RE: Annette Garner v.

Med-legal Provider:	Farshad D. Yadegar
Date of Evaluation:	January 4, 2021
WCAB Number:	ADJ12721676
Claim Number:	1341863
Date of Injury:	10/31/2019

This package contains the PQME report of Farshad D. Yadegar as well as all documents required by the administrative director, dated March 29, 2021. Included in this package is med-legal report, the HICFA (CMS 1500) billing form, a signed copy of the provider's W-9, QME 122 Form, and a legal proof of service for these documents. This package was tracked via USPS. To determine the actual date of receipt, the tracking numbers are listed below and listed on the service list contained in the Proof of Service.

Natalia Foley Esq., Workers Defenders Anaheim
USPS Tracking #: 9114902307224786085927

Nadine M. Elkhattat Esq., Michael Sullivan & Associates
USPS Tracking Number: 9114902307224786085934

Diane McClellan, National Interstate Ins. Co.
USPS Tracking Number: 9114902307224786085910

Payment or objection in the form of an EOR must be received within 60 days from receipt of this package (per USPS tracking), per **8 CCR§9794**.

CCR §9794 (c) **A claims administrator who contests all or any part of a bill for medical-legal expense, or who contests a bill on the basis that the expense does not constitute a medical-legal expense, shall pay any uncontested amount and notify the physician or other provider of the objection within sixty days after receipt of the reports and documents required by the administrative director using an explanation of review. Any notice of objection shall include or be accompanied by all of the following:**

If payment is made more than 60 days from the date of receipt, the payment **MUST INCLUDE** 10% penalty and 7% interest from the date of receipt of the bill must be paid per **LC § 4622.**

LC § 4622. **All medical-legal expenses for which the employer is liable shall, upon receipt by the employer of all reports and documents required by the administrative director incident to the services, be paid to whom the funds and expenses are due, as follows:**

(a) (1) Except as provided in subdivision (b), within 60 days after receipt by the employer of each separate, written billing and report, and if payment is not made within this period, that portion of the billed sum then unreasonably unpaid shall be increased by 10 percent, together with interest thereon at the rate of 7 percent per annum retroactive to the date of receipt of the bill and report by the employer.

If this bill is not paid within 60 days as required by statute, or if the required penalty and interest are not paid when payment is made more than 60 days from the receipt of this bill, this office will file a petition for Determination of Non-IBR Medical-Legal Dispute seeking all applicable penalties, interest, costs, expenses, fees, and sanctions. Under **Rule § 10451.1.**

Rule § 10451.1 (c) (3) **Petition for Determination of Non-IBR Medical-Legal Dispute Filed by a Medical-Legal Provider (A) A medical-legal expense provider may file a "Petition for Determination of Non-IBR Medical-Legal Dispute" with respect to any medical-legal expense dispute not subject to IBR if: (i) a defendant breaches its duty to timely file a petition and/or declaration of readiness as required by Labor Code section 4622(c) and Rule 10451.1(e)(2); or (ii) a defendant breaches a duty under Labor Code section 4622(a) and/or (b) or the Rules of the Administrative Director at an earlier stage of the non-IBR dispute.**

X 561-25-6071

Garner, Annette 11 15 59

1832 W. 79th St.

Los Angeles CA

90047 (323) 229-8544

X

X Y4 1341863

X National Interstate Ins. Co.

X

10 31 19

10

Z04.6

Authorization Letter Enclosed

03 29 21	11	ML 106 -95	A	5937.50	95	ZZ	103TC0700X 1124068697

551835801 X 5937.5

(323) 522-9919

Farshad David Yadegar, Psy.D.
879 W. 190th St., #400
Gardena, CA 90248

03/29/21 1124068697 PSY20302

Farshad David Yadegar, Psy.D.
117 S. Doheny Drive, #208
Los Angeles, CA 90048
1124068697 PSY20302

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
FARSHAD DAVID YADEGAR

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☒ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ ________

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.
117 S. DOHENY DRIVE #208

Requester's name and address (optional)

6 City, state, and ZIP code
LA CA 90048

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number
551 - 83 - 5801

or

Employer identification number
__ __ - __ __ __ __ __ __ __

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person ▶** [signature] **Date ▶** 03/29/21

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

RECEIVED
JAN 04 2021
BY

WORKERS DEFENDERS LAW GROUP

8018 E Santa Ana Cyn Ste 100-215
Anaheim Hills CA 92808
Tel: 714 948 5054
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www.workerlegal.com

Natalia Foley. Esq
Managing Attorney
Tel: 310 707 8098
nfoleylaw@gmail.com
UAN: WORKERS DEFENDERS ANAHEIM
ERN: 13792552

TO: PQME Farshad D. Yadegar, M.D.
5001 E Commcercenter Dr., Ste. 230
Bakersfield, CA 93309

RE: ANNETTE GARNER VS MISSION SCHOOL TRANSPORT INC
DOB: 11/15/1959
WCAB #: ADJ12721676; ADJ12721933
DOI: 01/01/2018 - 10/31/2019; 12/01/2018 - 11/01/2019
CLAIM #: 1341863

Date: 12/29/2020

REQUEST FOR SUPPLEMENTAL REPORT

DEAR DR. FARSHAD D. YADEGAR, M.D.

Thank you for your continuing service as PQME on the above case. We are in receipt of your PQME MMI report dated August 14, 2020 for the above applicant.

It appears that your review of the medical records is not complete. Specifically you indicated that you were not provided with the personnel file of the applicant.

Please find attached the requested medical file and other medical records for your review.

If this review will not change your medical opinion on any issue, please reflect that in you supplemental reports.

We therefore attach medical records in our possession for your review per List of Exhibits (see below).

Upon review, please provide your opinion in regard to the following:

1) Whether future medical treatment is recommended and what it is;
2) Whether work restrictions are required and if yes – what specific restrictions.
3) Whether consultation with other medical professionals of different specialties is required and if yes – what specialty is recommended?

Once the report is completed, please forward it to all attorneys of records in the case:

DEFENSE ATTORNEY:
Nadine M. Elkhattat, State Bar No. 237408
Michael Sullivan & Associates LLP
PO Box 85059
San Diego, CA 92186-5059

APPLICANT ATTORNEY:
NATALIA FOLEY, Esq
WORKERS DEFENDERS
8018 E Santa Ana Cyn Ste 100-215
Anaheim Hills CA 92808

Should you have any questions or concerns, please do not hesitate to contact us at your own convenience.

List of exhibits

All exhibits can be downloaded here
https://www.dropbox.com/sh/p8q21iq8imlq4c8/AABd-EwXDxYTv5MbdI7hdubza?dl=0

Ex 01	MRI OF CERVICAL SPINE	07/04/2020
Ex 02	MRI OF LUMBAR SPINE	07/04/2020
Ex 03	MRI OF LEFT SHOULDER WITHOUT CONTRAST	07/16/2020
Ex 04	MRI OF LEFT KNEE WITHOUT CONTRAST	07/16/2020
Ex 05	DEU rating per Dr. Eric Gofnung P&S report	06/03/2020
Ex 06	Psych Med Report by Dr.Flores	07/24/2020
Ex 07	Psych Med Report by Dr.Flores	06/18/2020
Ex 08	Med Report by Ortho PQME Dr.Charles Schwarz MD	10/13/2020
Ex 09	Psych Med Report by Dr.Flores	06/12/2020
Ex 10	Psych Med Report by Dr.Flores	06/11/2020
Ex 11	Med report by Psych PQME dr Farshad D Yadegar MD	07/23/2020
Ex 12	Med report First Initial By PTP Dr Gofnung DC	12/02/2019
Ex 13	Med Report by Dr.Gofnung DC	01/06/2020
Ex 14	Med Report by Dr.Gofnung DC	02/03/2020
Ex 15	Med Report by Dr.Gofnung DC	03/02/2020
Ex 16	Med report P&S By PTP Dr Gofnung DC	04/01/2020
Ex 17	Transcript of the Deposition	01/23/2020
Ex 18	Full Ortho CT Application	11/09/2019
Ex 19	Full Psych CT Application	11/09/2019
Ex 20	Kaizer Medical Records	06/23/2008
Ex 21	Kaizer Medical Records	01/30/2012
Ex 22	Kaizer Medical Records	02/18/2019
Ex 23	Personnel File	

Yours Sincerely,
Attorney for Applicant,

Natalia Foley, Esq.
WORKERS DEFENDERS LAW GROUP

PROOF OF SERVICE

State Of California
County of Los Angeles

I am employed in the county of Los Angeles, State of California.
I am over the age of 18 years and not a party to the within action; my business address is:
8018 E Santa Ana Canyon rd ste 100-215
ANAHEIM CA 92808

I am readily familiar with the firm's business practice of processing correspondence for mailing. In the ordinary course of business, the correspondence would be deposited with the United States Postal Service on that same day with postage thereon fully prepaid at my business address above. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after the date of deposit for mailing as listed.
On 12/29/2020 I served the foregoing documents described as:

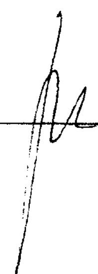
REQUEST FOR SUPPLEMENTAL REPORT
on the interested parties in this action, by placing a true copy thereof in a sealed envelope with postage thereon fully prepaid, in the United States Mail at my address stated above, addressed as follows:

WCAB (AHM)
1065 N PACIFIC CENTER DR STE 170
ANAHEIM CA 92806

MICHAEL SULLIVAN & ASSOCIATES LLP
PO BOX 85059
SAN DIEGO, CA 92186-5059

NATIONAL INTERSTATE INSURANCE COMPANY
PO BOX 549
RICHFIELD OH 44286

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Executed on: 12/29/2020 at Los Angeles, CA



By IRINA PALEES,
Legal Assistant to Attorney
Natalia Foley, Esq

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

DECLARATION REGARDING PROTECTION OF MENTAL HEALTH RECORD

(Health and Safety Code § 123115(b) and § 36.5, Title 8, California Code of Regulations)

NOTE: THE MENTAL HEALTH RECORD(S) ATTACHED TO THIS DECLARATION MUST NOT BE SEEN BY OR COPIED BY Annette Garner **FOR THE REASONS**
(Print name of injured employee)
STATED BELOW:

I, **Farshad D. Yadegar**, declare as follows:
(Print your name)

1. I am licensed in the state of California as a **Psychology** (Type of license), license number **PSY20302**

2. The attached medical record pertains to:

Employee name: **Annette Garner**

Address: **1832 W. 79th St., Los Angeles, CA 90047** Phone: **(323) 229-8544**

W.C. Claim number: **1341863**

W. C. Claims administrator: **Diane McClellan** Phone: **(330) 523-5178**

3. In my professional medical judgment and pursuant to Health and Safety Code § 123115(b), the attached mental health record, or the portions of this record designated below and on the face of the record, if seen or copied by the employee named above, will or is likely to result in a substantial risk of significant adverse or detrimental medical consequences to the employee, including but not limited to, (describe medical basis for conclusion):

In mental health evaluations there is the disclosure by the claimant of personal information, industrial and non-industrial, summarized records from treating and expert doctors and results from psychological testing leading to opinions, clinical and forensic, which can cause a negative impact to the psychological functioning of that claimant. It is in the claimant's best interest not to be given the actual report.

4. On **January 4** 20**21**, I was asked by the above named employee, or I was required by law, to serve a copy of this medical record on the employee.

5. On that same date, I advised the employee that the record only could be inspected by, copied or provided to a licensed physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, on behalf of the employee, and that the employee must use that mechanism to obtain the record.

6. The employee has designated the following physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, for alternate service of the employee's copy of this record:

Name:____________________

Address:____________________

Phone:__________ Fax:__________

Medical license no. (CA, if known):__________

Date of employee designation of this physician or health care provider:__________
(MM/DD/YYYY)

7. For the above reasons, in response to the employee's request of **01/04/2021** (date MM/DD/YYYY) for a copy of the record, I responded in the following manner: *(Check one below, as appropriate.)*

☑ I declined to allow the employee to personally inspect or receive a copy of the record.

☐ I declined to allow the employee to personally inspect, receive a copy or to be served personally with a copy of the record. However, at the employee's request, I did provide to, or serve a copy of the record on, the physician or health care provider designated by the employee as noted below:

Name:____________________

Address:____________________

Phone:__________ Fax:__________

Date of Service:____________________

Manner of Service: (mail, overnight mail, courier, fax)__________

8. From this time forward, I shall note in the medical file for this employee each time any licensed physician, within the definition of Labor Code 3209.3 or a health care provider as defined in Health and Safety Code § 123105, requests to inspect or copy this record on behalf of the employee.

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

Date signed: 03/29/2021

__________ **Farshad D. Yadegar**

(Signature) (Print name)

Address: **117 S. Doheny Drive, #208, Los Angeles, California 90048** Phone: **(323) 522-9919**

File record of requests for copies of the attached record made subsequent to the declaration date above:

Date	Person	License type and License number

Farshad David Yadegar Psy.D., QME
Qualified Medical Evaluator, State of California
Licensed Psychologist/California Lic. Number: PSY 20302
420 South Beverly Drive, Suite 100-18
Beverly Hills, California 90212
Office/Fax: 323-522-9919

March 29, 2021

Natalia Foley Esq.
Workers Defenders Anaheim
8018 E. Santa Ana Canyon Rd., Ste. 100-215
Anaheim, CA 92808

Nadine M. Elkhattat Esq.
Michael Sullivan & Associates
PO Box 85059
San Diego, CA 92186-5059

RE: **Annette Garner**

Employer:	Mission School Transportation
WCAB Number:	ADJ12721676
Claim Number:	1341863
Panel QME No.:	7338246
Date of Injury:	01/01/2018 - 10/31/2019
Date of Initial Exam:	August 14, 2020, and August 28, 2020
Date of Supp. Request:	January 4, 2021

PANEL QUALIFIED MEDICAL EXAMINATION IN PSYCHOLOGY SUPPLEMENTAL REPORT

On August 14 and 28, 2020, Ms. Garner underwent an initial Panel Qualified Medical Examination in Psychology (PQME #7338246) at my office, located at 879 W. 190th St., Suite 400, Gardena, California 90248, and I subsequently issued a comprehensive psychological report.

I am now in receipt of a letter requesting comments regarding the personnel records, and additional medical records that were provided totaling 1,124 pages.

WARNING: Psychological reports are highly confidential; the contents should not be revealed to anyone except those professionals who are directly involved in the processing of the claim. It is particularly important that the contents of a psychological report not be shown or given to the subject of the examination. Major distortions and misinterpretations may occur and cause the individual to experience unnecessary emotional upset. Therefore, this report should not be read to the applicant, even in part, for the above reasons. Any individual ignoring or violating this admonition assumes full responsibility for the applicant's subsequent reactions.

BILLING OF SUPPLEMENTAL REPORTS - Revised July 1, 2006

This supplemental report falls under the new billing guidelines for Medical-Legal reporting as revised by the Administrative Director for implementation as of July 1, 2006, and as specified in *Title 8, California Code of Regulations, Chapter 4.5, Division of Workers' Compensation.*

Section 9793 defines a "Supplemental medical-legal evaluation" as an evaluation which does not involve an examination of the patient, but instead is based on the physician's review of records; and test results or other medically relevant information that were not available to the physician at the time of the initial examination, and which are incorporated in the preparation of a narrative medical report completed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician following the evaluator's completion of a comprehensive medical-legal evaluation.

Section 9795 amends the medical-legal fee schedule for Workers' Compensation and designates fees for billing supplemental medical-legal evaluations under code **ML 106**. "The physician shall be reimbursed at the rate of **RV 5**, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician" *($12.50 x 5 = $62.50 per quarter hour, or AME's at $15.625 x 5 = $78.13 per quarter hour).*

I verify under penalty of perjury that the total time I spent on the following activities is true and correct:

a.	Review of new medical file and relevant old medical file	9.50 hours
b.	Preparing the supplemental report	14.25 hours

TOTAL: 23.75 hours

In the following sections, I will provide an overview of my previous findings, review the additional records, and then discuss the additional records as they pertain to my opinions.

In order to fully respond to these requests, my initial report was reviewed in its entirety.

I. INTRODUCTION/ IDENTIFYING INFORMATION

At the time of the August 14 and 28, 2020, evaluation, Ms. Garner was noted as being a 60-year-old, right-handed, African-American, married female with 12 years of education. The applicant was born on November 15, 1959. She was residing in a guest room of a house that belonged to a family friend located in South Los Angeles with her husband.

Ms. Garner started her employment with Mission School Transportation (formerly Atlantic Express) on December 1, 1997, as a school bus driver. She learned about the job through an advertisement on the radio. The applicant applied for the job in person when she felt that she was ready to join the workforce when her son turned 13 years old. She continued to work in the same position until she stopped working for the Mission School Transportation on October 22, 2019. According to the November 2, 2019, Application for Adjudication, Ms. Garner's claim involves stress due to hostile work environment sustained during the period of continuous trauma from January 1, 2018, to October 31, 2019. She has one prior workers' compensation claim that was related to an incident of assault that she had experienced around nine years ago when another employee assaulted her by hitting her on the back. As a result, she was placed off work for a month. Ms. Garner had received disability and a small settlement for her injuries.

The applicant reported having been concerned about her financial status at the time of her initial evaluation because she was on disability and worried about her job, thinking that she may never get hired again. Ms. Garner had received five sessions of individual and group therapy over Zoom before her initial evaluation.

II. REVIEW OF INITIAL PQME REPORT DATED OCTOBER 12, 2020

Ms. Garner met DSM-5 criteria for Adjustment Disorder, with mixed Anxiety and Depressed Mood, which had become stabilized and was at a mild level of severity. There was no evidence of a Personality Disorder or maladaptive traits, and no indication of preexisting psychological work impairment in this case.

Secondary to her mental disorder, the applicant was temporarily totally disabled on a psychological basis from October 22, 2019, when she initially sought medical care due to stress and then was placed off work, through August 14, 2020, the date of her initial evaluation. Ms. Garner's psychological condition had stabilized as of the time of the initial examination, August 14, 2020, at a mild level of severity, reaching Maximal Medical Improvement.

In my opinion, Ms. Garner's level of psychological impairment was associated with a GAF rating of 65, which translated to a Whole Person Impairment rating of 8% before adjustments for Future Earning Capacity, Occupation, and Age.

In my opinion, the predominant cause (greater than 50%) of the development of the applicant's psychological condition was the alleged series of personnel actions, including the write-ups and suspension, which was respectfully deferred to the Trier of Fact to determine the accuracy of her account regarding the fact pattern of the alleged series of personnel actions, including the write-ups and suspension and compensability.

With respect to apportionment, in my opinion, 20% of Ms. Garner's permanent psychological impairment was apportioned to her physical complaints that she attributed to her work duties throughout her employment. The remaining 80% was apportioned to the alleged series of personnel actions, including the write-ups, and suspension, the nature of which was respectfully deferred to the Trier of Fact.

The applicant would have benefitted from future medical care, to include 10-to-12 sessions of psychotherapy in order to address her residual depression and anxiety, as well as enhancing her coping skills. If additional psychological treatment was requested and deemed medically necessary, then it should have been provided. The recommended mental health treatment was respectfully deferred to the Trier of Fact to determine if it was industrially supportable.

III. SUMMARY OF ADDITIONAL MEDICAL RECORDS/DOCUMENTS

January 15, 2010 **Jason Sloves, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant presented with swelling in the right side of her face. She complained of body aches for one-to-two weeks and some swelling in her right parotid. Assessments were as follows: (1) "Health Check-up, Adult;" and (2) Viral Syndrome. Laboratory workup and x-ray mammography screening of the bilateral breast were ordered.

March 3, 2010 **Michelle Park, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant presented with itchy dry throat. Tactile f/c was noted. She had significant cough for three weeks, mostly dry. She was unable to sleep secondary to cough with no improvement despite various over-the-counter medications [unspecified] to control her cough. She reported having slight runny nose and congestion.

Assessment was Cough for Six-to-Eight Weeks. Nasarel, Claritin, and Tessalon were prescribed. Supportive measures were recommended. She was to return to clinic if no improvement.

April 12, 2010 **Donna Asimont, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant presented with complaints of weight loss and dry cough. She reported not feeling well for three months. She also reported feeling tired. She was experiencing shortness of breath and nausea. Assessments were as follows: (1) Malaise and Fatigue; (2) Shortness of Breath; and (3) Cough. X-ray of the chest and laboratory workup were ordered. The claimant was to follow-up with her primary care physician [name unspecified].

April 12, 2010 **Thomas Kim, M.D. – Kaiser Permanente (Diagnostic Study)**

X-rays of the Chest revealed the following: (1) There were slightly increased interstitial markings in both lungs; (2) Nonspecific pneumonia was considered involving the bilateral perihilar regions; and (3) Clinical correlation was needed.

April 19, 2010 **Lawrence Schneider, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant presented for follow-up routine for possible pneumonia. In "December 09," she reported URI with sore throat, aches, and "ears full." She then was having dry cough since "January." She reported having poor appetite, nausea, weakness, and shortness of breath. She had a substantial weight loss of 38 pounds. She was a non-smoker. She recently had laboratory workup. An x-ray of the chest was obtained [date unspecified], which revealed a possible pneumonia. She reported taking Ampicillin prescribed by a private doctor [name unspecified] with no benefit. Past Surgical History was significant for Gastric Bypass in 1988.

Assessments were as follows: (1) Pneumonia (Primary Encounter Diagnosis); (2) "Screening for CA, Breast;" (3) "Screening for CA, Cervix;" (4) "Screening for CA,

Colon;" and (5) "Health Check Up, Adult." X-ray mammography screening of the bilateral breast and laboratory workup were ordered. Azithromycin was prescribed.

July 15, 2010 **Lawrence Schneider, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant complained of shortness of breath, palpitations, and arm [laterality unspecified] numbness. She reported shortness of breath upon exertion and heart palpitations. She also complained of left arm pain, numbness, and paresthesias, as well as weight loss and left low back pain. She reported having pneumonia earlier this year. Her current weight was 198 pounds.

Additional Assessments were as follows: (1) Shortness of Breath; (2) Palpitations; (3) Abnormal Loss of Weight; and (4) Arm Pain. X-ray of the chest and cervical spine, electrocardiogram, and treadmill test were ordered.

July 15, 2010 **Seong-Cheon Kim, M.D. – Kaiser Permanente (Diagnostic Study)**

X-rays of the Chest (in comparison with chest x-ray dated April 12, 2010) revealed cardiac silhouette appeared normal in size. Again noted were questionable mild increased perihilar opacities bilaterally, left slightly worse than right. These findings were grossly unchanged since the prior examination. There were no new focal consolidations. The pleural spaces were clear. Surgical clips and sutures were noted overlying the abdomen.

Impression was a mild and subtle increased perihilar opacities bilaterally as described above. These findings were unchanged since the prior examination. While a chronic interstitial process could have a similar appearance, clinical correlation was recommended. A follow-up CT scan of the chest with IV contrast may be obtained for further clarification as clinically indicated.

July 15, 2010 **Seong-Cheon Kim, M.D. – Kaiser Permanente (Diagnostic Study)**

X-rays of the Cervical Spine revealed degenerative changes.

August 12, 2010 **Andrea Green, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant presented with questionable mild increased perihilar markings. She was referred for evaluation of abnormalities on imaging. She had upper respiratory infection symptoms in "December." She consulted to the medical doctor [name unspecified] in "March" with slight fever and cough. She reported a mild intermittent shortness of breath. Her cough was worse with eating, and she was coughing

up clear mucus. She occasionally would cough up food with blood. She noted that her cough had improved post use of Azithromax, which is an antibiotic. She had lost weight of 60 pounds over this illness while continuing to eat normally. She noted facial and lymph node swelling, which had improved. She reported lifelong acne. She had an occasional left-sided pain with arm [laterality unspecified] numbness, which had resolved. She reported a brief abdominal discomfort, nasal voice, and heavy menses.

Past Medical History was significant for Obesity. Past Surgical History was remarkable for Gastric Bypass in 1984, and Bunions in "191." As to Social History, the claimant is single. She worked for LAUSD as a Bus Driver. She worked in "aircraft" 25 years prior to date at Hughes California Paso Robles. She denied smoking tobacco and using recreational drugs.

Assessment was Interstitial Lung Disease (Primary Encounter Diagnosis). Laboratory workup was ordered. The claimant would continue to be assessed. She probably would need bronchoscopy with biopsy post CT.

August 12, 2010 **Danny Asejo, Respiratory Therapist – Kaiser Permanente**

A Pulmonary Function Test revealed the following Interpretations: (1) Spirometry was within normal limits; (2) Lung volumes were within normal limits; (3) There was a mild decrease in diffusing capacity; and (4) Poor test performance was indicated by volume extrapolation/FVC.

October 2, 2010 **Myungsun Moon, M.D. – Kaiser Permanente (Diagnostic Study)**

An MRI of the Brain with and without Contrast revealed the following Impressions: (1) No enhancing lesions in the brain; (2) Scattered bilateral foci of white matter changes. This was nonspecific and exact etiology and clinical significant uncertain. Clinical Correlation and follow-up could be obtained as clinically indicated; (3) Nodules in the bilateral parotid glands; and (4) Sinus inflammatory disease in the bilateral frontal, bilateral ethmoids, bilateral maxillary, and left sphenoid sinuses.

January 23, 2012 **Tumani Moore-Leatherwood, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant presented with left flank pain and left groin pain. She stated that approximately two-to-three weeks prior to date, she developed left lower back pain intermittent with "wrong move," resolving with reposition. She was a School Driver [name of the employer unspecified]. She had ten days left groin pain. Her right groin was swelling.

Review of Systems was positive for myalgia, back pain, and joint pain. Assessments were as follows: (1) "Prophylactic Vaccine for Tetanus, Diphtheria, Acellular Pertussis;" (2) Strain Thigh, Medial Tendon; and (3) Obesity. Calcium Carbonate, Ascorbic Acid, Garlic, and Adacel were prescribed. X-rays of the breast were ordered. Laboratory workups were ordered.

January 28, 2013 **Lawrence Schneider, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant presented with weight loss. She gained 45 pounds in the past two years. She wanted another bariatric surgery to lose weight. However, her body mass index was 39. She did not qualify. Past Surgical History was remarkable for Gastric Bypass in 1984 and Bunions in "191." Assessments were as follows: (1) Obesity; and (2) "Screening." Laboratory workups were ordered.

May 27, 2013 **Ronald Scott, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant presented with neck pain and low back pain. She had a hard time driving the school bus, as well as sleeping at night because of stress. For the last two-to-three weeks, she had back pain and shoulder pain. She took Motrin over the counter. She stated that Motrin helped her somewhat. She also had "little" tingle to her left forearm.

The claimant reported that she had trouble walking because of her low back pain. It started about a week prior to date. She did not recall significant pain in the past. Assessments were as follows: (1) Cervicalgia; and (2) Low Back Pain. Naproxen, Prednisone, and Methocarbamol were prescribed. She was to follow up if symptoms worsen or fail to improve.

November 28, 2014 **Lawrence Schneider, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant presented for annual physical examination. Her estimated body mass index was 38.61. In 2010, she had interstitial lung disease. She possibly had sarcoidosis, but she never had lung biopsy. She stated that she had a heart murmur. She wanted to have bariatric surgery, but her body mass index was 38.

Additional Assessments were as follows: (1) "Routine Adult Health Check Up Examination;" (2) "Declines Influenza Vaccination;" (3) "Declines Vaccination;" (4) "Screening Mammogram for Breast Cancer;" and (5) "Screening for Colon Cancer." X-ray mammogram and x-rays of the chest were ordered. Laboratory workups were ordered. ECG was obtained on this date.

November 28, 2014 **[Name of Examiner Not Provided] – Kaiser Permanente (Diagnostic Study)**

An ECG revealed a normal study.

December 8, 2014 **Jennifer Kim, M.D. – Kaiser Permanente (Diagnostic Study)**

An Ultrasound of the Left Breast (in comparison with December 8, 2014, and November 28, 2014, studies) revealed the following Impressions: (1) There was no sonographic evidence of malignancy; (2) The 4-mm oval cyst in the left breast was consistent with a simple cyst and appeared benign; and (3) A routine screening mammogram was recommended within two years.

December 26, 2014 **Sami Alskaf, M.D. – Kaiser Permanente**

A Metabolic Obesity and Nutrition Center (Inpatient/Outpatient) Consultation indicated that the claimant presented with obesity consultation, pre-surgical programs, and medical weight loss program. She complained of obesity, malnutrition, and post bariatric surgery issues. She was referred to MONC for weight management consultation. Her chronic medical conditions were stable. She worked as a Bus Driver. She is married and has three children, with one abortion due to miscarriage [date unspecified].

The claimant was abused physically by her brother. At age of eighteen, she was 220 pounds. At age of 27, she had a gastric bypass. She went down to 169 pounds on this date. Her weight made her feel less healthy, less secured, and uncomfortable. In her opinion, she was overweight due to overeating, junk food, "comfort eater," stress, and eating late. She would like to lose weight on this date due to health reasons, lifestyle reasons, and self-esteem issues. She was "emotional/stress/anxious/boredom/social eater." Her eating habit helped her to reduce stress/anxiety. She often ate junk food. She preferred eating carbohydrates, sweets, cheese, meat, salty, restaurant food, home cooked food, tea (occasional), water, soup (occasional), and vegetables/fruits (for three servings).

On the PHQ-9, the claimant obtained a score of 10 because of her appetite disturbance, decreased energy, loss of interest in regular activities, and weight. Her significant stressor was weight. Her exercise habit was walking. She spent two-to-four hours a day watching television. She consumed more calories in the morning, noon, and in the evening. She ate more every day. Her work time schedule was 40-to-50 hours per week. Her sleep time was at 11:00 p.m. She would be awake at 3:00 or 4:00 a.m. Her sleep hours were less than five hours per day.

The claimant was enrolled in gastric bypass program. Assessments were as follows: (1) Obesity; and (2) "History of Gastric Bypass." Past Medical History was significant for Obesity on November 28, 2014. Past Surgical History was remarkable for Gastric Bypass in 1984 and Bunions in "191." Vitamin D and MV I/D with Calcium were prescribed. No capsules/hard gel form, soda, sweets (especially candies) as well as sleeping seven hours per day were advised. She was qualified for medical programs [unspecified] and not the surgical programs. Her target weight was 170 pounds. Exercise program was approved for 30 minutes for six-to-seven weeks. Low fat and low salt diet were recommended.

May 26, 2015 **<u>Chetan Bharel, M.D. – Kaiser Permanente</u>**

An ED Provider Note indicated that the claimant presented with chest pain, which started 20 hours prior to date. She experienced midline burning sensation. Her symptoms stopped, but then recurred seven and a half hours prior to arrival.

Patient Active Problems List were Obesity and History of Gastric Bypass. Past Surgical History was remarkable for Gastric Bypass in 1984 and Bunions in "191." Family History was remarkable for asthma in her father and diabetes in her mother. Review of Systems was positive for chest pain. X-ray of the chest was obtained on this date. Laboratory workups were ordered. Oxygen was administered. Aspirin, Ondansetron, and Famotidine were prescribed.

Assessment was Chest Pain. Under Plan, the claimant was reassured that, at this time, her symptoms did not appear to represent a serious threatening condition. She was to follow up with her primary care physician as arranged in discharge navigator. She was to continue her previously prescribed medications as directed. She was discharged home in stable condition.

May 26, 2015 **<u>Ata Rezvanpour, M.D. – Kaiser Permanente (Diagnostic Study)</u>**

An x-ray of the Chest revealed a normal study.

January 5, 2018 **<u>Lawrence Schneider, M.D. – Kaiser Permanente</u>**

A Progress Note indicated that the claimant presented with right arm pain. On this examination date, she complained of right shoulder pain and overweight. She wanted to have diet pills. Dr. Schneider explained to her that diet pills are harmful. Additional Assessments were as follows: (1) "Declines Cervical Cancer Screening (PAP Smear);" (2)

"Vaccination for Diphtheria, Tetanus, and Acellular Pertussis;" and (3) "History of Gastric Bypass." X-ray mammogram and laboratory workups were ordered.

February 10, 2019 **Jay Takata P.A. – Kaiser Permanente**

A Progress Note indicated that the claimant had no cardiac risk factors and felt some palpitations since "Friday." She believed that she had a tooth infection on her left upper side. Past Medical History was significant for Obesity, BMI 38-38.9, Adult.

Assessments were as follows: (1) Toothache; and (2) Palpitations. Laboratory workups were ordered. Amoxicillin-Pot Clavulanate and Potassium Chloride were prescribed.

February 10, 2019 **Sharn Deep L.V.N./Jay Takata P.A. – Kaiser Permanente (Diagnostic Study)**

An Electrocardiogram revealed the following results: (1) Sinus rhythm occasional premature ventricular complexes; (2) Possible left atrial enlargement; and (3) Borderline.

February 10, 2019 **Alison Kim, M.D. – Kaiser Permanente (Diagnostic Study)**

X-rays of the Chest revealed no findings for acute airspace disease.

February 18, 2019 **Neelam Pathikonda, D.O. – Kaiser Permanente**

A Progress Note indicated that the claimant presented for urgent care recheck. She had low potassium. She went to urgent care for palpitations, which she had since resolved. She continued to feel "something" in her chest described as "slight" tightness that was constant and resolved currently. She had a history of interstitial lung disease. Her "ACE" levels were elevated. She also had vaginal itching. She had recent use of antibiotics [unspecified].

Assessments were as follows: (1) Vaginal Pruritus; (2) "Screening for Colon Cancer;" (3) "Declines Influenza Vaccination;" (4) "Screening for Cervical Cancer;" (5) "Screening for "HPV;" (6) Interstitial Lung Disease; (7) Prediabetes; and (8) "Screening for Hepatitis."

Laboratory workups were ordered. Fluconazole and Hydrocortisone were prescribed. The claimant was referred to health education.

April 8, 2019 **Michael Gottus, P.A. – Kaiser Permanente**

A Progress Note indicated that the claimant had left upper dental pain. She was examined in February for "same." She was better with antibiotics [unspecified] and did not follow up with her dentist [name unspecified]. She had pain and swelling.

Assessment was Toothache. Tylenol was prescribed. The claimant was to follow up with her dentist.

September 23, 2019 **Mission School Transport, Inc.**

A Company Statement and Details indicated that on this date, Annette Garner was advised that based on the documentation on her "DBRs," she was in violation of excessive time. She was also instructed to not make any unauthorized stops and to make the immediate corrections moving forward so this would not result in disciplinary action.

On this date, Reggie Young, Operation Manager, agreed to look further into Ms. Garner's alleged violations. As of October 14, 2019, after the completion of this investigation, Ms. Garner alleged findings were found to be violations of Union/Company policy.

As to Summary, it was Mission School Transport Inc.'s goal for all employees to be successful in their job; however, be advised that if issues continue, disciplinary action may result, up to and including termination.

October 15, 2019 **Miscellaneous**

A Document (signed by Mr. Young) regarding: "Annette Garner" indicated that on this date, Mr. Young was in his office having a manager's meeting with Floyd and JT, at approximately "9:55." Mr. Young received a call from the accounting department. Mr. Young could not hear who was talking, nor what they were saying. Mr. Young could only capture the voice of Ms. Garner. She was yelling or screaming at someone. As Mr. Young ran upstairs, JT and Floyd followed. As Mr. Young walked in, he asked Ms. Garner what was the problem and to calm down. La Shonda was just trying to get Ms. Garner to complete her "DBR's." Ms. Garner replied with "What's all this?" Mr. Young stated "What?" Ms. Garner replied, "You brought all this security with you." Mr. Young turned around and looked to see JT and Floyd behind him. Mr. Young replied to Ms. Garner, "They are not security, they are my staff." Ms. Garner then stated, "I don't like being threatened." Mr. Young then replied to Ms. Garner, "You are not being threatened, just fix your DBR and you're done." Ms. Garner was not listening and became very angry and upset. As Ms. Garner was exiting the accounting department door, she stated "I don't believe all this security shit!" Ms. Garner was yelling with very inappropriate behavior and attitude as she was walking down the stairs.

As Mr. Young was returning to his office, he heard Ms. Garner yelling out in the driver's room and acting very inappropriate, telling the driver [name unspecified] what happened upstairs. So Mr. Young walked in the driver's room and replied to Ms. Garner, "Please! Don't air out your personal business in front of the driver." Ms. Garner replied and stated something like, "I can tell whoever I want, you brought in all of your security shit!" Mr. Young replied, "Okay that's enough, you can go home for the day."

October 15, 2019 **Mission School Transport Inc.**

A Corrective Action Plan Suspension (addressed to Ms. Garner, from Mr. Young) regarding the Subject: "Inappropriate Behavior," indicated that level of corrective action was suspension "p.m. only."

As to Problem, it is of utmost importance for Mission School Transport, Inc. employees to be dependable professionals, honoring the trust placed in Mission School Transport Inc. company.

On October 14, 2019, Ms. Garner failed to read a message in "TCP" requesting her to see the accounting department regarding completing a "DBR." On this date, as Ms. Garner was meeting with La Shonda, Mr. Young received a call from Tania, and all Mr. Young could hear was Ms. Garner's yelling in the background. As Mr. Young came upstairs, she instructed Ms. Garner to complete her DBR, and Ms. Garner stated that she was being threatened by the message in "TCP." As Ms. Garner was leaving the office, she made an inappropriate comment, stating "all this security shit!" Ms. Garner was also reminded that MST LA do not tolerate any intentional or unintentional acts that create a hostile, offensive work environment.

Mission School Transport Inc. investigation determined that Ms. Garner's conduct was inappropriate behavior in violation of the company policy. Ms. Garner's disciplinary action was unpaid suspension for her p.m. shift on this date.

Any further violations of this nature would result in further disciplinary action and/or suspension up to and including termination.

As to Action Plan, this matter was currently under investigation. The outcome would be determined upon completion of the investigation. As to Follow-Up, Ms. Garner was pending returning to work.

October 15, 2019 **Miscellaneous**

A handwritten Driver's Incident Report (completed by La Shonda Ratliff, [designation unspecified]) indicated that "this morning" at 9:45 a.m., Ms. Garner came into Ms. Ratliff's cubicle and stated, "You need to explain what I need to do because you guys are starting to do too much and I'm starting to feel threatened." As Ms. Ratliff began to explain what was wrong with the "DBR" dated October 11, 2019, Ms. Garner stopped Ms. Ratliff and stated, "Hold up, I feel threatened and I need to get this off my chest." Ms. Ratliff then turned her chair around and moved to the corner of the cubicle because Ms. Garner had her finger in Ms. Ratliff's face. Ms. Ratliff asked Ms. Garner what was she talking about or referring to. Ms. Garner stated, "You guys having messages on the time clock is a threat and I'm not scared." At this point, Ms. Garner was yelling at Ms. Ratliff and hovering over her in her cubicle. Ms. Ratliff told Ms. Garner that the message went out to everyone per Mr. Young, and if Ms. Garner read it, she would see Ms. Young's name, so Ms. Ratliff requested Ms. Garner to stop yelling at her, and Ms. Ratliff would call Mr. Young to come up. Ms. Ratliff then dialed Mr. Young's number, and he answered, but Ms. Garner was yelling so loud that Mr. Young could not hear Ms. Ratliff, so Mr. Young kept saying "hello" about three time. At this time, Tania Rivera stepped in and began to calm Ms. Garner down, but then Ms. Garner began yelling at Ms. Rivera when Mr. Young, Floyd, and JT walked in. Mr. Young asked Ms. Garner to calm down and just fix the "DBR," and Ms. Garner stated, "What's this security shit, fuck this," and walked out of the accounting office. This was the second time.

October 15, 2019 **<u>Miscellaneous</u>**

A handwritten Driver's Incident Report (completed by Ms. Rivera, Account Manager) indicated that Ms. Garner was told to fix a "DBR" as per the notice she received on the time clock. There were several other drivers in line behind her waiting to speak to Ms. Ratliff, while Ms. Garner's voice became louder and louder, accusing Ms. Ratliff of "singling" her out, harassing, and threatening her. Ms. Rivera stood behind the cubicle and told Ms. Garner to "please calm down, no one is threatening you," as Ms. Ratliff already tried to explain to Ms. Garner what the notice was for. She then turned around and raised her voice at Ms. Rivera, saying things like "You guys can't threaten me." Ms. Rivera noted that she just had to step in with Ms. Garner last week when Ms. Garner also got loud with Ms. Ratliff regarding the "same" ("Correcting DBR's"). This happened on approximately September 24.

JT heard the noise as well. Ms. Garner continued to stand halfway in Ms. Ratliff's cubicle, yelling at her that she would not, did not have to, and was not going to correct her paperwork. At some point, Ms. Ratliff dialed Mr. Young's number while Ms. Garner continued going on and Ms. Rivera continued to try and calm her down. Mr. Young answered on speaker phone and must have heard the yelling/shouting. And soon after, Mr. Young, Floyd, and JT came in the office to check on the situation. Immediately, Ms. Garner

started shouting things like "Oh hell no! What y'all think y'all doing coming up her like y'all the damn police...," "What's up with all this security showing." Shortly after Ms. Garner was escorted out of Ms. Ratliff and Ms. Rivera's office, she continued to yell around in the driver's room downstairs. Ms. Garner was of a violent nature. Ms. Rivera witnessed her punching their first payroll check in the past, and every time she had to see the office staff regarding her paperwork, she created a scene. By standing at Ms. Ratliff's entrance, Ms. Rivera was not sure if Ms. Garner would let her anger take over.

October 16, 2019 **Mission School Transport, Inc.**

A handwritten Driver's Incident Report (signed by Anthony Harmon [designation unspecified]) indicated that Mr. Harmon entered the driver's room and heard Ms. Garner voicing her opinion about "DBR's." She was asked to re-do. She was "very" obnoxious and extremely loud. At that time, Mr. Young came in and asked her very politely to tone it down. Mr. Young also stated in a very professional tone that she should not tell her business. Ms. Garner became irate. Ms. Garner began screaming at Mr. Young and stated, "I can tell my business to anyone I want. You cannot tell me who I can tell my business to." Mr. Harmon felt that this was very unprofessional by Ms. Garner. At the same time, Mr. Harmon felt that Mr. Young handled the situation professionally at all times. Mr. Young did not let Ms. Garner rattle or anger him. So Mr. Young later told Ms. Garner to come into his office. Mr. Young put "please" on the end of that "praise."

In addition, Mr. Harmon felt that Ms. Garner was very wrong, and she was putting the manager in a very difficult position. Mr. Young handled that situation very professionally. Also, Mr. Harmon later told Ms. Garner that she did not have to let the incident get out of control due to her ego. Mr. Harmon felt that she should apologize to Mr. Young.

October 16, 2019 **Kambiz Ashoorzadeh, D.O. – Kaiser Permanente**

A Progress Note/Work Status Report indicated that the claimant had been having headaches often. Her pain was shooting throughout the body. She worked as a School Bus Driver. She was under a lot of pressure through her job. She had to urinate often for the last few months and her job did not want her to interrupt the work too much. She attributed the frequent urination to holding urine a lot and also drinking plenty of fluids.

Active Problem Lists included Obesity, BMI 35-39.9, Adult and History of Gastric Bypass [date unspecified].

Assessments were as follows: (1) "Stress Counseling;" (2) Urinary Frequency; (3) "Screening for Mammogram for Breast Cancer;" (4) "Screening for Colon Cancer;" and (5) "Vaccination for Influenza.

The claimant was referred to "population care." PHQ9 questionnaire was to be administered. Laboratory workups and mammography were ordered.

The claimant was placed off work on this date through October 18, 2019. Dr. Ashoorzadeh requested to allow Ms. Garner to have more break time to be able to use the bathroom more frequently.

October 25, 2019 **[Illegible Examiner's Signature] – Uptimum Medical Group**

A Medical Note indicated that the claimant was under "my" care and diagnosed with "Medical Reason" on this date. "I" am releasing her back to work or school on this date.

November 2, 2019 **Workers' Compensation Appeals Board – State of California**

An Employee's Claim for Workers' Compensation Benefits filed for the CT injury sustained from January 1, 2018, through October 31, 2019, described as "stress" due to hostile work environment. The name of employer was not provided.

November 2, 2019 **Workers' Compensation Appeals Board – State of California**

An Employee's Claim for Workers' Compensation Benefits filed for the CT injury sustained from December 1, 2018, through November 1, 2019, described as stress and strain due to repetitive movement over period of time to the neck, left shoulder, left shoulder blade, left arm, upper back, fingers, legs, feet, and chest pain. The name of employer was not provided.

November 9, 2019 **Workers' Compensation Appeals Board – State of California**

An Application for Adjudication of Claim filed for the CT injury sustained from January 1, 2018, through October 31, 2019, described as "stress" due to hostile work environment, while employed with Mission School Transport, Inc. as a Bus Driver.

November 9, 2019 **Workers' Compensation Appeals Board – State of California**

An Application for Adjudication of Claim filed for the CT injury sustained on December 1, 2018, through November 1, 2019, described as stress and strain due to repetitive movement over period of time to the chest, shoulders, upper extremities, neck, and lower extremities while employed with Mission School Transport, Inc. as a Bus Driver.

November 23, 2019 **Jake Rofman, M.D. – Kaiser Permanente**

A Work Status Report indicated that the onset of condition [details not provided] was on November 22, 2019. The claimant was taken off work from November 25, 2019, until November 27, 2019.

November 23, 2019 **Jake Rofman, M.D. – Kaiser Permanente**

A Progress Note indicated that the claimant presented with generalized body pain or aches and "pos" high heart rate. She developed back pain since the day prior to date between her shoulder blades and lower back. Her pain began when lying in bed.

Diagnoses were as follows: (1) Muscle Spasm of Thoracic Back; (2) "Declines Influenza Vaccination;" (3) "Screening Mammogram for Breast Cancer;" (4) Obesity, BMI 36-36.9, Adult; and (5) "Weight Loss Counseling." Flexeril was prescribed. The claimant was to use heat. Stretching and massage were recommended.

December 2, 2019 **Mayya Kravchenko, D.C. – Eric E. Gofnung Chiropractic Corp.**

A Doctor's Excuse indicated that the claimant was under Dr. Kravchenko's professional care and had been placed on temporary total disability on this date through January 6, 2020, due to her work-related injuries that occurred from January 1, 2018, through October 31, 2019. Dr. Kravchenko excused her from any work that was missed due to her injuries/condition.

December 2, 2019 **Eric Gofnung, D.C./Mayya Kravchenko, D.C. – Eric E. Gofnung Chiropractic Corp.**

A Primary Treating Physician's Initial Evaluation Report and Request for Authorization indicated that the claimant was employed by Mission School Transportation as a Bus Driver at the time of the injury. She began working for this employer on December 1, 1997. She worked full-time.

The claimant's job activities included driving a bus and pre-trip requiring lifting the hood and forceful pulling. During the course of work, the claimant was required to perform

sitting, walking, standing, flexing, twisting, side-bending, and extending the neck, bending and twisting the waist, squatting, climbing, crawling, and kneeling.

The claimant would use the bilateral upper extremities repetitively for simple grasping, power grasping, fine manipulation, keyboarding, writing, forceful pulling up to 15 pounds, reaching at shoulder level, reaching above shoulder level, and reaching below shoulder level. She was required to lift and carry objects while at work.

The claimant worked nine hours per day and five days per week. Her work hours varied. Lunchtimes and rest breaks were to be taken during her four hours downtime. Her job involved working 100% outdoors.

The last day the claimant worked for Mission School Transportation was on October 22, 2019, at which time she was placed on temporary disability by her doctor [unspecified]. She was on disability from October 23, 2019, through December 2, 2019.

As to Prior Work History, the claimant worked for the Mission School Transport, Inc. for 22 years.

As to History of Injury and Treatment as Presented by Patient, the claimant worked in a stressful environment, and as a result, she experienced anxiety and difficulty in sleeping. She attributed the injuries to the repetitive movements of gripping, grasping, and prolonged sitting while driving a bus doing city driving as well as freeway driving. She used her hands and arms to turn the steering wheel repetitively. She used her left foot to brace and hold while driving on bumpy streets. She also used forceful pulling when lifting the hood of the bus to make daily inspections. She noted that in order to avoid bouncing, which increased her back pain while driving the bus, she bounced in her seat constantly.

In late 2018, the claimant developed the onset of pain in her neck, upper back, left shoulder, and shoulder blade with radiating "shooting" pain into her mid-back. She also developed pain to her left hip, leg, and foot. She reported her pain to her manager, as well as dispatch personnel [names unspecified]. She took days off intermittently due to persistent pain and discomfort. Her complaints were minimized, and she was not offered medical care.

The claimant sought medical care on her own. She presented to Kaiser for evaluation. She was taken off work for a few days and was prescribed medication [unspecified] for pain. She continued working with pain and discomfort. She recalled that she returned to Kaiser on two separate occasions when she had flare-ups.

Due to persistent pain, the claimant presented to another physician which she could not recall his name at this time. She was evaluated and prescribed medication [unspecified] for

anxiety. She was taken off work from October 25 through November 25. She returned to work, but due to increased pain and anxiety, she returned to the physician who took her off work through November 25, 2019. She was last treated with the private practice physician in October 2019.

The claimant returned to Kaiser urgent care due to severe upper back and left shoulder pain. She was evaluated by the physician on duty [name unspecified]. She was taken off work through December 2, 2019.

The claimant initially reported her injury to the employer in late 2018. After reporting the injury to the employer, she was not provided with an Employee Workers' Compensation Claim Form. She was not provided with medical attention. She was unaware if information regarding Medical Provider Networks and her rights was posted in her place of work. Upon being hired, she was not provided with information relating to Medical Provider Networks and her rights if injured at work. Upon reporting her injury, she was not provided with information relating to Medical Provider Network and her rights if injured at work.

The claimant presented to this facility for further evaluation and treatment of her industrial injuries.

On this examination date, the claimant complained of neck pain. It was moderate-to-severe, and the symptoms occurred frequently. There was radiating pain from the neck into her shoulders and her head, and she had been experiencing frequent headaches. She was experiencing burning sensations. She had difficulty falling asleep, and was often awakened during the night by the neck pain. There was stiffness and restricted range of motion in the head and neck. Her pain level varied throughout the day. Her pain medication [unspecified] provided her pain improvement, but she remained symptomatic.

The claimant complained of left shoulder pain. The pain radiated to her arm and bicep. She experienced weakness and restricted range of motion for the shoulder, as well as numbness and burning sensation in her shoulder and arm. She complained of stiffness, and experienced increased pain with repetitive movement of the arm/shoulder. She was not able to sleep on her left shoulder due to the pain. She had difficulty falling asleep, and awakened throughout the night due to pain and discomfort.

The claimant complained of thoracic spine pain. The pain radiated into her left shoulder blade, upper back, into her left shoulder, and arm. She complained of tightness in the mid-back area.

The claimant complained of left hip pain. The pain was becoming "sharp," "shooting," and "burning." Her pain traveled to her left leg into her left calf. She had a locking sensation in the hip. She had difficulty sleeping, and awakened with pain and discomfort.

The claimant complained of pain to her feet. The symptoms occurred intermittently in her feet, at time becoming "pins and needle-like" pain. The pain was dominant in her left foot. She had episodes of swelling, numbness, and tingling in her feet. She had difficulty standing and walking for a prolonged period. Her pain worsened when she flexed, extended, or rotated her feet. She walked with an uneven gait. Her pain medication [unspecified] provided her temporary relief.

The claimant had continuous episodes of anxiety, stress, and depression due to chronic pain and disability status. She had difficulty sleeping, often obtaining a few hours of sleep at a time. She worried about her medical condition and the future. Her condition worsened due to continued work, lack of medical treatment, and activities of daily living.

As to Past Medical History, it was noted that approximately seven years prior to date, while working for the same employer, the claimant sustained an injury to her left upper back when she was punched by a co-worker. Medical care was rendered "in the prescribed medication and physical therapy." She made a full recovery.

Past Medical Surgery was remarkable for Gastric Bypass approximately 30 years prior to date, and Removal of Bunion Surgery to Both Feet approximately 38 years prior to date.

As to Hospitalization, the claimant was asymptomatic and without any disability or impairment prior to the continuous trauma injury from January 1, 2018, through October 13, 2019, as related to the neck, back, left shoulder/arm, left shoulder blade, left hip, leg, feet, and "psyche."

Review of Systems was positive for trouble sleeping, muscle pain, stiffness, anxiety, depressed mood, social withdrawal, emotional problems, and stress.

As to Family History, the claimant's mother is deceased and passed away from diabetes and pneumonia. Her father is deceased and passed away [dates unspecified] from a heart attack. She has four brothers and two sisters. They are well and in good health.

As to Social History, the claimant is married and has five adult children. She completed high school.

Diagnostic Impressions were as follows: (1) Cervical Spine Myofasciitis, Cervical Facet-Induced Versus Discogenic Pain, Cervical Radiculitis, Left; (2) Thoracic Spine

Myofasciitis, Thoracic-Induced Versus Discogenic Pain; (3) Lumbar Myofasciitis; (4) Left Shoulder Tenosynovitis/Bursitis; (5) Left Shoulder Impingement Syndrome, Rule Out; (6) Left Carpal Tunnel Syndrome; (7) Patellar Tendinitis, Left; (8) Internal Derangement of the Left Knee, Rule Out; (9) Bilateral Pes Planus; (10) Left Plantar Fasciitis; and (11) Insomnia, Anxiety, and Depression.

As to Discussion and Treatment Recommendations, the claimant was recommended a treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy. Treatment for the left ankle and foot was deferred to podiatrist.

X-rays of the cervical and thoracic spine and left foot, MRI of the cervical spine and left shoulder, and NCV/EMG of upper extremities were ordered. The claimant required psychiatric consultation with Dr. Musher. She required pain management consultation.

As to Medical Causation Regarding AOE/COE, in Dr. Gofnung's and Ms. Kravchenko's opinion, it was within reasonable degree of medical probability that the causation of the claimant's neck, back, left upper extremity, and left lower extremity injuries and resultant conditions, as well as needed for treatment, were industrially related and secondary to continuous trauma injuries from January 1, 2018, through October 31, 2019, while working for Mission School Transport, Inc. as a Bus Driver.

The claimant's condition was not permanent and stationary at this time. She was in need of further treatment.

As to Work Status, the claimant was temporarily totally disabled until reevaluation in four weeks.

January 6, 2020 **Eric Gofnung, D.C./Mayya Kravchenko, D.C. – Eric E. Gofnung Chiropractic Corp.**

A Primary Treating Physician's Follow-Up Evaluation Report and Request for Authorization indicated that the claimant was to continue with her treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy as recommended. As to Work Status, the claimant was to remain temporarily totally disabled until her next follow-up in four weeks.

January 23, 2020 **Workers' Compensation Appeals Board – State of California**

A 108-page Deposition of Annette Garner revealed the following information:

The claimant testified that she had a prior deposition taken about seven or eight years prior to this deposition date. This was in relation to a claim that she filed against Atlantic Express when a co-worker assaulted her [date unspecified].

When asked if she ever had gone by any name other than Annette Laverne Garner, the claimant stated that her maiden name was Annette Laverne Harris. She was using her maiden name from birth up until 1983 when she got married.

The claimant admitted to taking Tylenol with Codeine in the past 24 hours. The medication was prescribed at an Urgent Care in Kaiser for her pain to the neck and back.

The claimant recalled being involved in a personal motor vehicle accident more than 30 years prior to this deposition date. She was the driver and sustained a whiplash injury. She also had lower back pain and stiffness. She received chiropractic therapy [name of facility unrecalled, and name of chiropractor unspecified] in relation to the accident. She believed she treated with the chiropractor for about a month.

The claimant had been living at her current address for 27 years. She lived with her husband. They had been married for 36 years. She has three children, who are all adults and are no longer living with her. She admitted to helping them out financially, but not on a regular basis. She stated that her husband filed for bankruptcy about 15 years prior to this deposition date.

The claimant completed twelfth grade and graduated from Paso Robles High School [date unspecified]. She had not taken any college courses and had not obtained any certificates. She also does not have any plan on going to school or enrolling any time in the future.

The claimant admitted to being employed at Mission School Transportation at the time of this deposition. She started working in 1997 [job title unspecified]. She had been working at the same job for 22 years, but Mission School took over the company five years prior to this deposition date.

The claimant indicated that she last physically worked at Mission School on October 22, 2019. When further asked what happened on that day which caused it to be her last day at Mission School, the claimant related that she had been missing some work because the pains to her back, neck, and shoulders had gotten to be "too much." She was also having numbness in her hands, legs, and feet, as well as tightness in her shoulders.

The claimant stated that she consulted at the Urgent Care in Kaiser about a week prior to October 22, 2019, and was prescribed Tylenol with Codeine. She reiterated that she had been experiencing the pains for "years," and had to be off work many times. She clarified

that she really did not report this; it was just basically letting her several co-workers, dispatchers, and managers know that she was having back pain, and she could not work. She recalled expressing it to her managers, Floyd Trice and Reggie Young.

The claimant stated that by the time she left for work in the morning on October 22, 2019, she informed dispatch that she was to take the afternoon off because she was in pain. She was not sure if it was the same day or the following day that she went to the doctor.

The claimant testified that she was a Bus Driver at Mission School Transportation. Her job was to basically drive a school route, picking up students from home to school. She had been on a particular school route [unspecified] for about three years. In the morning, she was driving about two-and-a-half-to-three hours, and then about three-to-four hours in the evening. She was paid hourly, and her rate of pay was $23. She was working between seven and seven-and-a-half hours a day. Her direct supervisors were Mr. Young and Mr. Trice.

The claimant acknowledged that aside from actually being on the bus, driving, and steering, she was required to do a daily report, but it was just a simple little paper form. It involved a little writing by hand. There was the bus check first thing in the morning, then the DBR for pay, at the end of the day. These were paperwork she did daily, and she would do the writing for about five minutes. The claimant affirmed that her job required grasping and gripping of the steering wheel. There was also pulling involved because every morning she had to pull the hood of the bus up for a check. She believed the hood of the bus weighed about 15-to-20 pounds. She admitted that she enjoyed her job.

The claimant confirmed that she received write-ups, but not for work performance. It was "just miscellaneous stuff." She recalled that the most recent was when she was written up in around September 2019 "for saying that a manager was a dispatch manager." She explained that it was made known to the drivers that Mr. Trice was a dispatch manager. She noted that Mr. Trice asked her to take the employee handbook to the safety department. She clarified that everyone was handed the handbook, and in the back part of the handbook, they had to sign it. She noted that she was given the permission to read it first before she would sign it. She was reading the handbook when Mr. Trice told her to take it back. She insisted that she would take it back, but she was going to read it first. She had "a few more words" with Mr. Trice, and she reminded him that the safety department handed her the handbook, and he was just the dispatch manager. From there, it went bad. She was written up by Mr. Trice and was sent home. She noted that she did not sign the write-up.

The claimant was also written up [date unspecified] for going to the ladies' room and taking a bathroom break. She pointed out that it was a bathroom break that she took just before her first pick-up, so she was being called in for that. She indicated that they were allowed to go to the bathroom either on their downtime or when they get to the school. The