired. She has noted an increase in the cough, phlegm, sore throat and headaches over the past week even though she has been taking some over the counter medications. She complained of being exhausted with even the most elementary work. Review of systems remains the same as previous visit. Vitals: BP: 120/70. Height: 5'2". Weight: 129 lbs. Pulse: 72. RR: 16. Temperature: 97.8. General examination revealed Examinee appeared dyspneic and exhausted. HEENT examination revealed the tympanic membrane was neither red nor retracted. The nasal mucosa was injected and watery. The throat has white exudate with injection. Diagnoses: Anemia, iron deficiency. Pharyngitis. Plan: Ordered complete blood count, SMA-7, cholesterol, liver function test, thyroid panel, urinalysis and pregnancy test. Work Status: Off work from 04/13/16 to 04/20/16. Full duty on 04/21/16. Follow up as needed.

04/13/16 Quest Diagnostics. Laboratory Report.
Lipid Panel. Total Cholesterol: 106.

Complete Blood Count includes Differential/Platelets. Hemoglobin: 12.4. Hematocrit: 37.2. HCG Total: Positive.

Basic metabolic panel, hepatic function panel, thyroid panel and complete urinalysis were performed and their values were found to be within normal range.

04/20/16 Dr. Valentin Hernandez. History and Physical. Examinee has missed the period and was worried of the consequences since it was scheduled to occur two weeks ago and has noticed some cramps and tenderness. She has been having progressive and worsening weakness over the past month and ran out of breath with almost any work and not being able to complete most things which she was able to be do in the past. She was worried about the consequences and being weak and tired and having difficulties doing normal work. Review of systems remains the same as previous visit except persistent cough with expectoration and sore throat. Vitals: BP: 120/60. Height: 5'2". Weight: 130 lbs. Pulse: 74. RR: 16. Temperature: 98.1. General examination revealed Examinee was under stress and tired. Diagnoses: Amenorrhea. Anemia, iron deficiency. Follow up as needed

05/27/16 Dr. Valentin Hernandez. EDD Request for Medical Information. Examinee had been under the care from 04/13/16 to 04/20/16. Examinee's disability began on 04/13/16. Examinee had tremulous/difficulties in concentrating. She was pregnant and was considering abortion. Diagnosis: Anxiety. Plan: Referred to psychiatry for evaluation and treatment. Recommended exam and pregnancy test. Full duty on 04/20/16.

04/13/20 Dr. Valentin Hernandez. History and Physical. Examinee complained of fevers associated with cough and phlegm and sore throat and headaches which were not getting better even though she has attempted to fight it. She has been having a purulent cough over the past few days not getting any better and also noted difficulties with hoarseness even though she has been doing gargling. Examinee has difficulties in moving the wrists, closing the hands, and walking because of pains of the ankles, knees and hips hurting at different times but getting worse over the past two weeks. Review of systems was significant for cough, phlegm, fevers, dyspnea, persistent cough with expectoration, sore throat and joint pains. Diagnoses: Bronchitis. Pharyngitis. Osteoarthritis. Follow up as needed.

05/11/20 Urgent Care Note. Examinee was sick for several days with complaints of cough and fever. Vitals: BP: 105/57. Height: 62". Weight: 128 lbs. Pulse: 86. RR: 17. Temperature: 98.7. BMI: 23.41 kg/m2. HEENT examination revealed mastoid tenderness, and sinus percussion tenderness. Diagnoses: Acute frontal sinusitis. Rx: Z-pak.

05/14/20 Sean Waldbillig, A.S.W./Connelly Jenks, L.C.S.W. Stars Behavioral Health Group. BHUCC Client Resource Evaluation. Examinee reported income from work as an RN. She was having enough food. She reported looking for resources for leave from work due to Covid-19 related stressors. She would be provided with FMLA related resources. She was having a car for

transportation as needed. Plan: Recommended private therapy options through Aetna near Hawthorne and therapy resources (window of tolerance, grounding, and information on EMDR therapy). Provided with information for FMLA due to work stressors related to Covid.

05/14/20 Michael Arrajj, R.N. Stars Behavioral Health Group. SBHG Claim Note 18.12. Examinee has anxiety, panic attacks and stress. Diagnosis: Generalized Anxiety disorder. Plan: Start Ativan 0.5 mg Bib prn and Vistaril 25 mg BID prn. Given referrals for private therapy. Encouraged to consider a leave of absence from work (had 20 people die at her work from Covid), FMLA. Encouraged to consider EMDR treatment. Also told she could return to clinic as needed for follow up and support. Discharged with all her property to return home and in s/w less distress.

05/14/20 Michael Arrajj, R.N. Stars Behavioral Health Group. BHUCC Nursing Assessment. Examinee came in with complaints of stress and anxiety, states there have been a member of events and she was 'trying to hold it together". Around two weeks ago, Examinee was exposed to coronavirus. Had a test on May 5 and that was negative. About 6 years ago, her daughter had a breakdown, was unstable for 5 years, but has been better for the last year. At that time there was also severe marital stress. She has limited history of psych treatment. Saw a psychiatrist in 2017. Not known if she was ever treated with medications. Vitals: BP: 109/61. Height: 5'2". Weight: 130 lbs. Pulse: 77. RR: 14. Temperature: 97.7. BMI: 23.8 kg/m2. Mental status examination revealed depressed mood and tearful affect. Plan: Recommended to see therapist.

05/14/20 Star View Behavioral Health Urgent Care Centers. Consent Form. Examinee had consented for treatment.

05/14/20 Star View Behavioral Health Urgent Care Centers. Medication Consent and Review. Prescribed Ativan 0.5 mg and Vistaril 25 mg bid.

05/14/20 Pre-Test Brief Psychiatric Rating Scale (BPRS). Examinee has scored 39.

05/14/20 Post-Test Brief Psychiatric Rating Scale (BPRS). Examinee has scored 38.

05/14/20 Columbia-Suicide Severity Rating Scale (C-SSRS). Columbia-Suicide Severity Rating Scale was performed.

05/15/20 Irine Achuamang, N.P. Stars Behavioral Health Group. BHUCC Practitioner Assessment. Examinee walked into the CWIC for an assessment. She reported increased anxiety, intense feeling of being overwhelmed, recurrent shaking hands and panicky feeling, shortness of breath and increased HR. Anxiety attacks occurred multiple times a day and made it hard for her to complete daily activities and particularly her job. Examinee reported intense discomfort and inability to have a relaxed mind at work which usually triggers a need to run away from the situation. She reported poor sleep on some days, excessive sleep on other days, very poor appetite, intense sadness and an urge to cry several times a week. She has been experiencing anxiety and

occasional sadness for several years, however she has always been able to regulate herself. Symptoms have gotten worst over the last month and she was unable to bring her thoughts and emotions under control as she did in the past. Examinee was seeking therapeutic services. Psychiatric History: Anxiety. Past Medications: Ativan and Gabapentin. Social History: Alcohol consumption. Mental status examination revealed anxious mood, and worried & tearful affect. Diagnoses: Generalized anxiety disorder. Major depressive disorder recurrent mild. Rx: Vistaril 25 mg and Ativan 0.5 mg. Plan: Examinee agrees to PRN medications only for anxiety. Requested psychiatric referral. Advised to avoid nicotine, alcohol, and illicit drugs while on medication. Continue routine follow up with Primary Medical Doctor. Maintain heart healthy diet and daily activity as tolerated. Minimize or avoid caffeine. Return to BHUCC as needed. Follow up with outpatient clinic as directed.

05/19/20 Sean Waldbillig, A.S.W./Connelly Jenks, L.C.S.W. Stars Behavioral Health Group. BHUCC Progress Note. Examinee was seeking medication support and therapeutic support due to added stressors related to Covid-19 pandemic and work as an RN. She reported anxiety symptoms specifically increase in worry which was difficult to control, overthinking, fear of contracting Covid-19/spreading Covid to family members, and feeling on edge. She met medical necessity due to difficulties in maintaining work and daily functioning due to anxiety. Examinee reported increased stressors due to working as an RN at a SNF during pandemic. She was not working on Covid unit but still befog at risk. She noted few precautions being taken with minor use of PPE and many of her clients were dying. She noted 20 plus clients dying in the last few months related to Covid who she had worked with over 10 years. Examinee noted having increased difficulties supervising her team as an RN. Examinee noted not trusting organization and worries about Spreading covid between patients or to family she noted uncertainty about her ability to continue working. She reported past trauma and toes which was being brought up by pandemic. Her trauma mostly not classifiable on the LEC. Examinee's mother died suddenly when she was 19 years old and her father died 3 years later. She reported being the Primary Caretaker for her Grandmother for multiple years through her Grandmother's Alzheimer and up until death. She reported taking care of her daughter then age 26 through onset of psychosis. She also reported period of homelessness, and her husband leaving her 3 years ago due to stress of caretaking for her daughter with psychosis. She also noted taking care of her younger sister from age 5 onward due to her parents dying. She was open to discussing some coping mechanisms. She noted reaching out for medical support and getting two Covid tests recently. She reported both tests were negative. She had support from her children and then adult sister. She was receptive to therapy at BHUCC and wanted community therapy. Plan: Examinee would be discharged with medication and follow up for psychiatry/therapy through her private insurance near Hawthorne. Examinee was provided with information for FMLA leave due to work stressors related to Covid. She provided with therapy resources (window of tolerance, grounding, and information on EMDR therapy).

06/08/20 Dr. Valentin Hernandez. Telehealth Visit. Examinee has noted pleuritic chest pains associated with a persistent cough which seem to be getting worse over the past few days and making it difficult to do any type of work. She has noted an increase in the cough, phlegm, sore throat and

headaches over the past week even though she has been taking some over-the-counter medications. She was having difficulties in moving the wrists, closing the hands, and walking because of pains of the ankles and knees and hips hurting at different times but getting worse over the past two weeks. Examinee's period was due a week ago and has not come and possibly due to new onset irregularity or even pregnancy, would have missed it and was then concerned. Examinee reported increase in cough, phlegm, fevers, sore throat, headaches, shortness of breath and cough with a thick phlegm. Examinee has been having pains over the joints and some of them have become swollen and has not had their usual period and was concerned. Review of systems was significant for cough, phlegm, fevers, dyspnea, persistent cough with expectoration and sore throat and diffuse joint pains. Diagnoses: Bronchitis. Pharyngitis. Osteoarthritis. Amenorrhea. Follow up as needed.

06/23/20 Dr. Valentin Hernandez. History and Physical. Examinee's joint pains were getting worse even with the medicines especially in the mornings, even though she has tried applying warm packs and towels to the joints. She has been having a purulent cough over the past few days not getting any better and also noted difficulties with hoarseness even though she has been doing gargling. She was quite worried about the future and whether they would be able to control and or manage the future problems that would be coming. Noted pains in most of the large joints especially over the knees and a purulent greenish cough, with sore throat and headaches and upset over the way life was taking a turn and is quite nervous. Review of systems was significant for diffuse joint pains, persistent cough with expectoration, sore throat, nervous and depressed over the events in their life. Vitals: BP: 98/60. Height: 62". Weight: 125 lbs. Pulse: 78. RR: 16. Temperature: 96.6. BMI: 22.9 kg/m2. General examination revealed Examinee appeared nervous. HEENT examination revealed nose and turbinates were red and purulent. The pharynx was red with pus. Examination of the neck revealed to be supple with tender anterior nodes. Has decreased range of motion and was tender bilaterally from C1-C7. Examination of the abdomen revealed epigastric tenderness. Examination of the extremities revealed swelling and tenderness over the knees and ankles with decreased range of motion. Neurologic/Psychiatric examination revealed Examinee was anxious, depressed and worried. Diagnoses: Osteoarthritis. Pharyngitis. Anxiety. Rx: Buspar 10 mg qhs. Plan: Ordered complete blood count, SMA-7, liver function tests, thyroid panel, urinalysis and cholesterol. Work Status: Off work from 06/23/20 to 06/29/20. Full duty on 06/30/20. Follow up as needed.

07/06/20 LabCorp. Laboratory Report. Comprehensive Metabolic Panel. Glucose: 47.
Urinalysis, Routine. Appearance: Cloudy. WBC Esterase: Trace. WBC: 6-10. Mucus Threads: Present.

Complete blood count with differential/platelet, hepatic function panel, thyroxine (T4), T3 uptake and free thyroxine index were performed and their values were found to be within normal range.

07/20/20 Dr. Valentin Hernandez. History and Physical. Examinee complained of dysuria for the past week associated with fevers and not getting better with fluids and medications. Examinee also had

flank pains. She was having worsening and pruritic burning pains all over the toes and feet as well as the groin which was quite red. Review of systems was significant for dysuria, burning, fevers, spreading and worsening fungus on the skin. Diagnoses: Urinary tract infection. Tinea corporis. Rx: Bactrim DS bid and Lamisil 250 mg qd. Plan: Ordered Covid-19. Follow up as needed.

07/28/20 Illegible Signature. Gelbart & Associates. Psychiatric Consultation. Examinee has been feeling anxious. Review of systems was significant for crying spells, fatigue, shortness of breath, sweats, shakes, dizziness and palpitations. General examination revealed Examinee appeared tired. Mental status examination revealed anxious mood, congruent and nervous affect. Diagnoses: Axis I: Generalized anxiety disorder. Axis II: Deferred. Axis IV: Stressor at home. Axis V: 75. Plan: Recommended Psychotherapy. Follow up in one week. (There is illegible information on these pages for review).

07/31/20 LabCorp. Laboratory Report. SARS-CoV-2 Antibody, IgG: Negative.

09/09/20 Dr. Valentin Hernandez. History and Physical. Examinee complained of unrelenting cough of green and yellow phlegm which was associated with a painful sore throat and hoarseness over the past week. Also reported increase in the joint pains and it was more difficult to move in the morning than in the afternoons although the medications have not been helping to any significant degree. There was an effusion of the knee with tenderness and warmth. Review of systems was significant for persistent cough with expectoration, sore throat and diffuse joint pains. Diagnoses: Pharyngitis. Osteoarthritis. Follow up as needed.

11/09/20 Dr. Koruon Daldalyan, Internal Medicine/Marvin Pietruszka. Del Carmon Medical Center. Primary Treating Physician's Initial Evaluation Report. Date of Injury: CT 01/06/20-06/30/20, CT 07/06/19-07/05/20. History of Injury: Examinee filed two continuous trauma claims between the dates of 07/06/19 and 07/05/20 and between 01/06/20 and 06/30/20, for injuries that she sustained during the course of her employment. At the time of her injuries, she was working for Sunbridge Hallmark Health Services at Playa del Rey Center, a skilled nursing facility. The company had a license facilitating up to 99 patients. She worked as the supervisor and would provide supervising duties for the entire staff including the CNA's, LVN's and other registered nurses. She also performed administrative duties. Throughout the course of her work there was a very low amount of staff. Examinee began to notice that she was performing various job duties besides her administrative duties as the registered nurse supervisor. She would perform duties for CNA's, LVN's and other RN's. She began to have increased stress levels. When she reported her stress to her supervisors, she was advised that additional personnel would be hired for assisting her. The company never hired additional personnel causing her stress levels to continue. She eventually presented to an urgent care center as she had the onset of a panic attack. She was provided various medications and she was referred to a psychiatrist for which she continued in treatment with. She was prescribed various medications including Prozac and Buspar. She did have some relief with both of these medications. However, at this time, she was on Tylenol and

at times she takes Ativan. Her significant stress continued at the workplace. She also has other symptoms including abdominal pain, nausea, vomiting, diarrhea, weight loss, difficulty with concentration and sleep, headaches, dizziness, musculoskeletal pain that has progressed since leaving her workplace. She also complained of complains of pain in the cervical spine, left shoulder, left elbow and left hand. She also complains of numbness of the left hand, as well as dropping items with the left hand. She also complains of bilateral knee, left ankle and left foot pain; difficulty sleeping due to her musculoskeletal pain; wakes up several times a night because of the pain; difficulties with activities of daily living. Review of systems significant for headaches, dizziness, light-headedness, chest pain, palpitations, shortness of breath, pain, nausea, vomiting, diarrhea, weight loss, cervical spine pain 8/10, lumbar spine pain 7/10, left shoulder pain 8/10, left elbow pain 7/10, left wrist pain 7/10, bilateral hand pain 5/10, left hip pain 6-8/10, right knee pain 6/10, left knee pain 7/10, left ankle pain 6/10, left foot pain 6/10, peripheral edema and swelling of the ankles, anxiety, depression, difficulty concentrating, difficulty sleeping, and difficulty making decisions and diaphoresis. Current Meds: Tylenol 1000 mg, Ativan 0.5 mg, Prozac 10 mg and Buspar 10 mg. Vitals: BP: 109/53. Weight: 130 lbs. Pulse: 65. RR: 17. Temperature: 97.0. Examination of the head revealed left sided temporomandibular joint tenderness. Musculoskeletal examination revealed tenderness of the left side of the cervical spine, lumbar paraspinal musculature, left shoulder, left elbow and left wrist. Tinel's was positive at the left wrist. There was tenderness of the left hand and left knee. Decreased range of motion of cervical spine, lumbo-sacral spine, shoulder, hips and wrist. Examinee's lab and diagnostic studies were performed and reviewed. Subjective Complaints: Headaches, dizziness, light-headedness, chest pain, palpitations, shortness of breath, abdominal pain, nausea, vomiting, diarrhea, weight loss, cervical spine pain, lumbar spine pain, left shoulder pain, left elbow pain, left wrist pain, bilateral hand pain, left hip pain, right knee pain, left knee pain, left ankle pain, left foot pain, peripheral edema and swelling of the ankles, anxiety, depression, difficulty concentrating, difficulty sleeping, difficulty making decisions and diaphoresis. Objective Findings: Left-sided temporomandibular joint tenderness. Tenderness of the left side of the cervical spine, lumbar paraspinal musculature, left shoulder, left elbow, left wrist, left hand and left knee. Tinel's was positive at the left wrist. Diagnoses: Musculoskeletal injuries involving cervical spine, lumbar spine, left shoulder, left elbow, left wrist, bilateral hands, left hip, bilateral knees, left ankle and left foot. Cervical spine sprain/strain. Lumbar spine sprain/strain. Internal derangement, left shoulder. Epicondylitis left elbow. Carpal tunnel syndrome left wrist. Internal derangement left knee. Internal derangement bilateral ankles. Elevated blood pressure, rule out hypertension. Cephalgia. Vertigo. Chest pain. Palpitations. Dyspnea. Gastritis secondary to non-steroidal anti-inflammatory drugs medications. Nausea/vomiting. Irritable bowel syndrome manifested by diarrhea. Weight loss. Peripheral edema/swelling of ankles. Anxiety disorder. Depressive disorder. Sleep disorder. Diaphoresis. Rx: Ativan 0.5 mg daily. Plan: Prescribed Flurbiprofen topical cream to apply BID and Gabapentin topical cream to apply BID. She was referred for an EMG nerve conduction study of the upper extremities. Continue current medication. Work Status: Temporary and total disability for a period of one month. Follow up in 6 weeks.

01/04/21 Dr. Koruon Daldalyan/Marvin Pietruszka. Del Carmon Medical Center. Primary Treating Physician's Progress Report. Examinee continued to be in treatment for anxiety and musculoskeletal pain. She had a deposition approximately one week ago. Current Meds: Flurbiprofen topical cream and Gabapentin topical cream. Vitals: BP: 99/41. Weight: 139 lbs. Pulse: 65. RR: 16. Temperature: 97.5. Examination revealed left sided temporomandibular joint tenderness. Examinee's lab and diagnostic studies were performed and reviewed. Subjective complaints and objective findings remain the same as previous visit. Diagnoses: Musculoskeletal injuries involving cervical spine, lumbar spine, left shoulder, left elbow, left wrist, bilateral hands, left hip, bilateral knees, left ankle and left foot. Cervical spine sprain/strain. Lumbar spine sprain/strain. Internal derangement, left shoulder. Epicondylitis left elbow. Carpal tunnel syndrome left wrist. Internal derangement left knee. Internal derangement bilateral ankles. Elevated blood pressure, rule out hypertension. Cephalgia. Vertigo. Chest pain. Palpitations. Dyspnea. Gastritis secondary to non-steroidal anti-inflammatory drugs. Nausea/vomiting. Irritable bowel syndrome manifested by diarrhea. Weight loss. Peripheral edema/swelling of ankles. Anxiety disorder. Depressive disorder. Sleep disorder. Diaphoresis. Rx: Lansoprazole 15 mg daily. Plan: Advised to continue current medications. Rest of the treatment plan remains the same as previous visit. Disability Status: Temporary and total disability for one month. Causation: Industrial. Follow up in 6 weeks.

01/06/21 Dr. Eric E. Gofnung. Eric E. Gofnung Chiropractic Corp. Primary Treating Physician's Follow up Evaluation Report and Request for Authorization. Date of Injury: 07/06/19-07/05/20. Since last visit on 11/30/20, Examinee had an evaluation with Dr. Koruon Daldalyan, occupational medicine specialist, who prescribed her analgesic creams and with underwent x-rays. Current Complaints: Examinee complained of moderate neck pain, bilateral shoulder pain, low back pain and left knee pain; bilateral wrist and hand pain slight, with numbness and tingling of the hands; bilateral ankle and foot pain, slight; sleeping problems, stress, headaches, and abdominal pain. Examination of the cervical spine revealed tenderness to palpation with muscle guarding of bilateral paracervical and left upper trapezius musculature. Tenderness and hypomobility were noted at C3 through C7 vertebral regions. Shoulder depression test was positive on the left. Ranges of motion for the cervical spine was decreased and painful. Examination of the left shoulder revealed tenderness to palpation with myospasm of left supraspinatus, infraspinatus, and periscapular musculature. Hawkin's test was positive at the left shoulder. Ranges of motion for the shoulders was decreased and painful on left. Examination of the left elbow revealed tenderness to palpation at left elbow medial epicondyle and left forearm flexor muscle group. Left Golfer's test was positive. Ranges of motion for the elbows were within normal limits with pain at the left elbow. Examination of the left wrist/hand revealed tenderness to palpation at left carpals, distal ulna, distal radius, TFCC. Tenderness at left thenar region. Tinel's sign was positive at the left. Finkelstein's and Phalen's test were positive at the left. Ranges of motion for both wrists were within normal limits with pain at the left. Examination of the fingers revealed digital painful ranges of motion of digits one and five on the left hand. Tenderness at the left thumb was noted during palpation. Ranges of motion for the fingers were within normal limits with pain at the left first and fifth digits. Left deltoid 4/5. Sensory testing was not performed on that day's

visit; however, prior testing showed dysesthesia at left C6, C7 dermatomal levels, dysesthesia in left hand medial nerve distribution. Examination of the thoracic spine revealed tenderness to palpation with myospasm of left parathoracic and left trapezius musculature. · Tenderness and hypomobility were noted at T1 through T8 vertebral regions. Kemp's test was positive on the left. Ranges of motion for thoracic spine were decreased and painful. Examination of the lumbosacral spine revealed tenderness to palpation with muscle guarding of bilateral paralumbar musculature. Tenderness at left sacroiliac joint. Tenderness and hypomobility at L3 through L5 vertebral regions. Milgram's test was positive. Sacroiliac joint compression test was positive on the left. Ranges of motion for the lumbar spine were decreased and painful. Examination of the left knee revealed tenderness to palpation at left knee medial joint line. Tenderness to palpation was noted at left lower leg musculature, including gastrocnemius and peroneal musculature. McMurray's test was positive at the left knee. Pain and weakness at the left knee during the squat. Range of motion for the knees decreased with pain on the left. Examination of the ankle and feet revealed tenderness to palpation at left talus, calcaneus, talonavicular joint, anterior talofibular ligament, Achilles tendon and tibialis posterior tendons. Anterior drawer test was positive on the left. Ranges of motion of the ankles were within normal limits with pain at the extremes. Diagnoses: Cervical spine myofasciitis. Cervical facet-induced versus discogenic pain. Cervical radiculitis left, rule out. Thoracic spine myofasciitis. Thoracic facet-induced versus discogenic pain. Lumbar spine myofasciitis. Left sacroiliac joint dysfunction, sprain/strain. Lumbar facet-induced versus discogenic pain. Lumbar radiculitis left, rule out. Left shoulder tenosynovitis/bursitis. Left shoulder impingement syndrome, rule out. Left elbow medial epicondylitis. Left brachioradialis tendinitis. Left wrist tenosynovitis. Left carpal tunnel syndrome, rule out. Triangular fibrocartilage complex tear, left, rule out. Knee internal derangement, left, rule out. Tenosynovitis of left lower leg. Tenosynovitis of left ankle and foot. Left Achilles tendinitis. Anxiety and depression, sleeping difficulty. Abdominal pain. Flare-up secondary to no treatment for the last month as well as performance of activities of daily living as evidenced by physical examination. Plan: Recommended to continue with comprehensive treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy and home exercise program. Ordered x-rays for cervical, thoracic, lumbar spine, left shoulder, left elbow, left wrist, left knee, and left ankle; MRI of the cervical spine, lumbar spine, left wrist and left knee. Work Status: Modified duty. Restrictions: No lifting in excess of 15 lbs. No repeated work with left arm above shoulder height. No repeated bending or twisting. No repeated or forceful grasping, torquing, pulling, and pushing with left hands. No repeated squatting, kneeling, or climbing. If modified duty as indicated was not provided, then she was considered temporarily totally disabled for four weeks. Follow up in 4 weeks.

01/27/21 Dr. Eric E. Gofnung. Eric E. Gofnung Chiropractic Corp. Primary Treating Physician's Follow up Evaluation Report and Request for Authorization. Examinee has been receiving chiropractic and physiotherapeutic treatment while under Dr. Gofnung's care and was feeling better. She has seen an internist Dr. Koruan Daldalyan twice where she underwent some x-rays as well as was given prescription medication for her stomach pain and anxiety as well as received analgesic cream. Present Complaints: Examinee complained of moderate neck pain with radiation to left

shoulder, slight to moderate left shoulder/left elbow pain, slight bilateral wrist/hand pain, moderate low back pain with radiation to left posterior hip, slight left knee pain with occasional episode of locking, slight left ankle and foot pain, sleeping problems, anxiety, stress, headaches, and abdominal pain. Examination of the left shoulder revealed tenderness over left supraspinatus. Examination of the left elbow revealed tenderness over the left lateral epicondyle and left forearm extensor muscle group. Left Cozen's test was positive. Examination of the left wrist/hand revealed tenderness over the left thumb over the first carpometacarpal joint and metacarpophalangeal joint. Finkelstein's test was positive. Phalen's test on the left wrist was positive. Rest of the exam remains the same as previous visit. Diagnoses: Cervical spine myofasciitis. Cervical facet-induced versus discogenic pain. Cervical radiculitis left, rule out. Thoracic spine myofasciitis. Thoracic facet-induced versus discogenic pain. Lumbar spine myofasciitis. Left sacroiliac joint dysfunction, sprain/strain. Lumbar facet-induced versus discogenic pain. Lumbar radiculitis left, rule out. Left shoulder tenosynovitis/bursitis. Left shoulder impingement syndrome, rule out. Left elbow medial epicondylitis. Left brachioradialis tendinitis. Left wrist tenosynovitis. Left carpal tunnel syndrome, rule out. Triangular fibrocartilage complex tear, left, rule out. Knee internal derangement, left, rule out. Tenosynovitis of left lower leg. Tenosynovitis of left ankle and foot. Left Achilles tendinitis. Anxiety and depression, sleeping difficulty. Abdominal pain. Flare-up secondary to no treatment for the last month as well as performance of activities of daily living as evidenced by physical examination. Plan: Recommended acupuncture evaluation and treatment. Rest of the treatment plan remains the same as previous visit. Work Status: Modified duty. Restrictions: No lifting in excess of 15 lbs. No repeated work with left arm above shoulder height. No repeated bending or twisting. No repeated or forceful grasping, torquing, pulling, and pushing with left hands. No repeated squatting, kneeling, or climbing. If modified duty as indicated was not provided, then she was considered temporarily totally disabled. Follow up in 4 weeks.

03/01/21 Dr. Koruon Daldalyan/Marvin Pietruszka. Del Carmon Medical Center. Primary Treating Physician's Progress Report. Examinee continued to complain of right knee pain and would undergo an x-ray that day. Vitals: BP: 102/51. Weight: 138 lbs. Pulse: 82. RR: 18. Temperature: 98.0. Exam remains the same as previous visit. Examinee's lab and diagnostic studies were performed and reviewed. Diagnoses: Musculoskeletal injuries involving cervical spine, lumbar spine, left shoulder, left elbow, left wrist, bilateral hands, left hip, bilateral knees, left ankle and left foot. Cervical spine sprain/strain. Lumbar spine sprain/strain. Internal derangement, left shoulder. Epicondylitis left elbow. Carpal tunnel syndrome left wrist. Internal derangement left knee. Internal derangement bilateral ankles. Elevated blood pressure, rule out hypertension. Cephalgia. Vertigo. Chest pain. Palpitations. Dyspnea. Gastritis secondary to non-steroidal anti-inflammatory drugs. Nausea/vomiting. Irritable bowel syndrome manifested by diarrhea. Weight loss. Peripheral edema/swelling of ankles. Anxiety disorder. Depressive disorder. Sleep disorder. Diaphoresis. Rx: Lansoprazole 15 mg daily. Treatment plan remains the same as previous visit. Work Status: Temporary and total disability for a period of one month. Follow up in 6 weeks.

03/12/21 Dr. Eric E. Gofnung. Eric E. Gofnung Chiropractic Corp. Primary Treating Physician's Follow up Evaluation Report and Request for Authorization. Examinee has not undergone any x-ray or MRI studies as recommended by the Dr. Gofnung. She was claustrophobic and requested an open MRI. She has been exercising at home as instructed to tolerance. She has not had any formal treatment for her orthopedic injuries for close to four weeks. Examinee developed right knee pain due to favoring the left knee. Examinee has difficulty in standing up from a seated position with spasming occurring of her lower leg musculature. Present Complaints: Examinee complained of slight to moderate neck/left elbow pain, slight left shoulder pain, moderate left wrist/hand and thumb pain, moderate low back pain, minimal to slight left knee pain, right knee pain with spasming, left ankle and foot pain was resolved. Rest of the complaints remains the same as previous visit. Examination of the right knee revealed tenderness to palpation over the medial joint line with pain and difficulty rising from squatting position. Right knee McMurray's test elicited increased pain. Rest of the exam remains the same as previous visit. Diagnoses: Thoracic spine myofasciitis. Thoracic facet-induced versus discogenic pain. Lumbar spine myofasciitis. Left sacroiliac joint dysfunction, sprain/strain. Lumbar facet-induced versus discogenic pain. Lumbar radiculitis left, rule out. Left shoulder tenosynovitis/bursitis. Left shoulder impingement syndrome, rule out. Left elbow medial epicondylitis. Left brachioradialis tendinitis. Left wrist tenosynovitis. Left carpal tunnel syndrome, rule out. Triangular fibrocartilage complex tear, left, rule out. Knee internal derangement, left, rule out. Tenosynovitis of left lower leg. Tenosynovitis of left ankle and foot. Left Achilles tendinitis. Anxiety and depression, sleeping difficulty. Abdominal pain. Flare-up secondary to no treatment for the last month as well as performance of activities of daily living as evidenced by physical examination. Treatment plan remains the same as previous visit. Work Status: Modified duty. Restrictions: No lifting in excess of 15 lbs. No repeated work with left arm above shoulder height. No repeated bending or twisting. No repeated or forceful grasping, torquing, pulling, and pushing with left hands. No repeated squatting, kneeling, or climbing. Follow up in 4 weeks.

04/30/21 Dr. Eric E. Gofnung. Eric E. Gofnung Chiropractic Corp. Primary Treating Physician's Permanent and Stationary Evaluation Report. Date of Injury: CT 07/06/19-07/05/20.
Examinee was asymptomatic and without any disability or impairment prior to the continuous trauma injury from 07/05/19 to 07/05/20 as related to the neck, bilateral shoulder, greater in the left shoulder, left arm, wrist/hand and finger, low back, left hip, bilateral knees, ankles and bilateral feet. Current Complaints: She complained of neck pain, intermittent and slight to moderate, worsened with prolonged posturing and turning the head from side-to-side; left shoulder pain, intermittent and slight, occasionally increasing to moderate with overhead reach; left elbow pain, occasional and minimal; left wrist, hand and thumb pain, occasional and slight; low back pain, intermittent and slight to moderate; left knee pain, occasional and minimal; right knee pain, frequent and slight, associated with occasional spasming; left ankle and foot pain, resolved; sleeping problems, anxiety, and stress. Examinee reported difficulty with writing, typing, with a rating of 4/5, difficulty with standing, sitting, reclining, walking, and going up and downstairs, with a rating of 3/5, difficulty with grasping or gripping, lifting, and manipulating small items with a rating of 3/5 and difficulty with riding in a car, bus, etc, driving a car, restful

night sleep pattern, and sexual function) with a rating of 3/5. Review of systems was significant for trouble sleeping, muscle and joint pain, stiffness, anxiety, depressed mood, social withdrawal, emotional problems, and stress. Vitals: BP: 139/85. Height: 5'2". Weight: 135 lbs. Pulse: 70. Examination of the left shoulder revealed tenderness over the left supraspinatus near insertion as well as over the subacromial and subdeltoid bursa. Left shoulder ranges of motion were normal with pain at extremes, particularly with flexion and abduction. Examination of the left wrist & hand revealed tenderness over the left thumb over the first carpometacarpal joint and metacarpophalangeal joint. Finkelstein's test was positive. Ranges of motion of the left hand digits were within normal limits with tenderness at the left thumb at extremes of range of motion. Examinee's grip strength was 20/20/20 on left and 25/20/20 on right. Rest of the exam remains the same as previous visit. Examinee's medical records were reviewed. Diagnoses: Cervical spine myofasciitis. Cervical spine facet-induced versus discogenic pain. At C4-C5, 2 mm disc bulge and osteophyte complex with mild bilateral foraminal narrowing and contact on bilateral exiting nerve root. At C5-C6, 1.9 mm disc bulge with osteophyte complex with bilateral foraminal narrowing and contact on bilateral exiting nerve root. At C6-C7, 2.5 mm disc bulge with osteophyte complex with bilateral foraminal narrowing and contact on bilateral exiting nerve root. Thoracic spine myofasciitis. Thoracic facet-induced versus discogenic pain. Lumbar spine myofasciitis. Left sacroiliac joint dysfunction, sprain/strain. Lumbar facet-induced versus discogenic pain. Lumbar radiculitis left, rule out. Left shoulder tenosynovitis/bursitis. Left shoulder impingement syndrome, rule out. Left elbow medial epicondylitis. Left brachioradialis tendinitis. Left wrist tenosynovitis. Left carpal tunnel syndrome, rule out. Triangular fibrocartilage complex tear, left, rule out. Left knee pain, resolving. Right knee sprain, rule out internal derangement, moderate joint effusion. Intrameniscal hyperintensity in posterior horn of medial meniscus, grade II signal. Mild laxity of lateral collateral ligament suggestive of partial tear/contusion. Intrasubstance hyperintensity in anterior cruciate ligament. Degenerative narrowing with thinning of articular cartilages at patellofemoral and tibiofemoral joints. Tenosynovitis of left lower leg, resolved. Tenosynovitis of left ankle and foot, resolved. Left Achilles tendinitis, resolved. Anxiety and depression, sleeping difficulty. Abdominal pain, resolved. Plan: Encouraged to go to gym and perform strength training with light weight. Examinee requires orthopedic surgical consultation. Rest of the treatment plan remains the same as previous visit. Disability Status: Examinee was declared Permanent and Stationary. Subjective Factors of Disability: The subjective factors of disability consisted of neck pain, intermittent and slight to moderate worsened with prolonged posturing and turning the head from side-to-side. Left shoulder pain, intermittent and slight, occasionally increasing to moderate with overhead reach. Left elbow pain, occasional and minimal. Left wrist, hand and thumb pain, occasional and slight. Low back pain, intermittent and slight to moderate. Left knee pain, occasional and minimal. Right knee pain, frequent and slight, associated with occasional spasming. Left ankle and foot pain, resolved. Sleeping problems, anxiety, stress. At present, Examinee reported having abdominal pain. Objective Factors of Disability: With regards to cervical spine, the objective factors of disability consisted of palpatory tenderness. Decreased and painful ranges of motion. Abnormal orthopedic testing. Abnormal MRI results. With regards to thoracic spine, the objective factors of disability consist of palpatory tenderness. Decreased and painful ranges of

motion. With regards to lumbar spine, the objective factors of disability consist of palpatory tenderness. Decreased and painful ranges of motion. Abnormal orthopedic testing. Abnormal MRI results. With regards to right knee, the objective factors of disability consist of palpatory tenderness. Abnormal orthopedic testing. Abnormal MRI results. Causation: The causation of Examinee's injuries, resultant conditions, as well as need for treatment with regards to cervical, thoracic and lumbar spine, left upper extremity and left lower extremity were industrially related and secondary to continuous trauma from 07/06/19 to 07/05/20 while working for Sunbridge Hallmark Health Serv. DBA: Playa Del Rey Ctr. Industrial injury. Apportionment: Dr. Gofnung apportioned causation with regards to cervical, thoracic and lumbar spine as 95% to continuous trauma and 5% in pre-existing degenerative changes. With regards to left shoulder and left wrist, 100% to continuous trauma and 0% to non-industrial causes. With regards to bilateral knees, 95% to continuous trauma and 5% to pre-existing degenerative changes. Impairment Rating: Total calculated whole person impairment was 32% by combining 28% spinal impairment with 6% upper extremity whole person impairment. Work Restrictions: Work Restrictions: No lifting in excess of over 20 lbs and furthermore restricted to occasional basis. Sit and stand as needed based on pain levels. If abdominal pain returned, she should be seen by an internist for further work. Future Medical Care: Provisions should be made for further chiropractic, physiotherapy, acupuncture, orthopedic, interventional pain management internal medicine and repeat imaging studies of x-rays, MRIs to include diagnostic testing of NCV/EMG studies if needed. Vocational Rehabilitation Benefits: Examinee was qualified injured worker if work restrictions could not be accommodated.

05/07/21 Dr. Valentin Hernandez. History and Physical. Examinee complained of unrelenting cough of green and yellow phlegm associated with a painful sore throat and hoarseness over the past week. She has been having an increase in the joint pains and it was more difficult to move in the morning than in the afternoons although the medications have not been helping to any significant degree. There was an effusion of the knee with tenderness and warmth. Review of systems was significant for persistent cough with expectoration, sore throat and diffuse joint pains. Vitals: BP: 98/60. Height: 5'2". Weight: 125 lbs. BMI: 22.9 kg/m2. Diagnoses: Pharyngitis. Osteoarthritis. Plan: Ordered complete blood count, SMA-7, liver function test, urinalysis, cholesterol test and thyroid panel. Follow up as needed.

06/09/21 Dr. Valentin Hernandez. History and Physical. Examinee was having difficulties in moving the wrists, closing the hands, and walking because of pains of the ankles and knees and hips hurting at different times but getting worse over the past two weeks. Examinee has been having a sore throat with cough and phlegm and green mucous with fevers which were not getting better even though she was drinking a lot of fluids. Review of systems was significant for persistent cough with expectoration, sore throat and diffuse joint pains. Diagnoses: Pharyngitis. Osteoarthritis. Plan: Prescribed Voltaren gel 1% 2 g. Follow up as needed.

06/11/21 Dr. Nicholas N. Dzebolo, Nuclear Radiology. Pacific MRI. MRI of the Cervical Spine revealed small degenerative anterior osteophytes at C3 through T1. Disc desiccation involving the entire

cervical spine. At C4-C5 a disc bulge is identified. A disc osteophyte complex is identified. Also noted is bilateral facet joint arthrosis. Disc material and facet joint hypertrophy cause mild bilateral neural foraminal narrowing. Associated contact on bilateral exiting nerve root is seen. Disc measures 2.0 mm. At C5-C6 a disc bulge is identified. A disc osteophyte complex is identified. Disc material abuts the thecal sac. Also noted is bilateral facet joint arthrosis. Disc material and facet joint hypertrophy cause mild bilateral neural foraminal narrowing. Associated contact on bilateral exiting nerve root is seen. Disc measures 1.9 mm. At C6-C7 a disc bulge is identified. A disc osteophyte complex is identified. Disc material abuts the thecal sac. Also noted is bilateral facet joint arthrosis. Disc material and facet joint hypertrophy cause mild bilateral neural foraminal narrowing. Associated contact on bilateral exiting nerve root is seen. Disc measures 2.5 mm.

Impression: Small degenerative anterior osteophytes at C3 through T1. Disc desiccation involving the entire cervical spine. C4-C5. A disc bulge is identified. A disc osteophyte complex is identified. Also noted is bilateral facet joint arthrosis. Disc material and facet joint hypertrophy cause mild bilateral neural foraminal narrowing. Associated contact on bilateral exiting nerve root is seen. Disc measures 2.0 mm. C5-C6: A disc bulge is identified. A disc osteophyte complex is identified. Also noted is bilateral facet joint arthrosis. Disc material and facet joint hypertrophy cause mild bilateral neural foraminal narrowing. Associated contact on bilateral exiting nerve root is seen. Disc measures 1.9 mm. C6-C7. A disc bulge is identified. A disc osteophyte complex is identified. Also noted is bilateral facet joint arthrosis. Disc material and facet joint hypertrophy cause mild bilateral neural foraminal narrowing. Associated contact on bilateral exiting nerve root is seen. Disc measures 2.5 mm.

06/11/21 Dr. Nicholas N. Dzebolo. Pacific MRI. MRI of the Lumbar Spine revealed mild disc desiccation at L4-L5. At L4-L5, a disc bulge is identified. Disc material abuts the thecal sac. Transiting and exiting nerve roots are normal. Disc deformity measures 1.6 mm. At L5-S1, a disc bulge is identified. Disc material abuts the thecal sac. Transiting and exiting nerve roots are normal. Disc deformity measures 1.8 mm.

Impression: Mild disc desiccation at L4-L5. Discal deformity L4-L5. A disc bulge is identified. Transiting and exiting nerve roots are normal. Disc deformity measures 1.6 mm. Discal deformity L5-S1. A disc bulge is identified. Transiting and exiting nerve roots are normal. Disc deformity measures 1.8 mm.

06/11/21 Dr. Amjad Safvi, Interventional Neuroradiology. Pacific MRI. MRI of Right knee without contrast revealed moderate joint effusion. There is intrameniscal hyperintensity within the posterior horn of medial meniscus, not extending to superior and inferior articular margins suggestive of Grade II meniscal signal changes. There is mild laxity of lateral collateral ligament with intrasubstance hyperintensity suggestive of partial tear/contusion. There is intrasubstance hyperintensity in anterior cruel ate ligament suggestive of myxoid degeneration. Posterior cruciate ligament: There is buckling of posterior cruciate ligament, however normal in signal intensity. Degenerative narrowing with thinning of articular cartilages is seen at patella-femoral and tibio-femoral joints.

Impression: Moderate joint effusion. Intrameniscal hyperintensity within the posterior horn of medial meniscus, not extending to superior and inferior articular margins suggestive of Grade II meniscal signal changes. Mild laxity of lateral collateral ligament with intrasubstance hyperintensity suggestive of partial tear/contusion. Intrasubstance hyperintensity in anterior cruciate ligament suggestive of myxoid degeneration. Degenerative narrowing with thinning of articular cartilages at patella-femoral and tibia-femoral joints.

06/11/21 Dr. Nicholas N. Dzebolo. Pacific MRI. X-ray of Left Elbow revealed mild sclerosis of the articulating margins of the proximal radius and ulna. Small osteophyte seen off the articulating surface of the proximal ulna.
Impression: Mild sclerosis of the articulating margins of the proximal radius and ulna. Small osteophyte seen off the articulating surface of the proximal ulna. No acute bony abnormality noted.

06/11/21 Dr. Nicholas N. Dzebolo. Pacific MRI. X-ray of Left Knee revealed small osteophyte seen off the medial intercondylar eminence. Mild sclerosis off the medial tibial articular surface. Small osteophyte seen off the lateral tibial plateau articular surface. Mild sclerosis off the lateral tibial articular surface. Small osteophyte off the posterior aspect of the patellar upper pole. Small enthesophyte off the upper patellar pole anteriorly.
Impression: Small osteophyte seen off the medial intercondylar eminence. Mild sclerosis off the medial tibial articular surface. Small osteophyte seen off the lateral tibial plateau articular surface. Mild sclerosis off the lateral tibial articular surface. Small osteophyte off the posterior aspect of the patellar upper pole. Small enthesophyte off the upper patellar pole anteriorly. No acute bony abnormality noted.

06/11/21 Dr. Nicholas N. Dzebolo. Pacific MRI. X-ray of Left Wrist revealed mild sclerosis of the articulating margins of the distal radius.
Impression: Mild sclerosis of the articulating margins of the distal radius. No acute bony abnormality noted.

06/11/21 Dr. Nicholas N. Dzebolo. Pacific MRI. X-ray of Lumbar Spine revealed grade I posterior listhesis of L5 on S1. Moderate straightening of the lumbar lordosis. Mild decreased disc height at T12-L1 and L1-L2. Degenerative small end plate osteophyte at L3 through L5. Mild apophyseal joint arthrosis at L5-S1.
Impression: Grade I posterior listhesis of L5 on S1. Moderate straightening of the lumbar lordosis. This may be positional or reflect myospasm. Mild decreased disc height at T12-L1 and L1-L2. Degenerative small endplate osteophyte at L3 through L5. Mild apophyseal joint arthrosis at L5-S1. No evident fracture is identified.

06/15/21 Quest Diagnostics. Laboratory Report.
Basic Metabolic Panel. Glucose: 112.
Complete blood count includes differential/platelet. HGB: 11.6. HCT: 34.9. MCH: 26.7.

Quantiferon TB Gold. Plus, 1 tube: Negative. NIL: 0.10. Mitogen: 8.75. TB1: 0.10. TB2: 0.01. Collagen Cross-Linked. N-Telopeptide: 16.

Lipid panel, hepatic function panel, HgbA1c, TSH, Total T4, Total T3, and complete urinalysis were performed and their values were found to be within normal range.

06/17/21 Dr. Koruon Daldalyan/Dr. Marvin Pietruszka. Del Carmen Medical Center. Primary Treating Physician's Progress Report. Examinee complained of right knee pain. Vitals: BP: 109/42. Weight: 140 lbs. Pulse: 83. RR: 13. Temperature: 95.5. Examination revealed positive posterior drawer sign, left-sided temporomandibular joint tenderness. Diagnostic Data: A pulmonary function test revealed an FVC of 1.71 L (62.6%), an FEV 1 of 1.29 L (58.1%), and an FEF of 1.21 L/s (50.0%). A 12-lead electrocardiogram revealed normal sinus rhythm and a heart rate of 68 per minute. Diagnoses: Musculoskeletal injuries involving cervical spine, lumbar spine, left shoulder, left elbow, left wrist, bilateral hands, left hip, bilateral knees, left ankle and left foot. Cervical spine sprain/strain. Lumbar spine sprain/strain. Internal derangement, left shoulder. Epicondylitis left elbow. Carpal tunnel syndrome left wrist. Internal derangement left knee. Internal derangement bilateral ankles. Elevated blood pressure, rule out hypertension. Cephalgia. Vertigo. Chest pain. Palpitations. Dyspnea. Gastritis secondary to non-steroidal anti-inflammatory drugs. Nausea/vomiting. Irritable bowel syndrome manifested by diarrhea. Weight loss. Peripheral edema/swelling of ankles. Anxiety disorder. Depressive disorder. Sleep disorder. Diaphoresis. Rule out posterior cruciate ligament tear. Rx: Tramadol 50 mg twice a day. Plan: Prescribed Flurbiprofen 20% topical ointment to apply bid. Work Status: Temporarily totally disabled for one month. Follow up in 6 weeks.

06/23/21 Dr. Eric E. Gofnung, Chiropractic Medicine. Eric E. Gofnung Chiropractic Corporation. Primary Treating Physician's Post Permanent and Stationary Follow up Report. Examinee was declared Permanent and Stationary by Dr. Gofnung on 04/30/21. Examinee was seen by a neutral doctor, an AME or QME, in late April of 2021 as well. A little over two weeks ago, her right knee condition worsened with no mechanism of injury and she on own went out and got a right knee brace as well as one-point walking cane which she uses and she has significant pain and difficulty at that time. Present Complaints: Examinee complained of neck pain, slight to moderate; left shoulder pain, slight to moderate; left elbow pain, minimal; left wrist, hand and thumb pain, slight; low back pain, moderate; left knee pain, minimal; right knee pain, frequent and moderate to severe; left ankle and foot pain, resolved; sleeping problems, anxiety, and stress. Cervical spine examination revealed tenderness to palpation of bilateral paracervical and left upper trapezius musculature; tenderness and hypomobility were noted at C5 through C7 vertebral regions; restricted and painful ranges of motion; positive shoulder depression test. Left shoulder examination revealed tenderness over the left supraspinatus near insertion as well as over the subacromial and subdeltoid bursa; positive Hawkin's test; painful ranges of motion in the left at extremes of ranges of motion. Left wrist & hand examination revealed tenderness over the left thumb over the first carpometacarpal joint and metacarpophalangeal joint; positive Finkelstein's test; ranges of motion of the left-hand digits were within normal limits with tenderness at the left

thumb at extremes of range of motion. Examinee's grip strength was 20/20/20 kg on left and 25/20/20 kg on right. Motor testing of the cervical spine and upper extremities revealed 4/5 on left deltoid. Thoracic spine examination revealed tenderness to palpation of bilateral paralumbar musculature; tenderness at left sacroiliac joint; tenderness and hypomobility at L3 through L5 vertebral regions; positive Milgram's test; positive sacroiliac joint compression test on the left; decreased and painful lumbar spine ranges of motion. Right knee examination revealed Examinee with a one-point walking cane as well as right knee brace with metal stays, which was pulled down during the exam revealing generalized swelling of the knee anteriorly. Examinee had generalized tenderness with greatest amount of tenderness over the patella. Examinee could not stand without the knee brace. Orthopedic testing was not performed on that day's visit. Diagnoses: Cervical spine myofasciitis. Cervical spine facet-induced versus discogenic pain. Thoracic spine myofasciitis. Thoracic facet-induced versus discogenic pain. Lumbar spine myofasciitis. Left sacroiliac joint dysfunction, sprain/strain. Lumbar facet-induced versus discogenic pain. Lumbar radiculitis left, rule out. Left shoulder tenosynovitis/bursitis. Left shoulder impingement syndrome, rule out. Left elbow medial epicondylitis, resolving. Left brachioradialis tendinitis, resolving. Left wrist tenosynovitis, resolving. Left carpal tunnel syndrome, rule out. Triangular fibrocartilage complex tear, left, rule out. Left knee pain, resolving. Right knee sprain, rule out internal derangement. Flare-up of right knee condition. Tenosynovitis of left lower leg, resolved. Tenosynovitis of left ankle and foot, resolved. Left Achilles tendinitis, resolved. Anxiety and depression, sleeping difficulty. Abdominal pain, resolved. Plan: Ordered x-rays of cervical spine, thoracic spine, lumbar spine, left shoulder, left elbow, left wrist, right knee, and left ankle; MRI of the left shoulder. Recommended Orthopedic consultation through outside Workers' Compensation systemfor further workup of her right knee issues; home exercises. Work Status: Modified duty. Restrictions: No lifting in excess of over 20 lbs and furthermore restricted to occasional basis. Examinee should be able to sit and stand as needed based on pain levels. If abdominal pain returned, she should be seen by an internist for further work. If modified duty as indicated was not provided, then Examinee was considered temporarily totally disabled until re-evaluation at next visit. Disability Status: Permanent & Stationary on 04/30/21.

06/30/21 Dr. Valentin Hernandez. History and Physical. Examinee's joint pains were getting worse even with the medicines especially in the mornings even though she has tried applying warm packs and towels to the joints. She has been having a sore throat with cough and phlegm and green mucous with fevers which were not getting better even though she was drinking a lot of fluids. She has noted pains in most of the large joints especially over the knees and sore throat with phlegm and cough with a thick phlegm. Review of systems was significant for diffuse joint pains, persistent cough with expectoration and sore throat. Vitals: BP: 110/60. Height: 62". Weight: 142 lbs. BMI: 25.1 kg/m2. Diagnoses: Osteoarthritis. Pharyngitis. Plan: Ordered pap smear, mammogram and Colonoscopy. Follow up as needed.

07/15/21 Dr. Edwin Haronian. Initial Orthopedic Evaluation of a Secondary Physician. Date of Injury: CT 01/06/20-06/30/20. Examinee sustained cumulative trauma injuries to her neck, left shoulder

lower back and right knee from 01/06/20 through 06/30/20 during the course of her employment as a registered nurse for Sunbridge Hallmark Health Services. During the course of her employment, she developed the onset of pain in her neck, left shoulder, lower back and right knee which she attributed to performing the repetitive physical demands of her job duties.She also described about three years ago, she had to jump over a fence in order to get a resident who escaped the facility where she worked. As she jumped and fell on the other side of the fence, she injured her right knee. Examinee also developed psychological and internal injuries due to work-related stress. She reported the injuries to her supervisors however she was not sent to a company doctor. Around 2018, she self-procured treatment with her Family physician who evaluated her and recommenced pain medications. Examinee underwent MRI studies of her left shoulder however she did not undergo other treatment at that time. She worked through 07/10/20 at which point she was terminated. Around August of 2020, she commenced treatment with Dr. Eric Gofnung who obtained MRI studies of her neck, lower back and right knees. Examinee underwent a course of physical therapy without improvement in her pain. She has not undergone other treatment for her orthopedic injuries. Present Complaints: Examinee complained of intermittent neck pain associated with occasional headaches, and neck stiffness; intermittent left shoulder pain with stiffness; constant lower back pain with weakness and giving way of her legs; frequent pain in her right knee associated with buckling and giving way. Symptoms were aggravated by when she tilted her head up and down or moves her head from side to side, prolonged sitting, standing, walking, and with bending of her neck and turning of her head; reaching, pushing, pulling, and any lifting, lifting her upper extremity above the shoulder level. Rest, exercise, ice and pain medication provide pain improvement, but she remains symptomatic. Examinee also has difficulty in sleeping and awakens with pain and discomfort; bending, twisting and turning; ascending and descending stairs. Examinee was unable to kneel and squat. Her pain level varied throughout the day depending on activities. Examinee has difficulty with activities of daily living. Past Medical History: Neck and back injury in a car accident, 30 years ago. Examinee underwent chiropractic treatment and fully recuperated. Job Description: Examinee began employment as a registered nurse for Sunbridge Hallmark Health Services since 2010. She worked eight hours per day, and five days per week. Her job duties at the time of injury included providing patient care, assisting with activities of daily living, passing and administering medications, charting on the computer and physical charts, assisting the patients in transferring and repositioning, operating a computer, pushing beds and wheelchairs, cleaning, sweeping, mopping, changing linen, making beds. The precise activities required entailed prolonged standing and walking, as well as continuous fine maneuvering of her hands and fingers, and repetitive bending, stooping, squatting, kneeling, twisting, turning, forceful pulling and pushing, forceful gripping and grasping, lifting and carrying 100+ pounds, torquing, reaching to all levels, and ascending and descending ladders. Employment History: Prior to working for the employer at the time of the injury, Examinee worked for IHSS as a homecare provider for ten years. Current Meds: Tramadol and Ativan. Vitals: Weight: 135 lbs. Height: 5'2". Cervical spine examination revealed spasm and tenderness over the paravertebral musculature and decreased range of motion. Range of motion was accomplished with discomfort and spasm. Motor power testing for the cervical spine was 4/5 on left Deltoid (C5) and Biceps (C6). Sensory testing revealed

decreased sensation on left with pain, C6 (Lat Forearm, Thumb, Index). Hoffman testing was positive on the left. JAMAR grip testing was 51/58/60 on right and 73/68/72 on left. Shoulder examination revealed tenderness over the left acromioclavicular joint. Impingement and Hawkins signs were positive on the left. Lumbar spine examination revealed Examinee ambulated with a cane. Impingement and Hawkins signs were positive on the left. Examinee's toe and heel walks and squat with pain. Pain and spasm present with range of motion. Supine straight leg raising: Right 40, Left 90 with right L5 pain. Deep tendon reflexes were reduced at the right knee. Sensory examination revealed decreased sensation with pain, L5 lateral leg, mid foot. Knee examination revealed right knee brace in place. Patellar crepitus was noted on the right. Tenderness was noted with firm compression on the right. There was medial and lateral Joint line tenderness noted on the right. McMurray's was positive on the right. Examinee's medical records were reviewed. Diagnoses: Cervical radiculopathy. Lumbosacral radiculopathy. Left shoulder impingement. Right knee tendinitis/bursitis. Plan: Requested all prior medical records and diagnostic studies. Recommended intra-articular injection as well as arthroscopy. Examinee would be provided anti-inflammatory and anti-gastritis medications as well as Ibuprofen gel. Correct usage of the knee brace and cane was discussed. Follow up in 6 weeks.

07/30/21 Dr. Omid Bendavid, Diagnostic Radiology. Beverly Tower-Women's. Tomosynthesis Digital Screening Bilateral Mammography revealed BI-RADS Category 1: Negative. Recommended annual mammography.

08/12/21 Dr. Koruon Daldalyan/Dr. Marvin Pietruszka. Del Carmen Medical Center. Primary Treating Physician's Progress Report. Examinee has MRI studies from 06/11/21. Vitals: BP: 104/42. Weight: 135 lbs. Pulse: 72. RR: 12. Temperature: 97.3. Examination revealed left-sided temporomandibular joint tenderness. Diagnostic Data: Electrocardiogram revealed normal sinus rhythm and a heart rate of 68 per minute. Diagnoses: Musculoskeletal injuries involving cervical spine, lumbar spine, left shoulder, left elbow, left wrist, bilateral hands, left hip, bilateral knees, left ankle and left foot. Cervical spine sprain/strain. Lumbar spine sprain/strain. Internal derangement, left shoulder. Epicondylitis left elbow. Carpal tunnel syndrome left wrist. Internal derangement left knee. Internal derangement bilateral ankles. Elevated blood pressure, rule out hypertension. Cephalgia. Vertigo. Chest pain. Palpitations. Dyspnea. Gastritis secondary to non-steroidal anti-inflammatory drugs. Nausea/vomiting. Irritable bowel syndrome manifested by diarrhea. Weight loss. Peripheral edema/swelling of ankles. Anxiety disorder. Depressive disorder. Sleep disorder. Diaphoresis. Rule out posterior cruciate ligament tear. Plan: Recommended close monitoring of blood pressures. Continue current medications. Work Status: Temporarily totally disabled for one month. Follow up in 6 weeks.

08/13/21 Dr. Edwin Haronian. Follow up Report of a Secondary Physician. Examinee has been increasing her activity level and discontinued the use of rigid brace. Examinee appeared to be walking well although she continued to utilize a one-point cane for assistance. Examination showed spasm, tenderness and guarding in the paravertebral musculature of the cervical and lumbar spine. Right knee has patellar crepitus on flexion and extension with medial joint line tenderness. Diagnoses:

Cervical radiculopathy. Radiculopathy, lumbosacral region. Impingement syndrome, shoulder. Chronic instability of knee. Unspecified osteoarthritis. Follow up in 8 weeks.

10/08/21 Dr. Edwin Haronian. Follow up Report and Request for Authorization of a Secondary Physician. Examinee was a reasonable daily walking program, but was unsure on stretching and strengthening activities which she could do safely in order to improve her strength and range of motion. Examinee has been released from the primary treating physician and therefore they requested authorization for 12 additional sessions of physical therapy for the neck, back, left shoulder and right knee. Would look forward to receiving authorization for these additional sessions since the physical therapy previously provided was largely passive in nature and she was left without a reasonable home exercise regimen. Examination revealed continued spasm, tenderness and guarding in the paravertebral musculature of the cervical and lumbar spine with decreased sensation noted in the left C6 and right L5 dermatomes. Left shoulder had mild impingement and Hawkin's sign with range of motion in flexion and abduction over 120 degrees. Right knee had patellar crepitus on flexion and extension with medial and lateral joint line tenderness. Altered signal was noted in the medial meniscus on the MRI study. Diagnoses: Cervical radiculopathy. Radiculopathy, lumbosacral region. Impingement syndrome, shoulder. Chronic instability of knee. Unspecified osteoarthritis. Plan: Continue to attempt the walking regimen. Refilled meds. It was Dr. Haronian's opinion that arthroscopy should be available to Examinee as a part of future care, but they were attempting to avoid that intervention. Follow up in 8 weeks.

10/19/21 Dr. Gustav Salkinder, Orthopedic Surgery. Salkinder Orthopedic Services, Inc. Panel Qualified Medical Evaluation and Report. Date of Injury: CT 01/06/20 to 06/30/20. CT 07/06/19 to 10/19/21. History of Injury: Examinee's problems started approximately in 2017, with the injury to the left shoulder. At that time, as she was helping a patient with transferring from bed to a chair, the patient suddenly collapsed on her. As she tried to hold the patient in order not to fall on the floor, she felt a pulling sensation in her left shoulder and arm, followed by pain. She reported the injury to the Director of Nursing, Ms. Rosa Manuel, however, was never referred for treatment. Examinee self-medicated with over-the-counter medication and went for evaluation to her Primary Care Physician, Dr. Hernandez. According to Examinee, she was referred for x-rays or MRI, the results of which were not available for Dr. Salkinder's review. Patient was informed by Dr. Hernandez that the studies were negative. Her left shoulder pain got better within a year; however, it did not disappear. She continued to have pain with rotation, overhead use and lifting more than 20 pounds with the left arm. Examinee also developed pain in the neck at that time, which continued after the left shoulder got better. Examinee experienced more pain in her neck while performing direct patient care. Approximately in late 2018-early 2019, Examinee had to jump over a fence in order to get the patient, who escaped from the facility where she worked. Examinee landed on her feet and felt pain in both of her knees, right greater than left. Examinee reported the injury to the supervisor, however, she was never referred for evaluation and treatment. She purchased a brace, and self-medicated with over-the-counter medications and never saw Dr. Hernandez for her bilateral knees. (There are records of multiple visits to Dr.

Hernandez with complaints of pain in multiple joints including both knees, and she was diagnosed by Dr. Hernandez with having osteoarthritis). With time, her knees improved but not 100%. Examinee continued to have pain as she continued working performing her regular job duties. With regards to the lumbar spine, Examinee developed the gradual onset of pain in her low back in 2019 from pushing and pulling patients in bed. She reported her symptoms to the supervisor, however, she was never referred for medical evaluation. She has not seen any medical providers for that. She stopped working at My Life Foundation on 04/01/20, due to COVID exposure at Playa Del Rey Center. She continued working performing her regular job duties at Playa Del Rey Center until 07/06/20, when she was terminated. Examinee retained an attorney, and on 10/05/20, she was referred for an evaluation and treatment to Dr. Eric Gofnung, who became her Primary Treating Physician. While under the care of Dr. Gofnung, she was referred for multiple MRIs and received 24 physical therapy treatments, 24 chiropractic treatments and 24 acupuncture treatments with some benefit. Injections were offered but she refused and also not interested in any kind of surgical procedure. She continued to be followed by Dr. Gofnung on a regular basis until she was discharged as Permanent and Stationary on 04/30/21. Examinee developed increased pain in her right knee approximately in June 2021. She contacted her attorney, and on 07/15/21, she was referred for an evaluation and treatment to Dr. Edwin Haronian, who became her new Primary Treating Physician. Dr. Haronian recommended additional physical therapy; however, the therapy was not authorized by the insurance carrier. No other treatment was provided to date. Present Complaints: Examinee complained of constant neck pain at 3-4/10 with intermittent radiation to the upper back and top portion of both shoulders and occasional radiation of pain into the left upper extremity down to the left hand. Pain was increased to 4-6/10 with repetitive bending, twisting, and prolonged positioning. Examinee also reported occasional mild discomfort in the left shoulder with prolonged overhead use of the left upper extremity. Intermittent lower back pain with occasional radiation to the right buttock and right thigh. With activities of daily living, she graded the pain as being 2/10 which increased to 4-5/10 with repetitive bending, twisting, sitting for more than one hour, standing and walking for more than 30 minutes, and with lifting more than 30 to 40 pounds. Right knee pain rated as 3/10 with activities of daily living and increased to 4-5/10 with standing for more than 1 hour, walking for more than 15 to 20 minutes, going up and down the stairs, and with kneeling, twisting and pivoting. Examinee reported occasional buckling and giving way of her right knee. Left knee occasional mild discomfort with prolonged standing and walking, with kneeling, and going up and down the stairs. Rest and medications decreased her symptoms. Examinee reported difficulty with activities of daily living. Past Medical History: Osteoarthritis diagnosed in 2012. Car accident in 2003, whiplash injury to the neck and back. Job Description: Examinee began working for Bold Quail Holdings, LLC, dba Playa Del Rey Center in April 2010. She was terminated on 07/06/20. Examinee worked as a registered nurse. She worked 10+ hours per day, 40 to 60 hours per week. Her job responsibilities included clinical operations including direct patient care four to five hours per day. The rest of the time, she was delegating staff assignments. She was performing staff management and staff education. During her work shift, Examinee spent two to three hours using computer keyboard and mouse. When Examinee performed direct patient care, she was assisting patients with washing, dressing, and assisting with transfers. She

was feeding the patients and changing diapers as needed. Her normal activities during a workday included occasional sitting, frequent walking, frequent standing, frequent bending at the neck and waist level, occasional squatting, occasional kneeling and frequent twisting at the neck and waist level. With regard to the upper extremities, she was constantly using her right and left hands for simple grasping, occasionally for power grasping with the right and left hands, occasionally for fine manipulation with the left hand, occasionally for pushing and pulling with the left hand and occasionally for reaching above and below the shoulder level. With regard to the lifting requirements, she was frequently lifting objects weighing up to 10 pounds. She would occasionally lift objects weighing up to 20 pounds. She was occasionally carrying objects weighing up to 20 pounds for a distance of several feet. She was pushing heavy medication cart and also pushing wheelchairs and pushing patients in bed while repositioning them. Her normal activities during workday did not include any driving of cars. She worked with the medical equipment. She was sometimes using safety glasses. She was exposed to biohazards. History of Concurrent Employments: From January 2009 until 04/01/20, she was working for My Life Foundation as a nurse consultant. She worked two to four hours per day, and two to three times per week. Her job responsibilities included assessing and consulting with the staff and clients in their homes. She also administered medications and performed wound care as needed. Her normal activities during workday included occasional sifting, occasional walking, occasional standing, occasional bending at the neck and waist level, occasional squatting, occasional climbing and occasional twisting at the neck and waist level. With regard to the upper extremities, she was frequently using her right and left hands for simple grasping and occasionally reaching below the shoulder level. There were minimal lifting and carrying requirements associated with her position. As part of her normal job duties, she was required to drive a car. In her spare time, she has been doing cosmetology, which involved hairdressing and makeup. In the last five years, she had about two clients per week, and would spend one to three hours with each client depending on what needed to be done. She mostly did hair and makeup. Examinee used the brush and a blow dryer and was holding a blow dryer in her right hand and the brush in her left hand. Social History: Quit smoking 8 to 10 years ago. Occasional smoker. Rare alcohol consumption. Current Meds: Naproxen 500 mg and Pepcid 20 mg. Vitals: Height: 5'2". Weight: 140 lbs. General examination revealed Examinee ambulated with a mild antalgic gait favoring the right lower extremity. Examinee was carrying a cane in her right hand but was not really using it for walking. Neck and cervical spine examination revealed tenderness to palpation over the paracervical muscle bilaterally; decreased lateral rotation and lateral bending bilaterally; positive Soto Hall test; positive Cervical Compression test on left; positive Spurling Maneuver bilaterally. Lumbar spine examination revealed tenderness to palpation over the paralumbar muscles bilaterally and over the gluteal muscles and sciatic notch on the right; straight leg raise test was positive on the right side at 75 degrees of leg elevation; asymmetric loss of range of motion; positive Sitting Root Test and Bragard Test on right; positive Kemp's test bilaterally. Upper extremities examination revealed tenderness to palpation over the acromioclavicular joint on the left; Neer's impingement sign, Hawkin's test and Jobe's test were mildly positive on left. Lower extremities examination revealed crepitus in the right knee with range of motion; tenderness to palpation over the right patellofemoral joint; able to squat 1/3 way. Positive Patella Grind test

and Quadriceps Inhibition test on right. Examinee's grip strength was 32/34/34 kg on right and 36/38/38 kg on left. Examinee's medical records were reviewed. Diagnoses: Chronic neck pain. Industrial aggravation of multilevel degenerative disc disease of cervical spine/degenerative arthritis of the cervical spine. Cervical radiculitis. Cervical facet syndrome. Chronic lower back pain. Small disc bulges at L4-L5 and L5-S1 levels without spinal canal stenosis or neuroforaminal stenosis, per MRI. Lumbar radiculitis. Patellofemoral arthralgia, right knee. Left knee strain, improved. History of osteoarthritis of both knees, non-industrial. Left shoulder strain, improved. Mild impingement syndrome of the left shoulder, improved. Work Status: Examinee remained temporarily totally disabled from 07/07/20 until 10/19/21. Disability Status: Examinee considered to have reached Maximum Medical Improvement as of the time of this evaluation on 10/19/21. Objective Factors of Disability: Physical examination findings on 10/19/21. Results of the diagnostic studies as described in the body of this report. Impairment Summary: Cervical Spine: 8% whole person impairment. Lumbar Spine: 6% whole person impairment. Chronic Pain: 2% whole person impairment. Gait Derangement: 7% whole person impairment. Calculated Whole Person Impairment was 21%. Causation: Examinee sustained a cumulative trauma injury (CT 07/06/19-07/25/20) to her neck, lower back, both knees and left shoulder as a result of the continuous repetitive nature of her job duties. It was also opined that except for the left shoulder injury, she has not sustained any injury to the upper extremities. Likewise, she did not sustain any injury to both hips or lower extremities, except for her both knees. At the time of the evaluation, Examinee had only complaints with regard to the left shoulder and both knees. She had positive findings on physical examination with regard to the cervical spine lumbar spine, left shoulder and right knee. Causation of the alleged injury on a non-orthopedic level, breathing, chest pain, irritable bowel syndrome, headache and high blood pressure is being deferred to the appropriate specialist in those fields. Apportionment: With regards to cervical spine, 80% of Examinee's residual disability was apportioned to the cumulative trauma injury she had sustained while working for Playa Del Rey Center, and 20% was apportioned to the above-referenced progressive non-industrial causative factors (degenerative arthritic changes in the cervical spine/degenerative disc changes in the cervical spine), which were considered, in all medical probability to continue to be causative/contributory. With regards to lumbar spine, 100% of the residual disability was apportioned to the cumulative trauma injury she had sustained while working for Playa Del Rey Center. With regards to right knee, 70% of the residual disability was apportioned to the cumulative trauma injury she had sustained while working for Playa Del Rey Center, 20% to the pre-existing arthritis, and 10% to her concurrent employment for My Life Foundation, which required her to stand and walk and also drive prolonged distances. Work Restrictions: Examinee was precluded from repetitive bending and twisting at the neck or waist. In addition, she was precluded from lifting more than 40 pounds. Examinee was also prophylactically precluded from prolonged overhead use of the left upper extremity, right knee, she was precluded from repetitive going up and down the stairs. Also precluded from kneeling, twisting and pivoting or other activities involving comparable physical effort. Future Medical Care: Future orthopedic evaluations should be provided, especially during episodes of exacerbations and/or worsening of her symptoms. Short courses of physical therapy, chiropractic treatments and acupuncture treatments, not to exceed 12-15 treatments per year in each modality,

should be provided to her in conjunction with the oral and topical medications that would be prescribed. She should also have an access to a pain management specialist for possible cervical epidural steroid injections and/or facet nerve block/facet joint injections. Based on the current MRI findings and Examinee's clinical findings, she was not a candidate for any surgical procedure on the cervical or lumbar spine. With regards to Examinee's left shoulder, she would require corticosteroid injection(s) in the shoulder, if her symptoms worsen and corticosteroid injection(s) in the right knee, if her symptoms worsen. Vocational Rehabilitation: If work with the above restrictions was not available, Examinee should be eligible to receive a Supplemental Job Displacement Voucher. Examinee started an online school in October 2020. She was studying towards the BS/Master's Degree in Psychology. She studies 30 hours per week; types two to three hours per week; sits most of the time; sometimes has live classes but most of the time, she has access on demand. She was expected to receive Bachelor of Science degree in 2022 and the Master's degree in 2024.

12/03/21 Dr. Edwin Haronian/Nicholas Cascone, PA-C. Follow up Report of a Secondary Physician. Examinee was status post medical-legal evaluation later during the month of October. Back examination again showed spasm, tenderness, and guarding in the paravertebral musculature of the cervical and lumbar spine. There was a decrease in sensation noted in the left C6 and right L5 dermatomes. The left shoulder had Impingement and Hawkin's signs with range of motion in flexion and abduction to approximately 120 degrees. Right knee examination revealed patellar crepitus on flexion and extension with medial joint line tenderness. Diagnoses: Cervical radiculopathy. Radiculopathy lumbosacral region. Impingement syndrome shoulder. Chronic instability of knee. Unspecified osteoarthritis. Plan: Meds refilled. Follow up in 8 weeks.

02/18/22 Dr. Edwin Haronian/Nicholas Cascone, PA-C. Follow up Report of a Secondary Physician. They continued to lack the report of the Medical-Legal Evaluator. As a result, they were confined to conservative management. Physical examination was unchanged from the previous visit. Diagnoses: Cervical radiculopathy. Radiculopathy lumbosacral region. Impingement syndrome shoulder. Chronic instability of knee. Unspecified osteoarthritis. Plan: Meds refilled. Follow up in 8 weeks.

04/08/22 Dr. Edwin Haronian. Synapse Orthopedic Group. Supplemental Medical Legal Report of a Secondary Physician and Review of Medical Records-ML-203-92. Examinee's medical records were reviewed. Discussion: Having reviewed those extensive number of medical records, that concluded with the QME report from Dr. Salkinder of 11/09/21, the QME has found industrial causation, has felt that Examinee had reached Maximum Medical Improvement in view that she did not wish to undergo injections and was not considered a candidate for surgery to either the cervical and lumbar spine. Would review the findings of the QME with Examinee discussed available treatment options on her behalf and would await her decision on the direction of the treatment she wishes to proceed. If based on the QMEs reporting, Examinee has not wished to proceed with injections or possible surgery, then would make a determination as to whether she

has reached Maximum Medical Improvement and was Permanent and Stationary. Requested all the medical records, related or unrelated to that case be sent to the attention for review.

In order for this Evaluator to render final and substantial compensability opinions as a QME, the necessary information on the issues that need to be addressed must be made available. The information required is necessary for diagnostic, compensability determinations or rating purposes.

THE FOLLOWING UP TO DATE TESTS/RESULTS/MEDICAL RECORDS ARE REQUESTED:

CBC WITH DIFFERENTIAL
METABOLIC 20
COLLAGEN PROFILE
HBA1C
TSH, T3, T4
URINALYSIS
PFT/DLCO
EKG
TREADMILL
ECHO
CXR PA/LAT
H. PYLORI BREATH

Epworth Sleepiness Score: 8/24

DIAGNOSTIC IMPRESSION:

1. Rheumatological Condition: Generalized Osteoarthritis with superimposed Calcium Pyrophosphate Disease (CPPD). Non-occupational, and most likely pre-existing.
2. Shortness of breath, probably secondary to anxiety. Normal spirometry.
3. Allergic rhinitis
4. probable Obstructive Sleep Apnea
5. GERD by history
6. Recurrent, intermittent bronchitis, pre-existing.
7. No evidence of hypertension.
8. Recurrent urinary tract infection, vaginitis.
9. Anemia, iron deficiency.

SUMMARY and CONCLUSIONS:

Pertinent finding from the review of medical records:

The chronology of the medical records dates back to January 2012. Laboratories performed in January 2012 were unremarkable, except for a glucose of 104 (unknown if fasting). The examinee's PMD was Dr. Valentin Hernandez. In December 2012 the examinee saw Dr. Hernandez complaining of fatigue, upper respiratory tract symptomatology and pain in most of the large joints, especially the knees. There was decreased range of motion and diffuse tenderness in the low back, cervical area and both knees had swelling and tenderness. The examinee was diagnosed with osteoarthritis and pharyngitis (this problem was recurrent). She also had vaginitis. As of May 2013 she complained of dysuria associated with fever and flank pain. She had persistent active cough and a sore throat.

As of December 2013 her symptoms were persistent, she continued to have persistent, productive cough, sore throat, as well as a pruritic rash over the feet and groin. She was diagnosed with an urinary tract infection, and iron deficiency anemia. Physical examination showed a purulent, hemorrhagic pharynx with cervical lymphadenopathy. She was diagnosed with tinea corporis and pharyngitis.

As of October 2015, the examinee persisted with a very productive cough, joint pain and swelling, hoarseness and a white vaginal discharge. She also had profound fatigue and shortness of breath. She had difficulty moving the wrists, closing the hands and walking because of pain in the ankles, knees and hips. Her weight was 122 pounds the blood pressure 118/60 and a pulse of 74. She was diagnosed with bronchitis, pharyngitis, vaginitis and osteoarthritis. HIV screening was nonreactive. Screening for venereal diseases was unremarkable.

As of May 2016, the examinee was pregnant.

In April 2020 she complained of fever, productive cough, sore throat and headaches. She had difficulty moving the wrists, closing her hands and walking due to ankle, knee and hip pain; this had worsened over the previous two weeks. In May 2020 the examinee complained of anxiety, panic attacks and stress. Medical records around this time document severe marital stress and problems with her daughter. Her daughter suffered from a psychiatric disorder. She has seen a psychiatrist in 2017. She went to a psychiatrist starting in May 2020. She complained of feeling overwhelmed, anxious and experiencing anxiety attacks. She was not sleeping well. She had experienced occasional sadness for many years. She was diagnosed with a generalized anxiety disorder and major depressive disorder.

In May 2020 the examinee also complained of concerns over the Covid-19 pandemic and the fact that she was working with high risk patients for Covid infection. She noted this was an increased stress, and some of her patients were dying.

The examinee continued to complain of persistent cough, sore throat, headaches as well as difficulty moving the wrists, walking and closing her hands due to ankle, knee and hip pain.

Sometimes her joints were swollen. The joint pain was worse in the mornings. As of July 2020 she was also complaining of burning pain to her toes, feet and groin areas. She was having intermittent fever, pain on urination and "worsening fungus on the skin". She was diagnosed with a fungal infection, tinea corporis.

The examinee saw a psychiatrist on 07/28/20. She was diagnosed with generalized anxiety disorder due to stressors at home. Psychotherapy was recommended. On 07/31/20 screening for Covid 19 was negative.

The examinee continued to complain of persistent productive cough, sore throat, hoarseness and increased joint pains with morning stiffness. Medications had not been helping. She had knee effusion with tenderness and warmth.

On 11/09/20 the examinee saw Dr. Pietruszka; I have already addressed this report in my previous report. However, there is a follow-up report dated 01/04/21 which I had not seen. The report addresses her musculoskeletal injuries with multiple diagnosis and a "rule out hypertension". The examinee was prescribed lansoprazole.
The examinee continued to treat with Dr. Gofnung, a chiropractor throughout 2021. He was addressing her musculoskeletal complaints. This provider deemed the examinee at MMI for her 07/05/19-07/05/20 cumulative type injury as of 04/30/21.

Another follow-up report from Dr. Pietruszka is dated 03/01/21. He continues to diagnose the examinee with gastritis and irritable bowel syndrome, however, there is no objective findings in support of these diagnoses. A follow-up report dated 06/17/21 showed an EKG was performed and it was normal. Pulmonary function testing showed an FVC of 1.71 (62.6 percent) and FEV1 of 1.29 (58.1 %). This is in contrast with the previous pulmonary function test that showed an FVC of 2.7 (82.5 percent) and FEV1 of 2.18 (81.7 percent), both of which are normal. The original tracings and calibration parameters were not available for my review.

The examinee went back to see Dr. Hernandez, her PMD in May 2021. She complained of increased joint pains, morning stiffness, knee effusion with tenderness and warmth. She also has sore throat and persistent productive cough. Vitals were normal. Her weight was 125 pounds. She went back to see Dr. Hernandez on 06/09/21 complaining of difficulty moving the wrists, hands and walking due to pain in ankles, knees and hips bilaterally.

An MRI of the cervical spine was completed by Pacific MRI on 06/12/21. Small degenerative anterior osteophytes were described at C3-T1. Other degenerative changes such as disc desiccation was also noted. Disc osteophyte complexes were noted at C4-C5, C5-C6 and C6-C7. Bilateral facet joint arthrosis causing mild bilateral neuroforaminal narrowing were also noted. An MRI of the lumbar spine was also completed. There is mild disc desiccation at L4-L5 with a disc bulge, but no impingement of the exiting nerves or the spinal cord.

An MRI of the right knee without contrast completed on 06/11/21 showed a moderate joint effusion. Degenerative changes with thinning of the articular cartilages were described. Myxoid degeneration and other degenerative changes were noted. An MRI of the left elbow also completed at the same time showed mild sclerosis of the articulating margins of the proximal radius and ulna with osteophytes. An MRI of the left knee also showed osteophytes mild sclerosis of medial tibial articular surfaces. There is also a small enthesophyte off the upper patellar pole anteriorly. Similar findings were described for the left wrist.

The examinee saw Dr. Hernandez on 06/30/21. She was complaining that her joint pains were getting worse. She was applying warm compresses to the joints.

The examinee saw Dr. Haronian, an orthopedist on 07/15/21. He was seeing her for a CT 01/06/20-06/30/20 injury. She was complaining of injury to her neck, left shoulder, lower back and right knee. The examinee was ambulating with a cane. She had left shoulder impingement, right knee internal derangement, cervical and lumbar radiculopathy. Intra-articular injection was recommended. On follow-up, the examinee had discontinued the use of her rigid brace and appeared to be walking well, still using a cane. Dr. Haronian diagnosed "unspecified osteoarthritis". He ordered physical therapy; arthroscopic surgery was on hold.

The examinee continued to treat with Dr. Haronian during 2022.

On 10/19/21 the examinee saw Dr. Salkinder, for an orthopedic PQME. This provider was addressing both of her cumulative trauma injuries. The Examinee provided a history of an injury that took place on 2017 resulted in a left shoulder injury. The examinee was trying to transfer the patient when he collapsed. Her PMD had diagnosed osteoarthritis; at the time of his evaluation, the examinee was on naproxen and Pepcid. She had stopped working for My Life Foundation on 04/01/20 (January 2009-04/01/20-nurse consultant, 2-4 hour/day, 2-3 times a week), but continued working for Playa del Rey Center until 07/06/20, when she was terminated. The examinee did cosmetology in her spare time (about two clients per week, spending 1-3 hours with each). There was a history of a motor vehicle accident in 2003 with the mechanism of injury of whiplash. Jamar dynamometer grip strength was 32/34/34 kilograms on the right and 36/38/38 kilograms on the left (these are normal). Examinee was diagnosed with a cervical facet syndrome and chronic low back pain, lumbar radiculitis. Dr. Salkinder concluded the examinee sustained a CT injury (07/06/19 through 07/05/20) to her neck, lower back, both knees and her left shoulder. Except for her left shoulder injury, the examinee had not sustained any injury to the upper extremities. He also stated that she had not sustained any injury to her hips or lower extremities, except for her knees. The examinee was at MMI at the time of his evaluation. In regards to the cervical spine, the examinee had a 10% WPI plus 2% add-on for chronic pain. She had a 6% WPI for the lumbar spine and a 7% WPI for the right knee. There were no positive findings on physical examination of the left shoulder or the left knee, and therefore WPI was 0% respectively. Overall Impairment Rating after combining the values was 21% WPI. She had osteoarthritis of both knees, and this was not industrial. The calculated WPI for this patient was 21%.

Apportionment was indicated. Dr. Salkinder acknowledged the examinee had multilevel degenerative arthritic changes of the cervical spine. He also added that absent in the industrial exposure, and based on the subjective and objective findings, the Examinee would have had residual cervical spine disability at the time of his evaluation. He apportioned the overall 12% cervical WPI 80% to cumulative trauma sustained while working for Playa Del Ray Center and 20% to the progressive nonindustrial causative factors (degenerative arthritic changes, etc.). There was no contribution from her work at My Life Foundation, as her job duties were not as physical, and she only worked very limited number of hours every week.

With respect to her lumbar spine, there was no indication for apportionment of permanent disability. In terms of apportionment two employers, 100% of her residual disability was due to her work at Playa Del Ray Center.

With regard to the Examinee's right knee, the examinee was diagnosed with having osteoarthritis. Apportionment of the 7% WPI to the right knee was 20% to pre-existing arthritis, 70% to her work at Playa Del Ray Center and 10% to her concurrent employment for My Life Foundation.

The examinee had permanent work restrictions precluding her from repetitive bending and twisting at the neck or waist; she was also precluded from lifting more than 40 pounds. She was to avoid repetitive climbing and descending stairs, kneeling, twisting and pivoting of her right knee and engaging in prolonged overhead use of the left upper extremity.

CAUSATION:

In regards to my previously expressed opinions, I stated:

1. The examinee did not fulfill the diagnostic criteria for hypertension. Her blood pressure measurements fell within the normal range throughout the entire review of medical records.
2. In regards to the chest pain and shortness of breath, the clinical picture was benign, and I doubted she had any serious underlying cardiopulmonary conditions, but could not rule out the possibility of GERD.
3. The examinee had been arbitrarily diagnosed with Irritable Bowel Syndrome (IBS), just based on the recent onset of diarrhea. This did not fulfill the diagnostic criteria for IBS. I opined that Dr. Petruszka's diagnosis was not supported by objective evidence or diagnostic criteria, and therefore was speculative. The same rationale applied to his diagnosis of gastritis.
4. The clinical musculoskeletal symptomatology, presenting with a pattern of recurrent, symmetric joint pain and swelling, effusion and warmth suggested a rheumatologic disorder. I ordered testing to that effect.

In terms of stressors, the medical records have shown the examinee had an ongoing history of severe marital problems, issues with her daughter, and around 2017 or 2018 she filed for

bankruptcy, based on her deposition content. She also testified that 2019 or so some family members (her uncle, and her cousin) passed away.

Definitive causation opinions were pending test results. Testing was ordered.

I have reviewed and engagement letter issued by Amanda Manukian, Esq. on behalf of the defendants. It presents with two cumulative trauma type claims, one spanning 01/06/20-06/30/20 hostile work environment due to the mandated to wear an N95 mask. The examinee claimed injury to breathing, chest pain, irritable bowel syndrome, headache and high blood pressure. The claim was denied at the time of my evaluation.

The second claim is also a cumulative trauma type claim spanning 07/06/19 through 07/05/20. This included the musculoskeletal complaints.

Each of these cumulative trauma claims addressed different employers. I was asked to segregate the causation liability between employers if indicated.

COMMENTS:

Imaging studies of numerous joints have shown mild to moderate degenerative changes, including osteophytes as well as sclerosis of several articular surfaces. These findings are usually associated with progressive, long-standing degenerative changes or inflammatory conditions. Sickle cell traits and hyperparathyroidism are two unusual, and frequently unrecognized causes for the findings.

However, based on what I have seen, her clinical picture is consistent with Generalized Osteoarthritis and superimposed Calcium Pyrophosphate Disease (CPPD). A large percentage of osteoarthritis patients have concomitant Calcium Pyrophosphate Disease (CPPD), and in these patients, in addition to the morning stiffness and diffuse joint pain, there may be prominent joint swelling, joint effusions, warmth and tenderness. Patients with Generalized Osteoarthritis and CPPD present with synovitis, marked joint swelling, tenderness that can substantially limit activity. In these individuals, symptoms may be restricted to one or a few joints at a time, however polyarticular involvement, frequently involving the knees, wrists, MCP joints may occur. Because Calcium Pyrophosphate Disease is acutely inflammatory, these patients present with profound fatigue during activation periods, and their hemograms (CBC & Diff) may present with what appears to be "iron deficiency anemia", which is rather anemia of chronic disease. At times this clinical picture may be difficult to differentiate from Rheumatoid Arthritis.

An effective way of differentiating between these conditions is a rheumatological screening profile; I originally ordered this group of tests, however, the examinee has not complied. Another, perhaps more invasive way of determining if the examinee has CPPD is to analyze joint fluid (her effusion) for calcium pyrophosphate crystals.

OPINION:

Musculoskeletal Injury Claim:

This examinee has Generalized Osteoarthritis and Calcium Pyrophosphate Disease. These conditions are non-occupational, and explain most of her joint complaints. This refers to both periods of her cumulative trauma claims, as noted above.

I reviewed Dr. Salkinder's apportionment opinions as I have detailed above. I do believe, however, that when he considered the degenerative changes, he assumed that her clinical course would follow the typical degenerative spinal and bone changes we see in most of our patients.

However, it is clear from the medical records reviewed, as well as her clinical features that she more likely than not, suffers from Generalized Osteoarthritis and CPPD. This combination makes for a more aggressive clinical evolution, leading to an accelerated loss of joint integrity and a more severe clinical presentation. With this in mind he may reconsider apportionment, because undoubtedly this disease combination has a prominent role on her subjective and objective findings, and as a result, is an integral part of the causation of her overall impairment. However, I will defer that to Dr. Salkinder.

In regards to which of the employers would have a higher level of potential exposure with possible exacerbation/aggravation of her nonoccupational musculoskeletal symptomatology, I tend to agree with Dr. Salkinder. The medical records speak of her difficulties performing physical activities during the times in which her disease was active, and this is consistent with her clinical conditions. Based on his analysis, Playa del Rey Center had the most intense physical demands, both because of the activities that she was required to do and also because of the length of her work week. Based on these considerations, if I had to rate her non-compensable Generalized Osteoarthritis and CPPD, I would apportion the overall ratable impairment 70% to Playa del Rey and the remaining 30% divided between her activities of daily living and her work with Life Foundation.

In regards to the question on appropriate work restrictions for her nonoccupational rheumatological conditions, I concur with Dr. Salkinder's suggestions. In terms of temporary disability, the examinee may have periods in which her conditions are active and flared up, requiring time off from work. This is particularly necessary in highly active, physical job activity requirements. I am not aware of any other sources of physical disability in addition to her rheumatological condition and the orthopedic problems noted above.

I cannot opine on the treatment provided for her Generalized Osteoarthritis and CPPD, because in essence, Dr. Hernandez provided very little treatment and performed minimal testing in order to appropriately document her rheumatological conditions. The appropriate approach to her symptomatology would have been to screen her for a rheumatologic condition, document the

Date of Report: July 11, 2022

presence of inflammation by measuring ESR rate and/or CRP values and treating the condition appropriately with nonsteroidal anti-inflammatory agents, or other modalities depending on the diagnosis.

Use of an N 95 mask as Covid 19 PPE (Personal Protective Equipment):

Initially, at the very beginning of the Covid 19 pandemic, masks were not required, even within health care facilities. However, as the number of cases escalated, hospital admissions became rampant and people were increasingly dying, PPE was deemed to be mandatory. PPE was not only used for protecting health care personnel from getting infected with Covid 19, but also to protect healthy patients from being exposed to health care personnel that may have been infected in were asymptomatic.

The appropriate way of fitting PPE, especially respiratory masks is to fit the mask appropriately to the individual, and then perform testing to make sure that the mask not only fits well and protects the wear from infection, but also serves as a barrier for the wearer. From her history, it appears that the employer did not follow the usual protocols utilizing occupational medicine to properly fit masks to individuals required to wear them. When these guidelines are not followed, then masks become ineffectual and may, in fact, be uncomfortable to wear.

In comparison with other types of masks (i.e., double canister masks), N95 represent the least of respiratory burdens. Their construction usually requires a slightly increased respiratory effort in some individuals, as compared to surgical masks. Most individuals can tolerate an N95 mask for long periods of time; for others, it requires getting used to it. Research on N95 mask use has shown that around 90%[1] of medical personnel usually tolerate N95 mask well for extended appears of time, however, a minority of individuals complain of perceived shortness of breath, difficulty with physical exertion, lightheadedness and difficulties communicating with others. Skin reactions, redness and occasionally rashes may be observed, especially in areas where the mask is in contact with the skin for long periods of time.

However, wearing an N95 does not cause long-standing "difficulty breathing, chest pain, irritable bowel syndrome, headache and high blood pressure" as this examinee has claimed.

Internal Medicine complaints:

In the 01/06/20-06/30/20 injury, the examinee claimed injury to breathing, chest pain, irritable bowel syndrome, headache and high blood pressure.

I have not seen evidence of high blood pressure, and with few exceptions, her blood pressure has been well within the normal range throughout a variety of medical encounter records spanning

[1] Rebmann, T. et.al., Physiologic and other effects and compliance with long-term respirator use among the medical intensive care unit nurses, American Journal of Infectious Control, 2013 December; 41 (12): 1218-23

several years. As I noted previously, she does not fulfill the diagnostic criteria for primary hypertension.

At the time of my evaluation, the examinee's headache had resolved. Dr. Salkinder mentioned the possibility of a cervical myofascial syndrome, and I agree. I will defer any further comments on this issue to the orthopedists.

As I have said emphatically in my previous report, there is absolutely no evidence of irritable bowel syndrome, and the examinee does not fulfill the ROME criteria for this condition.

Finally, Dr. Pietruszka performed serial spirometry testing. This was largely unnecessary, as the parameters do not change substantially in such a short time, in particular if the spirometry is conducted according to the American Thoracic Society standards. Dr. Pietruszka did not include calibration records for the spirometry equipment, demographics, which protocol was used during the test, pictures of the flow-volume loops or the length of the expiratory effort. Without these parameters, it is not possible to identify the quality of the results, and therefore I used the best results he obtained as my reference when evaluating this Examinee's respiratory function. The best results show normal respiratory function, and therefore do not support any injury to the respiratory system.

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Providing piecemeal information on complex cases is highly inefficient and exponentially bogs down my QME schedule for production of supplemental reports by increasing the amount of reports that must be produced to close a case. As a QME, I have no control over these repeated requests, nor the approval of the requested workup or availability of the needed medical records.

Therefore, I respectfully request that the parties assist in securing the necessary information as enumerated above and abstain from requesting any additional reports until ALL the information requested above is available for my review.

If the information is not available to the parties for legal or administrative reasons, that fact must be made clear to this Evaluator so I can proceed to estimate causation and impairment with the caveat that my professional opinion may be speculative, AND may be changed at a future date if new information becomes available, but it is the best that can be provided within reasonable medical probability with the information at hand.

I thank you for referring this patient to my practice. Please feel free to call if you have any questions regarding this report.

Date of Report: July 11, 2022

DISCLAIMER

Declaration Pursuant Title 8, CCR § 10606

The undersigned certifies that, where applicable, this report was prepared in compliance with Section 10606 "Physician's Reports as Evidence"

Disclosure of Information Pursuant to Section 4628 [(a), (b), (c), (j)]

Claimant: Anisa Chaney

Examining Physician: **Nelhs Betancourt, MD, MPH, DABT, CHCQM, CIME**

Specialties: **Internal Medicine/Occupational Medicine**
Occupational Toxicology

Qualifications: **Diplomate, American Board of Internal Medicine, Certificate No: 121664**
Qualified Medical Evaluator Certificate Number: 915187
American Board of Independent Medical Examiners, re-certified 2020
Diplomate, American Board of Toxicology, 2012, 2017
Medical College of Wisconsin, MPH Degree, 1998
Master's Degree in Public Health - Occupational Medicine
Board Certified Health Care Quality Management
Physician Advisor, Workers' Compensation
Medical Director, Occupational and Environmental Health Program, OccMed, Inc.
Occupational Medicine Consultant

If this report shows a Review of Records, the preliminary medical records review was conducted by a professional record transcribing unit. The resulting document was then reviewed by this Evaluator using the original records for reference, corrected, and supplemented as necessary. The transcription of this report was done by this evaluator using voice recognition software. The subscriber performed the final dictation, and a professional proofreader corrected the report for grammatical and typographical errors as well as for internal inconsistencies.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, except as noted herein, that I believe to be true. Signed, dated below.

Pursuant to Section 5703

I declare under penalty of perjury that there has been no violation of Labor Code Section 139.3, in that I have not offered, delivered, received or accepted any rebate, refunds, commission, preference, patronage dividend, discount or other consideration whether in the form of money or otherwise as compensation or inducement for any referred examination or evaluation. The contents of the report and bill are true and correct to the best of my knowledge.

Limited scope of this evaluation

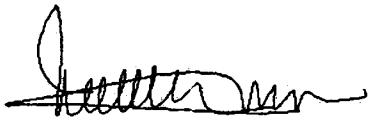
The scope of this report and any treatment offered, implemented or proposed by the health care provider signing below is specifically directed to address the issue(s) presented solely by the occupational injury, and not intended to address non-occupational medical conditions not related to the current injury. Therefore, the examination included herein is not to be construed as a complete medical exam for general health surveillance purposes.

Date of Report: July 11, 2022

Pursuant to Labor Code Sec. 3208.3 (h)

If applicable under the circumstances set forth in this report, I defer to the Trier of Fact to determine if this is a Good Faith Personnel Action.

Date of Report: July 11, 2022. Signed this 12th day of July, 2022 at City of Corona, Riverside County, California.



Nelhs Betancourt, MD, MPH, DABT, CHCQM, CIME
BC Internal Medicine
BC Independent Medical Examiner
BC Health Care Quality Management
BC Occupational Toxicology
Occupational Medicine
Physician Advisor, Workers' Compensation

CHANEY, Anisa 605476 NB QME 74737

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name Anisa Chaney v Bold Quail Holdings, LLC Sunbridge Hallmark Health Services dba Playa Del Rey Ctr

Claim No. 2080381794 **EAMS or WCAB Case No. (if any):** 13521045

I, Jacob Bocanegra declare:

1. I am over the age of 18 and I am not a party to this case.

2. My business address is: **Arrowhead Evaluation Services 1680 Plum Lane, Redlands, CA 92374**

3. On the date shown below, I served this Comprehensive Medical-Legal Report with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms 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 services 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***	***Addressee and Address***
A	07-13-2022	Eva Reale, Zurich Insurance SENT ELECTRONICALLY
A	07-13-2022	Natalia Foley WORKERS DEFENDERS LAW GROUP 751 South Weir Canyon Road STE 157-455, Anaheim, California 92808
A	07-13-2022	Amanda A. Manukian, Floyd Skeren Manukian Langevin, LLP 3835 R East Thousand Oaks Boulevard #630 Westlake Village, CA 91362

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Declarant

Print Name

Jacob Bocanegra