SYNAPSE ORTHOPEDIC GROUP

EDWIN HARONIAN, M.D.
DISORDERS & SURGERY OF THE SPINE

- Minimally Invasive Spine Surgery
- Complex & Revision Spine Surgery
- Comprehensive Spine Care
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- Fellow, American Academy of Orthopedic Surgeons
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Patient Name	:	Bhargav Shah
Date of Service	:	December 19, 2022
Claim #	:	DLRW2022096551
Employer	:	Disneyland Resort/92802
Date of Birth	:	May 1, 1956
Date of Injury	:	CT:10/21/20-10/21/22
File #	:	20079633

INITIAL COMPREHENSIVE ORTHOPEDIC EVALUATION REPORT OF A PRIMARY TREATING PHYSICIAN AND REQUEST FOR AUTHORIZATION

The above captioned patient, a 66-year-old right-hand dominant male, presented in my Pomona office, located at 724 Corporate Center Drive, 2nd Floor, Pomona, California 91768, on December 19, 2022, for an orthopedic evaluation.

The following is a presentation of my initial evaluation and over all recommendations. The history was obtained by my medical historian, Ms. Alma Azucar. I then reviewed the history in detail with patient.

HISTORY OF INJURY:

Mr. Shah is a 66-year-old right-hand-dominant male who sustained industrial injuries as a result of a cumulative trauma dated CT: 10/21/2020 - 10/21/2022, while employed as a Food Preparer with Disneyland Resort/92802.

The patient states over the course of employment, he gradually developed pain to his neck, shoulders, wrists/hands, mid and lower back, lower extremities at the hips, and knees,, which he attributes to his work duties, entailing: preparing and making hot sandwiches, slicing meats and cheese, bringing the food to the front for them to hand out to the customers, lifting and carrying product, slicking meats, lifting and carrying

product weighing up to 50+ pounds, pushing carts loaded with product. He was pressured to work at a fast pace and often made to work overtime.

The precise activities required entailed prolonged standing and walking, as well as continuous fine maneuvering of his hands and fingers, and repetitive bending, stooping, squatting, twisting, turning, forceful pushing and pulling, forceful gripping and grasping, reaching to all levels, torquing, lifting and carrying up to 50+ pounds.

He continued working full duty and his pain gradually worsened.

The patient is suffering with **stomach aches**, attributed to the fact he often skiped lunch and dinner due to the long hours of work. He often would just have a snack bar to kill his hunger. He has not been diagnosed.

He developed **anxiety and stress**, attributed to his persistent pain and working in a hostile environment. He has not diagnosed.

He was recently diagnosed with **diabetes and high cholesterol, and started** on medication. He attributes these conditions to his persistent pain and job-related stress. He is to inform his attorney of this diagnosis.

In 2018, he changed to a different position, after suffering a work-realted injury involving his right hand. This was a CT injury. His employer referred him for medical care. He received treatment in the form of office visits, pain medication, x-rays and MRI studies of the right hand were done, and he received physical therapy , and had **right hand surgery on** October 6, 2022. Upon initiation of treatment he was given work-restrictions.

In 2020, he was transferred to making sandwiches but no slicing of meats or lifting no greater than 10-15 pounds.

In early October 2022, he was taken off work on injury for his right hand for which he had surgery soon after, as noted above. He remains off work since.

He began medical care and treatment on his left hand in 2020. He received treatment in the form of office visits, pain medication, x-rays and MRI studies of the left hand were done, and was recommended surgery, which he is thinking about having it. He has been given permanent work-restrictions of no greater than 15 pounds. He was last examined for his left hand in February or March 2022.

On **July 7, 2022, he had a** fall at work, landing to his left knee. He reported the injury to his employer and was examined by the doctors on site. He was transferred via ambulance to the St. Jude's Hospital in Orange. He was taken off work. X-rays of the left knee were

taken. He was given pain medication. He was supplied with a knee brace and a one-point cane. He was examined once and advised to take time off work.

He was followed by the company physician. He was kept on full duty work. An **MRI study of the left** knee was done. He was examined once.

He sought legal counsel and was referred for medicla care.

In he was examined by Jend Medical Group in Los Angeles. He was kept off work. He was examined twice, as it was too far from his home.

He transferred treatment to Dr. Kurp, Bryan in Placentia. He was initially examined on September 23, 2022. He was kept off work. He began physical therapy to his left knee, at intervals of twice a week to present. He remains under his care.

He has not received any medical care or treatment to his neck, shoulders, mid and lower back, hips, or right knee.

She subsequently developed **anxiety, stress, sleeping disorders,** and stomach issues, attributed to her persistent pain, working in a hostile environment, and the fact she is not able to function at her fullest capacity. She has not been diagnosed. She takes OTC sleep-aids.

He remains off work since July 2022, when he was taken off work for his hands.

He presents to my office today for a comprehensive orthopedic evaluation.

JOB DESCRIPTION:
The patient states prior to working with Disneyland Resort/92802, he worked at Chevron Gas Station as a Cashier for six months.

The patient began employment with Disneyland Resort/92802 in June 8, 2012, as a Food Preparer.

He worked eight hours per day, five days per week, and a lot of overtime. His job duties at the time of injury included: preparing and making hot sandwiches, slicing meats and cheese, bringing the food to the front for them to hand out to the customers, lifting and carrying product, slicking meats, lifting and carrying product weighing up to 50+ pounds, pushing carts loaded with product. He was pressured to work at a fast pace and often made to work overtime.

The precise activities required entailed prolonged standing and walking, as well as

continuous fine maneuvering of his hands and fingers, and repetitive bending, stooping, squatting, twisting, turning, forceful pushing and pulling, forceful gripping and grasping, reaching to all levels, torquing, lifting and carrying up to 50+ pounds.

CURRENT WORK STATUS:
The patient is currently not working. He last worked on July 20, 2022, when he was taken off work on injury for his hands.

He is currently receiving worker's comp benefits.

PRESENT COMPLAINTS:
Neck:

The patient presents today with complaints of continuous aching in the neck, often becoming sharp and shooting pain. His pain travels to his arms and hands. He has episodes of numbness and tingling in his arms and hands. He has frequent headaches, which he associates with his neck pain. He has stiffness in the neck and his pain is aggravated when he tilts his head up and down or moves his head from side to side. His pain increases with prolonged sitting and driving. He has difficulty sleeping and awakens with pain and discomfort. His pain level varies throughout the day depending on activities. Icing/heating pads and light stretching take the edge off his pain.

Shoulders:

The patient has complaints of constant aching in the shoulders, at times becoming sharp, shooting, and throbbing pain. His pain travels to his arms and hands. He has a popping and clicking sensation in the shoulders. He has episodes of numbness and tingling in his arms. His pain increases with reaching, pushing, pulling, and with any lifting. His pain level varies throughout the day depending on activities. He has difficulty sleeping and awakens with pain and discomfort. Icing/heating pads and light stretching take the edge off his pain.

Wrists/Hands: (not on claim form)

The patient has complaints of continuous aching in the wrists/hands, becoming sharp, shooting, and burning pain with activity. His pain travels to his forearms. He has episodes of swelling, numbness, and tingling in his hands and fingers. He complains of cramping and weakness in his hands and fingers. His pain increases with gripping, grasping, and repetitive hand and finger movements. He has difficulty sleeping and awakens with pain and discomfort. His pain level varies throughout the day depending on activities. Icing/heating pads and light stretching take the edge off his pain.

Lower Back:

The patient has complaints of continuous nagging pain in the lower back, often becoming sharp and shooting pain. His pain travels to his legs and feet. He has episodes of swelling, numbness, and tingling in his legs and feet. He states coughing and sneezing aggravate his lower back pain. His pain increases with prolonged standing, walking, sitting, and driving. His pain also increases with bending, twisting, and turning. His pain level varies throughout the day depending on activities. He does not have bowel or bladder dysfunction. Icing/heating pads and light stretching take the edge off his pain.

Hips:

The patient has complaints of constant aching in the hips, worsening with prolonged standing and sitting in a fixed position. His pain travels to his legs. He experiences a locking, clicking and grinding sensation in the hips. He has episodes of numbness in the legs. His pain level varies throughout the day depending on activities. Icing/heating pads and light stretching take the edge off his pain.

Knees:

The patient has complaints of continuous aching in the knees, at times becoming sharp, shooting, and burning pain. His pain travels to his calves. He has clicking, popping and locking in his knees. He has episodes of swelling in the knees. His knees have given out, causing him to lose his balance. He has difficulty with prolonged standing and walking. He has difficulty ascending and descending stairs and at times walks with an altered gait. His pain level varies throughout the day depending on activities. Icing/heating pads and light stretching take the edge off his pain.

Internal:

The patient is suffering with **stomach aches**, attributed to the fact he often skiped lunch and dinner due to the long hours of work. He often would just have a snack bar to kill his hunger. He has not been diagnosed.

He developed **anxiety and stress**, attributed to his persistent pain and working in a hostile environment. He has not diagnosed.

He was recently diagnosed with **diabetes, hypertension, and high cholesterol, and started** on medication. He attributes these conditions to his persistent pain and job-related stress. He is to inform his attorney of this diagnosis.

MEDICAL HISTORY:
The patient is diabetic and has a history of high cholesterol, controlled with medication.

The patient has no known history of heart disease, high blood pressure, kidney disease, tuberculosis, cancer, ulcers, pneumonia, lung disease, eye problems, skin problems, asthma, hepatitis, liver disease, thyroid disease, gout, rheumatoid arthritis, Lupus, or arthritis.

SURGERIES:
As noted above, the patient underwent surgery to his right hand.

As a teenager, he had an appendectomy.

PRIOR/SUBSEQUENT INJURIES:
The patient denies any prior or subsequent accidents or injuries.

MEDICATIONS:
The patient is currently taking prescribed medication for diabetes and high cholesterol, but cannot recall the names of these.

ALLERGIES:
The patient has no known allergies to any medications.

SOCIAL HISTORY:
The patient is married with one son.

He does not drink and does not smoke.

FAMILY HISTORY:
Her family history is noncontributory.

HOBBIES:
The patient enjoys walking and outdoors, which he currently limits due to hjis pain.

ACTIVITIES OF DAILY LIVING:
The patient states that prior to the above noted injury he had no disabling conditions and could perform all activities of daily living without any difficulties.

The patient states since the injury dated CT: 10/21/2020 - 10/21/2022, there are episodes of increased pain causing him difficulty with showering, dressing, grooming, and with house chores. He avoids prolonged standing, walking, sitting, and driving. He avoids lifting and is more aware of proper body mechanics. He ambulates with a walking stick, if he is to walk more than 30 minutes .

PHYSICAL EXAMINATION:

HEIGHT: 5’03”
WEIGHT: 160 Lbs.

Cervical Spine Examination:
On visual inspection, there is no erythema, edema, swelling or deformity about the cervical spine or upper back area. The patient's head is held in a normal position. No torticollis was noted.

There is spasm and tenderness over the paravertebral musculature, upper trapezium and interscapular area but not over the cervical spinous processes or occiput.

Cervical Range of Motion	Patient ROM	Normal
Forward Flex	**45°**	50°
Extension	**55°**	60°
Lateral Flex (rt.)	**40°**	45°
Lateral Flex (lt.)	**40°**	45°
Rotation (rt.)	**70°**	80°
Rotation (lt.)	**70°**	80°

Range of motion was accomplished without discomfort and spasm.

Reflexes and special tests are as follows:

Reflexes and test	Right	Left	Normal
Triceps reflex	2+	2+	2+
Biceps reflex	2+	2+	2+
Brachioradialis reflex	2+	2+	2+
Tinel Signs (wrists)	Negative	Negative	Negative
Tinel signs (elbow)	Negative	Negative	Negative
Adson Test	Negative	Negative	Negative

Motor power testing for the cervical spine:

Muscle Group	Right	Left	Normal
Deltoid (C5)	5	5	5
Biceps (C6)	5	5	5
Triceps (C7)	5	5	5
Wrists Extensors (C6)	5	5	5
Wrist Flexors (C7)	5	5	5
Finger Flexors (C8)	5	5	5
Finger Abduction (T1)	5	5	5

Sensory Testing:

Dermatome	Right	Left	Normal

C5 (Deltoid)	Intact	Intact	Intact
C6 (Lat Forearm, Thumb, Index)	**Decreased with pain**	**Decreased with pain**	Intact
C7 (Middle Finger)	Intact	Intact	Intact
C8 (Little finger, Med. Forearm)	Intact	Intact	Intact
T1 (Medial Arm)	Intact	Intact	Intact
T2 (Medial Arm)	Intact	Intact	Intact

Shoulder Examination:

Shoulder Range of Motion	Right	Left	Normal
Flexion	**125°**	**160°**	180°
Abduction	**125°**	**160°**	180°
Extension	**35°**	**45°**	50°
Ext Rotation	**65°**	**80°**	90°
Ext Internal Rotation	**65°**	**80°**	90°
Adduction	**35°**	**45°**	50°

No tenderness was noted over the anterior deltoid, supraspinatus insertion or acromioclavicular joint. **Tenderness was noted over the biceps tendon bilaterally.**

Impingement and Hawkins signs were positive bilaterally. Job's sign was negative.

Apprehension test and re-location test were negative. No sulcus were present. Yergason test was negative. No deformity or incision was noted around the shoulder area. **An incision was noted over the right shoulder.**

Wrist & Hands Examination:

Wrist Range of Motion	Right	Left	Normal
Flexion	**55°**	**50°**	60°
Extension	**55°**	**50°**	60°
Ulnar Deviation	**25°**	**25°**	30°
Radial Deviation	**20°**	**15°**	20°

No mechanical block was noted to range of motion. **There was tenderness over the distal radius bilaterally** not the carpus. **Tenderness was noted at the right anatomic snuffbox and the left TFCC.** Finkelstein test was normal. Tinel testing was negative. **Phalen and reverse Phalen (praying position) testing were positive bilaterally.** Two-point discrimination was within normal limits.

No atrophy or tenderness was noted in the thenar, hypothenar and intrinsic hand musculatures. The pulses are present and equal bilaterally.

Finger Range of Motion is as Follows:

	MCP Joint		PIP Joint		DIP Joint	
	Right	Left	Right	Left	Right	Left
Thumb	60	60	80	80	N/A	N/A
	0	0	10	10	N/A	N/A
Index	90	90	100	100	70	70
	0	0	0	0	0	0
Middle	90	90	100	100	70	70
	0	0	0	0	0	0
Ring	90	90	100	100	70	70
	0	0	0	0	0	0
Little	90	90	100	100	70	70
	0	0	0	0	0	0

All normal values in the above table are 0° for extension and 90° for extension. No triggering was noted in any digit. Range of motion was painless without mechanical block. The thumbs bilaterally (adduction) reach the head of the 5th metacarpal. Thumb abduction is 90° bilaterally.

Lumbar Examination:
Patient has a normal gait and is ambulating with no assistive device. On visual inspection, there is no deformity, defect, or swelling about the dorsolumbar spine. No scar or incision was noted. There is no evidence of deformity such as scoliosis or kyphosis.

There is tenderness and spasm in the paravertebral muscle, but not the spinous processes and the flank. The sciatic notch area was not tender. **The patient toe and heel walks with pain. The patient squats with pain.**

Lumbar Range of Motion	ROM	Normal	Spasm	Pain
Forward Flex	**35°**	60° finger to ankle	**Present**	**Present**
Extension	**15°**	25°	**Present**	**Present**
Lateral Flex (rt.)	**15°**	25°	**Present**	**Present**
Lateral Flex (lt.)	**15°**	25°	**Present**	**Present**
Rotation (rt.)	**15°**	25°	**Present**	**Present**
Rotation (lt.)	**15°**	25°	**Present**	**Present**

Supine straight leg raising: Right 90, Left 90 with no back pain. Sitting straight leg rising was similar. Lasegue test was negative bilaterally.

Motor Function	Right	Left	Normal

Ankle Dorsiflex L4	5	5	5
Great Toe Ext L5	5	5	5
Ankle Planar Flex S1	5	5	5
Knee Ext L4, L5	5	5	5
Knee Flexion	5	5	5
Hip Abductors	5	5	5
Hip Adductors	5	5	5

Deep tendon reflexes are equal at the knee and ankle joints. Palpation over the sacroiliac joint did not elicit tenderness. The FABER (Patrick's) test was negative bilaterally.

Sensory Function	Right	Left	Normal
L3 Anterior Thigh	Intact	Intact	Intact
L4 Medial Leg, Inner Foot	Intact	Intact	Intact
L5 Lateral Leg, Mid Foot	**Decreased with pain**	**Decreased with pain**	Intact
S1 Post. Leg, Outer Foot	**Decreased with pain**	**Decreased with pain**	Intact

Knee Examination:

Knee Range of Motion	Right	Left	Normal
Flexion	135°	135°	135°
Extension	0°	0°	0°

On visual inspection, there is no erythema, ecchymosis, incision, deformity or defect about the knee. **Patellar crepitus is noted bilaterally. Tenderness is noted with firm compression bilaterally.** Patellar grind is negative. There is no swelling noted. Posterior to the knee there is no fullness and no masses were palpable. There is no medial or lateral joint line tenderness noted. There is no tenderness at the patellar tendon insertion at the distal pole of the patella. No tenderness is noted at the medial and lateral patellar facets. There is no valgus or varus instability at 0° or 30°. There is no anterior or posterior instability at 0° or 90°. **McMurray's is positive bilaterally.** Lachman's is negative.

REVIEW OF RADIOGRAPHIC EXAMINATION:
X-rays of the cervical spine were obtained. There was evidence of an anterior cervical fusion plate. The lateral view revealed that the plate at the C4-C5 level.

X-rays of the right shoulder revealed AC joint hypertrophy.

X-rays of the left shoulder revealed similar findings.

X-rays of the lumbar spine revealed severe disc collapse at the L5-S1 level. No deformity

was noted, however. There was no evidence of any instability.

X-rays of the knees bilaterally were obtained. Loss of medial joint height was seen bilaterally with varus configuration. The patellar height was within normal limits.

REVIEW OF MEDICAL RECORDS:
None available.

DIAGNOSES:
Cervical radiculopathy, status post arthrodesis.
Bilateral wrist tendinitis, rule out carpal tunnel syndrome.
Lumbar radiculopathy.
Bilateral knee internal derangement.
Bilateral shoulder impingement.

DISCUSSION:
The patient is a 66-year-old male who presents to my attention due to injuries that occurred while employed as a Food Preparer. Date of injury is noted to be in a continuous trauma basis. The patient has been employed as a Food Preparer for the past 10 years. The patient was required to be lifting, pushing, pulling, bending, twisting, and squatting. He developed pain and recently underwent surgery on October 2022 to his neck. The patient has had some memory issues as well as difficulty providing the history, however, it was noted that the actual operation was to his neck. The patient is indicating that over the years, he was required to lift, push, pull, bend, twist, and squat. He also developed non-orthopedic issues. He has had diabetes and hypertension and developed anxiety and stress, which is worsened since the time of the surgery. The patient is recalling multiple other specific injuries including October 2022, as well as July 2022.

The patient also underwent MRI studies of the left knee. He has been seen by multiple physicians. He is now presenting to my attention for this orthopedic evaluation. He is complaining of difficulty lifting, pushing, pulling, bending, and twisting.

Considering the 10 years of service as well as a type of work that the patient has performed over 10 years, there is reasonable indication of an industrial injury. I am requesting that my name be entered in your records to reflect upon the fact that I am taking over the role of the primary treating physician and that all of the patient's medical records will be forwarded to my attention. I will recommend the patient will use medications to control his symptoms. ***I am requesting authorization for neurodiagnostic studies of the upper and lower extremities***. ***I am requesting 12 sessions of physical therapy and six sessions of acupuncture***. I have requested from the patient to bring with him the MRI reports on the next visit to avoid redundancy in treatment and testing.

I am requesting authorization for six sessions of psychotherapy as well as psychological evaluation in light of the fact that he is complaining of anxiety and stress.

I will see the patient back in four to six weeks. We will make further recommendations at that time.

I hope the above information has been helpful to you and thank you for referring this patient to my office for orthopedic examination.

We are requesting that all the patient medical records, related or unrelated to this case be sent to our attention for review which will be incorporated in accessing the treatment and medical legal issues.

We request to be added to the Address List for Services of all Notices of Conferences, Mandatory Settlement Conferences and Hearings before the Worker's Compensation Appeals Board. We are advising the Worker's Compensation appeals Board that we may not appear at the hearings or Mandatory Settlement Conferences for the case in chief. Therefore, in accordance with Procedures set forth in Policy and Procedural Manual index No. 60610, effective February 1, 1995, we request that defendants, with full authority to resolve our lien, telephone our office and ask to speak with our "workers' compensation lien negotiator".

Authorizations for transportation, medication, physiotherapy, rehabilitation, a conditioning program and the above stated recommendations are requested based upon medically reasonable treatment requirements. This is per labor code 4600 and Title 8, Section 9792.6, C.C.R. and Rule 9785(b). Furthermore, we are requesting that all the medical records be forwarded to our office to avoid repetition in testing and treatment. Please provide us with information regarding the status of the case as soon as possible.

To complete this examination I have been assisted, as needed, for taking histories, taking x-rays, assisting with the patient, transcription of reports by some or all of the following personnel Alma Azucar, Maria Valles, Marlen Sanchez, Laura Casillas and Emily Shemwell. Sherry Leoni, DC, or Shahrzad Forat, DC, may also have assisted in compiling and editing of this report. If required an interpreter was provided. All of the above individuals are qualified to perform the described activities by reason of individual training or under my direct supervision. I certify that this examiner reviewed the history and the past medical records directly with the patient. The examination of the patient, and interpretation of tests and x-rays, was all performed by this examiner. The dictation and the review of the final report were performed entirely by me. The opinions and conclusions contained in this report are entirely my own. I declare, under penalty of perjury, that the information contained in this report, and any attachments, is true and correct, and that there has not been a violation in this report of Section 139.3 L.C. to the best of my knowledge and belief, except as to information that I have indicated was received from others. As to that information I declare under penalty of perjury, that I have accurately detailed the information provided me and, unless otherwise noted, I believe it to be true.

In order to prepare this report and complete the evaluation, time was spent without face to face with the patient. The billings reflect such time spent by the physician with the code 99358. Edwin Haronian, M.D. Inc. does not accept the Official Medical fee schedule as prime facie evidence to support the reasonableness

of charges. Edwin Haronian, M.D. is a fellow of the American Academy of Orthopedic Surgeons and is board certified, specializing in disorder and surgery of the spine. Under penalty of perjury under the laws of the State of California, services are billed in accordance with our usual and customary fees. Additionally, this medical practice providing treatment to injured worker's experiences extraordinary expenses in the form of mandated paperwork and collection expenses, including the necessity to retain highly-trained personnel to appear before the Workers' compensation appeals board. Based on the level of services provided and overhead expenses for services contained within our geographical area, we bill in accordance with the provisions set-forth in Labor Code Section 5307.1. Please be advised that Dr. Haronian has a financial interest in Osteon Surgery Center, Kinetix Surgery Center and Pomona Orthopedics.

January 2, 2023
Date

Edwin Haronian, M.D.
Certified Diplomate American
Board of Orthopedic Surgery
California License #A71385

County where executed: Los Angeles County

*Disneyland Resort
P O Box 3909
Anaheim, CA 92803
Attn: Arthur Monroy

*Law Office of Natalia Foley
751 S.Weir Canyon Rd,Ste 157-455
Beverly Hills, CA 90211

PROOF OF SERVICE
STATE OF CALIFORNIA

I am employed in the County of Los Angeles. I am over the age of 18 and not a party to the within action; my business address is:
5651 SEPULVEDA BLVD., SUITE 201, SHERMAN OAKS, CA 91411
On 1/3/2023 served the foregoing document described as:

EDWIN HARONIAN, M.D.

EVALUATION REPORT

Patient Name: **Bhargav Shah**
File Number: 20079633
Claim #: DLRW2022096551
DOS: 12/19/2022

On all interested parties in this action by electronic transmission a true copy of this narrative report from **5651 SEPULVEDA BLVD., SUITE 201, SHERMAN OAKS, CA 91411**

Addressed as follows:

Arthur Monroy
Disneyland Resort
P O Box 3909
Anaheim, CA 92803

Law Office of Natalia Foley
751 S.Weir Canyon Rd,Ste 157-455
Beverly Hills, CA 90211

I declare that I am over the age of 18 years and not a party to this action. I also declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on 1/3/2023 at

Emily Shemwell