SHAH, Bhargav 629555 NB QME 101387

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

Case Name Bhargav Shah v DISNEYLAND RESORT

Claim No. DLRW2022095173 **EAMS or WCAB Case No. (if any):** ADJ16483391

I, Ayerim Rodriguez declare:

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

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

3. On the date shown below, I served this Comprehensive Medical-Legal Report with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope addressed to the person or firm named below, and by:

A depositing the sealed envelope with the U.S. Postal Service with the postage fully prepaid.

B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U.S. Postal Service in a sealed envelope with postage fully prepaid.

C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

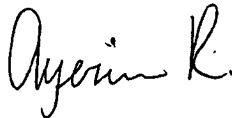
D placing the sealed envelope for pick up by a professional messenger services for service. (Messenger must return to you a completed declaration of personal service.)

E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of Service *(For each addressee, Enter A - E as appropriate)*	*Date*	*Addressee and Address*
A	05-23-2023	Arthur Daniel Monroy, Disney Workers Comp SENT ELECTRONICALLY P.O. BOX 3909 Anaheim, CA 92803
A	05-23-2023	Natalia Foley WORKERS DEFENDERS LAW GROUP 751 South Weir Canyon Road STE 157-455, Anaheim, California 92808

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

Signature of Declarant



Print Name
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Nelhs Betancourt, M.D.

Internal Medicine - Occupational Medicine - Occupational Toxicology
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May 9, 2023

Disney Worker's Compensation
PO Box 3909
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Attn: Arthur Daniel Monroy, Claims Evaluator

Work Defenders Law Group
751 S. Weir Canyon Rd., Suite 157-455
Anaheim, CA 92808
Attn: Natalia Foley, Esq.

Claimant Name:	**BHARGAV SHAH**
Social Security No.:	XXXX-XX-undisclosed
Date of Birth:	5/1/1956
Date of Panel QME:	May 1, 2023
Panel Number:	7560887
EAMS Number:	ADJ16483391;ADJ 16860757;ADJ 15867699
Date of Injury:	7/20/2022;CT 10/21/2020-10/21/2022; 7/3/2018
Claim #:	DLRW 2022095173; DLRW 2022096551; DLRW 2018083560
Employer:	Disneyland resort

COMPREHENSIVE PANEL QUALIFIED MEDICAL EVALUATION

State of California Workers' Compensation Program

Dear Concerned Parties:

The Claimant was evaluated on the date shown above, in my office as shown in the Disclaimer section. I personally performed this evaluation based upon specific request from the parties. I was asked to physically examine and evaluate the Claimant, and to prepare a report to answer specific medical legal issues as stated in the cover letter. Please find a copy of the letter requesting this medical legal report attached to this report.

Pursuant to Labor Code Sections 4620, 4621 and 4622, the evaluation and report of the Examinee is based on the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. The medical-legal billing codes used are effective 04/01/2021. Please find attached to this report a copy of the Official Medical Legal Billing Codes.

Based on 8 California Code of Regulations Sections 9793, 9794, and 9795, this report is billed under ML 201:

X -93 Interpreter needed at time of examination - [Nadia Ahmed Khan, Certification Number] not provided.

X -95 Evaluation performed by a panel selected Qualified Medical Evaluator

-97 Evaluation performed by a physician who is board certified in Toxicology, a physician who is certified as a Qualified Medical Evaluator in the specialty of Internal Medicine or a physician who is board certified in Internal Medicine, when a Toxicology evaluation is the primary focus of the medical-legal evaluation

MLPRR – I declare under penalty of perjury that I received and personally reviewed 982 pages of records.

HISTORY AS RELATED BY THE CLAIMANT:

Ms. Shah is a 67-year-old Hindu male Examinee originally hired as a Food Proper on June 6, 2012. The Examinee's last the at work took place on July 20, 2022. There are two dates of injury: July 3, 2018 and July 20, 2022.

History taking was laborious; there was an interpreter present who at times appeared to conduct a private conversation with the Examinee that lasted for some time, before I received a response to my questions.

The examinee did not refer having diabetes, glipizide 5 mg daily as one of his medications. He is also taking lansoprazole, atorvastatin and naproxen.

The examinee is complaining of neck and shoulder pain associated with a headache which is occipital to frontal and happens daily.

The examinee has a specific injury that took place on July 3, 2018. That claim includes the neck, back, shoulders and repetitive work with both upper extremities.

There is another specific claim that took place on July 20, 2022 with injuries to the back, knees and lower extremities. At the time the examinee was preparing trace of sandwiches; he had prepared 10 trays and was placing the trays, using his right hand into her refrigerator. His left knee suddenly "cracked", causing the examinee to lose his balance and fall. He stated that he did not slip, his left knee gave away and was injured during the process.

The examinee has a cumulative trauma type claim (10/21/20-10/21/22) for repetitive work with the upper extremity. This claim include his back, both shoulders, lower extremities, knee patella, digestive system and nervous system. At the time his employer was selling fried pickles and he had to cut the vegetables and other materials with a knife; this was not a mechanized activity. He was working in a cold room and prepared thousands of pickles slices to be coded and fried. The cumulative trauma also includes his gastrointestinal and nervous system.

The examinee worked in a cold environment. He advised this evaluator that the refrigerator was kept at 36° Fahrenheit and his prep area was at 42° Fahrenheit. He was only allowed to wear his chef's clothing with an under shirt and he was frequently cold. He was not allowed to wear a coat or any warmer clothing. To aggravate his discomfort with a temperature, the ceiling over the prepped area was low, and his workspace was positioned directly under a draft of cold air that came down on him. The vents were placed 5-6 feet apart and their cold air came down directly on him and all around him. In addition to his clothing, he wore cutting gloves (not metal, but cotton) as well as surgical gloves for food hand. His shoes were non-sleep, as required, and he wore an apron. He had a head cover and a mask was optional.

The examinee suffered from neck pain and had cervical spine surgery on October 6, 2022. Dr. Aflatoon did the procedure. After the surgery he did not do well, suffering from anxiety, knee swelling, fever and had a 10 pound weight loss.

The examinee is also complaining of problems with the fingers in both hands, his right hand is worse as compared to the left. The right fingers 2, 3 and 4 feel "numb" and he suffers from proximal interphalangeal joint pain and tingling. The symptoms are not present all the time, they are intermittent. He has not noticed any changes in color in his finger when they are in mirrors in cold water. He also has problems with his left hand. The fingers are only slightly painful, but he has pain in the form region. He denied any tingling in his fingers or hand. The examinee advised me that he had electrodiagnostic testing approximately 2 weeks prior to this encounter but he did not know the results.

The examinee is complaining of headache which goes down the neck and shoulders and at times radiates to his retro-orbital area and temples like a band. He denied a history of migraine headaches. His pain is worse in the morning; he wakes up at 6 AM with neck pain and headache. The headache improves with medication. He usually takes medications before going to bed at night. The headaches are aggravated by cold weather exposure. The examinee denied a history of photophobia but is uncomfortable with loud sounds. He denied any visual disturbances, unilateral head pain, or head trauma. The headaches are not associated to nausea and vomiting, but occasionally he feels slightly dizzy with prolonged walking exceeding 45 minutes to an hour. If he does get dizzy, he has to stop and look for support and rest.

He is also complaining of pain on swallowing, which is more bothersome in the morning. He feels his throat get more irritated when exposed to cold weather.

He complains of shortness of breath associated to anxiety. He does not have difficulty reading on activity and denied a history of productive or dry cough. He acknowledge snoring, noting that he is spouse is concerned because he stops breathing while sleeping. There is no history of hemoptysis, sinusitis, bronchitis or pneumonia. He does suffer from a chronic postnasal drip and nasal congestion and rhinitis when exposed to cold environments. There is no history of bronchial asthma, cancer, deep venous thrombosis, pulmonary embolism or connective tissue disorders.

The examinee denied smoking and stated that he is a vegetarian; he does not eat eggs or any poultry. He takes vitamins regularly.

The examinee complained of abdominal pain, which is usually secondary to gas. He suffers from constipation, but denied a history of diarrhea, jaundice, hepatitis or peptic ulcer disease. He denied a

history of epigastric pain, heartburn, chronic nausea and/or vomiting, vomiting of blood, black tarry stools, rectal bleeding or hemorrhoids. When he is constipated, he may go 2 days without a bowel movement. This does not happen all the time.

The examinee stated that he has had a stable weight which goes between 155 and 157. However, during the last 8 months his weight went up to 170 pounds, and now is around 160-163 pounds.

The examinee used to exercise before he got injured. Now he only does stretching secondary to chronic pain.

The examinee denied a history of chest pain, loss of consciousness, congenital heart disease, mitral valve prolapse, rheumatic heart disease, peripheral edema, congestive heart failure, palpitations, arrhythmias, shortness of breath on exertion or a history of myocardial infarction in the past. He has been diagnosed with a lipid disorder. He does complain of back and hip pain, which he described as mild.

Activities of Daily Living Survey, AMA Guides, 5th ed.

The Claimant denied any problems with self-care, communicating, sensory functions.

The Claimant referred the following problems: physical activities (walking), hand activities (fingering, sensation, perception of temperature), traveling (due to knee pain), sexual function (loss of sensual sensation due to pain). sleeping (not restful).

When asked: "What part or parts of your job could you perform now?", the Claimant responded:

“Currently not working at all.”

CURRENT COMPLAINTS:

Constant shoulder, neck, lower back pain along with headaches until medications are taken. Nothing is shown to make the problem worse. It is improved by a little exercise, meditation and movement.

Intermittent bilateral knees and right hand fingers. Claimant did not specify what makes it worse or better.

PAST HISTORY; PERTINENT FINDINGS:

The claimant does not drink alcohol. He has never smoked. He denied ever using recreational drugs.

Her exercise the claimant listed stretching twice a day, seven days a week. He consumes a diabetic diet but no coffee, 1 cup of caffeinated tea in the morning, and no sodas.

Family history is pertinent for a father who died at age 87 above-stated causes. His mother is currently alive, age 94, and in apparent good health. The claimant listed four brothers and two sisters ranging in ages from 51 to 70. One brother died at an unstated age of unknown causes. His maternal grandmother is currently 89, his maternal grandfather is currently 90, his paternal grandmother is 85, and his maternal

grandfather is 92. All his family members are in good health. The claimant is currently married, and listed one son age 35 in apparent good health.

As hobbies, the claimant did not list any. He denied having any other part-time or full-time jobs. He did not state if he does housework or yardwork.

Allergies: none.

Surgeries: surgery related to work injury on 10/6/2022.

REVIEW OF AVAILABLE MEDICAL RECORDS:

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

Note: A supplemental report will be required to include those records not having an attestation available at the date of production (per date on signed declaration below) of this report.

Various — Personal Records. Examinee's personnel information (Wage Statement Summary, Request for taxpayer) were documented.

07/03/18 — Worker's Compensation Claim Form (DWC 1). Date of Injury: 07/03/18. History of Injury: Examinee developed mid back, low back and shoulder pain.

07/03/18 — Nurse Visit. Disneyland Health Services. Examinee was doing food-prep, cutting fruits and vegetables, and moving heavy boxes and other items related to foods. Examinee had developed a gradual onset of upper and mid back pain along with bilateral shoulders over last 8 months that radiates to both sides of chest. He attributed that to repetitive motion of cutting fruits and vegetables along with the constant bending over and lifting over heavy boxes. Examinee reported that over the last 8 month. Pain level rated as 7-9/10 and described as constant. Past Medical History: Diabetes mellitus. High cholesterol. Thoracic back pain (upper, mid back and bilateral shoulder). Right arm examination revealed some tingling to fingertips; limited range of motion. Constant tingling to right arm to palpations. (Poor Quality Image.)

07/06/18 — Dr. Roger S. Hinkson, Occupational Medicine. Disneyland Health Services. Physician Visit. Examinee was here for back pain related to repetitive motion. Examinee complained of right hand has constant pain and intermittent numbness and tingling only in dorsal hand but not fingers. Has tightness in bilateral lower extremities if he stands too long. Examinee also has headache, pain radiated to bilateral shoulder. It hurts to stand or sit too long, lift or bend. It started 8 months ago. Examinee then worried too much of his gradual onset pain. Examinee saw his Primary Medical Doctor 6-7 weeks

ago for diabetes but discussed about his back. Examinee had x-ray and then saw specialist. Examinee had MRI for back on 07/17/18. Examinee's specialist guessed no diagnosis but said Primary Medical Doctor saw degeneration in x-ray. Examinee used Meloxicam 7.5 mg and it helped for 5 hours. Also given restrictions. Examinee came to HS because he did not look good one day and manager told him to come to HS. (Poor Quality Image.).

07/13/18 Dr. Roger S. Hinkson. Disneyland Health Services. Physician Visit. Examinee's back was 20% better. Examinee was able to lift hands much better at present. Examinee continued to have right side pain when he moved. Examinee used Ibuprofen but it caused gastric upset. Current Meds: Ibuprofen 600 mg. Back examination revealed mild right cervical and thoracic tenderness. Cervical range of motion was limited with pain. Forward flexion of low back was 8 from floor with pain. Positive for Hawkins test. Plan: Discontinue Ibuprofen. Start Naproxen 500 mg, one tablet twice a day. (Poor Quality Image.)

07/27/18 Rochelle A. Andres, A.R.N.P. Disneyland Health Services. Physician Visit. Examinee's pain to neck and upper back was much better after completing 3 or 4 physical therapy session. Examinee was able to move his neck and both shoulders fully with muscle tightness localized to top of both shoulders. Examinee's mid back pain was unchanged and at present felt it on left side. Examinee already had MRI. Current Meds: Naproxen 500 mg. Back examination revealed only minimal tenderness to palpation along upper and mid trapezius muscles and mid thoracic tenderness left than right. Plan: Discontinue Ibuprofen. Start Naproxen 500 mg. (Poor Quality Image.)

08/16/18 Dr. Sydney Stevens, Diagnostic Radiology. Open System Imaging. MRI of Cervical Spine revealed regional loss of the upper cervical lordotic curvature. From a development standpoint, overall canal size lower range of normal due to relatively short pedicles. There is moderate to increased fatty marrow signal endplate margins in association with disc disease C4-C5, C5-C6. There is also slight change at C6-C7. There is overall mild decrease in the marrow of T1 hyperintensity on the sagittal view suggesting a mild degree of benign increase in red marrow reconversion. Consider a Complete Blood Count to make sure Examinee is not anaemic. Specific Levels: Age-related disc desiccation signal at all levels with again mild to moderate degenerative disc disease C4-C5 and C5-C6. C3-C4: There is a 2 mm left lateral disc osteophyte complex with uncinate spurring with mild lateral recess stenosis. There is also a central disc bulge of 1.5 mm. C4-C5: Bilateral uncovertebral joint hypertrophy, significantly greater on right side at 2.5 mm. There is moderate right foraminal narrowing. There is mild left foraminal stenosis. C5-C6: Broad based disc osteophyte complex extends posteriorly by 1-2 mm, greater on the left with uncinate spurring. There is mild left foraminal stenosis and slight effacement thecal sac in the midline. Mild central stenosis is present with the AP dimension of the canal at 9 mm. C6-C7: A 2 mm central and right lateral disc bulge is present extending to the foramen with mild to moderate right lateral recess stenosis. The AP diameter of the canal is lower range of normal 10 mm. C7-T1, T1-T2: A 1 mm posterior central disc bulge without stenosis.

Impression: Developing degenerative disc disease C4-C5, C5-C6 and slight change at C6-C7 with regional areas of Modic 2 fatty marrow endplate signal. Vertebral body heights are maintained. C3-C4: Mild left lateral recess stenosis with a disc osteophyte complex. C4-C5: Bilateral uncovertebral joint hypertrophy, greater on the right with moderate foraminal stenosis. C5-C6: Broad based disc osteophyte complex with uncinate spurring on the left. There is mild left foraminal stenosis and marginal acquired central narrowing of the canal. C6-C7: Mild to moderate right lateral recess stenosis with a 2 mm central and right lateral disc bulge. There is mild overall decrease signal on the T1 images which may be within normal range versus mild increase in red marrow reconversion. Recommend a Complete Blood Count to make sure Examinee is not anaemic.

08/19/18 Dr. Roger S. Hinkson. Disneyland Health Services. Physician Visit. Examinee's condition was unchanged. Examinee complained of upper back pain and bilateral upper extremity pain. Assessment: Cervicalgia. Thoracic back pain. Rx: Naproxen 500 mg. (Poor Document)

08/20/18 Dr. Caithness A. Rodriguez, Family Medicine. Disneyland Health Services. Physician Visit. Examinee was here for follow up of back pain. Examinee had been to 6/6 physical therapy sessions but continued to have some discomfort, but it was improving. Reviewed MRI report with CM. Basically he has fairly advanced osteoarthritis/degenerative disc disease but no definite nerve compression. Symptoms at that point were stable. (MRI also suggested MRI to rule out anemia, Examinee had that done with his Primary Care Physician and it was normal). Current Meds: Naproxen 500 mg. Triazolam 0.25 mg. Assessment: Degenerative disc disease. Plan: Tylenol as needed. Regular exercise as discussed. Work Status: Trial of full duty. Modified duty from 09/05/18 to 10/26/18. Restrictions: No bending over or twisting at the waist more than 10 minutes per hour. No forceful stirring. No lifting/pushing/pulling more than 10 lbs. Follow up on 09/20/18 with Dr. Roger S. Hinkson.

09/05/18 Dr. Roger S. Hinkson/Rochelle A. Andres, A.R.N.P. Disneyland Health Services. Physician Visit. Examinee was here for upper and mid back pain follow up. Examinee was back to work and complained of pain flare-up when he does 2 specific job tasks making pickles (which required prolonged leaning forward at the waist) and stirring honey. Requested Pain Medication, and his Primary Care Physician recommended Celebrex. Past Medical History: Cervicalgia. Degenerative disc disease. Thoracic back pain. Upper back exam revealed mild tenderness along the periscapular muscles. Diagnoses: Degenerative disc disease. Rx: Celebrex 200 mg. Plan: Continue home stretches and exercise. 09/20/18 appointment rescheduled to 09/26/18. Work Status: Modified duty from 09/05/18 through 09/28/18. Restrictions: No bending over or twisting at the waist more than 10 minutes per hour. No forceful stirring.

09/28/18 Dr. Roger S. Hinkson. Disneyland Health Services. Physician Visit. Examinee's mid back was no better. Examinee said it hurts to mix. Current Meds: Celebrex 200 mg. Exam remains the same as previous visit. Diagnoses: Degenerative disc disease. Plan:

Continue Celebrex 200 mg. Restart physical therapy 2 x/weeks for 2 weeks. Work Status: Modified duty from 09/28/18 to 10/12/18. Restrictions: No bending over or twisting at the waist more than 10 minutes per hour. No forceful stirring. Follow up on 10/12/18.

10/12/18 Dr. Roger S. Hinkson. Disneyland Health Services. Physician Visit. Examinee's back continued to hurt a lot. Pain in mid back radiates to right lower extremity. Physical therapy helped but only temporarily. Examinee's work was painful. He used Thermacare packs daily. Examinee's work was hard, but he does not want tight restrictions and definitely does not want sit down work. Upper back exam revealed mild tenderness along the periscapular muscles, right more than left. Diagnoses: Degenerative disc disease. Plan: Refilled Celebrex 200 mg. Requested Transfer of Care to Orthopedics. Restart physical therapy 2 x/weeks for 2 weeks. Continue home exercises and stretches. Work Status: Modified duty from 10/12/18 to 10/26/18. Restrictions: No bending over or twisting at the waist more than 10 minutes per hour. No forceful stirring. No lifting/pushing/pulling more than 10 lbs. Follow up in 3 weeks.

11/29/18 Dr. Stanley G. Katz, Orthopedic Surgery. Healthpointe Medical Group, Inc. Initial Visit. Date of Injury: 07/03/18. History of Injury: Examinee was mixing a large pot and doing that repetitively with same employer for 8 years which caused pain to neck and mid back. Examinee stated that pushing and pulling motions prevented him from lifting bilateral arms completely up. Present Complaints: Examinee's neck pain was rated as 6-7/10 and described as burning pain level that would appear 3 hours into work shift. The pain affected his ability to pray and yoga. Also complained of constant 6/10 pain to mid back which increased as work shift continued. Review of systems was significant for joint pain. Vitals: BP: 124/84. Pulse: 70. Cervical spine examination revealed reduced and painful range of motion; tenderness; diminished sensation in right volar digits. Lumbar spine exam revealed reduced and range of motion, especially flexion. Straight leg raise test positive on left. Diagnoses: Other cervical disc displacement. Other intervertebral disc displacement. Rx: Celebrex 200 mg and Prilosec 20 mg one daily. Plan: Sign record release today and requested MRI results of lumbar spine from Kaiser. Work Status: Modified duty on 11/29/18. Restrictions: No lifting, pushing, and pulling over 10 lbs. Follow up on 01/10/19.

01/10/19 Dr. Stanley G. Katz/Jose Serrato, P.A. Healthpointe Medical Group, Inc. Primary Treating Physician's Progress Report (PR-2). Examinee's thoracic and lumbar spine was slightly better than last visit. Examinee complained of constant 5-6/10 mid back pain. Took Celebrex and Prilosec with some benefits. Rest of the complaints remains the same as previous visit. Review of systems remains the same as previous visit. Vitals: BP: 106/66. Pulse: 73. Neck examination revealed pain on cervical range of motion primarily on rotation extending to both upper traps. Lumbar spine examination revealed low back pain on lumbar flexion to 60 degrees. Positive left straight leg raises at 50 degrees. Slight low back pain on right straight leg raise test. Left sided pain noted on heel-toe walk. Diagnoses: Other cervical disc displacement. Other intervertebral disc displacement. Plan: Continue Celebrex 200 mg and Prilosec 20 mg. Requested authorization for MRI

of lumbar spine. Work Status: Modified duty on 01/10/19. Restrictions: No lifting, pushing, pulling over 10 lbs. Follow up on 02/14/19.

01/14/19 Comp Alliance. Request for Information Notice. Requested additional information for non-contrast MRI of lumbar spine.

01/17/19 Dee Rhoads, R.N. Comp Alliance. Approval Letter. Requested MRI of lumbar spine without contrast was approved.

01/29/19 Dr. Jay Kaiser, Diagnostic Radiology. National Orthopedic Imaging Associates. MRI of Lumbar Spine without contrast revealed developmentally small central canal. T12-L1: There is mild disc desiccation. There is minimal annular bulging with a small underlying bright annular fissure. There is mild anterior osseous ridging and type 2 endplate change. L2-L3: There is minimal disc desiccation without herniation or stenosis. L3-L4: There is disc desiccation. Mild broad-based annular bulging is seen. There is mild bilateral facet arthropathy and mild thickening of the ligamentum flavum. Thera is mild central canal stenosis. L4-L5: There is minimal disc desiccation. Mild broad-based annular bulging is seen. Thera is facet arthropathy and thickening of the ligamentum flavum with mild central canal stenosis. There is marginal osseous ridging with minimal bilateral foraminal stenosis. L5-S1: There is disc desiccation and marked loss of disc height. There is extensive type 2 endplate change. There is marginal osseous ridging with mild bilateral foraminal stenosis.
Impression: There is a developmentally small central canal. At T12-L1, there is minimal annular bulging with a small underlying bright annular fissure. At L3-L4, mild broad-based annular bulging. Mild bilateral facet arthropathy with mild central canal stenosis. No evidence of lateral stenosis. At L4-L5, facet arthropathy and thickening of the ligamentum flavum with mild central canal stenosis. Minimal bilateral foraminal stenosis. At L5-S1, disc degeneration and extensive type 2 endplate change. Mild bilateral foraminal stenosis.

02/14/19 Dr. Stanley G. Katz. Healthpointe Medical Group, Inc. Primary Treating Physician's Progress Report (PR-2). Examinee reported no improvement since last visit. Felt worse on 02/04/19 due to cold temperature. They were still working causing more damage to cervical spines down to lumbar spine. Pain was worse on lateral right lumbar spine Examinee complained of 9/10 cervical spine pain, described as pulsing; 7/10 thoracic spine pain described as burning; 6-7/10 lumbar spine pain described as feeling weight on lumbar spine as if he was carrying a heavy backpack or rock. Bilateral arms with limited range of motion. Examinee mentioned that his bilateral shoulder joints felt tight. Examinee reported using heated blanket at night for back and taking Celebrex with benefit. Cervical spine examination revealed reduced and painful rotation; tenderness. Lumbar spine exam revealed painful flexion; tenderness. Straight leg raises caused low back pain. Diagnoses: Other cervical disc displacement. Other intervertebral disc displacement. Plan: Continue Celebrex 200 mg. Recommended lumbar support; trial of chiropractic therapy x 6 for cervical and lumbar spine. Work Status: Modified duty on

01/14/19. Restrictions: No lifting, pushing, and pulling over 10 lbs. Follow up on 04/04/19.

02/18/19 Dr. Stanley G. Katz. Healthpointe Medical Group, Inc. Request for Authorization DWC Form RFA. Authorization requested for refill of Celebrex 200 mg and chiropractic therapy for cervical and lumbar spine.

02/18/19 Comp Alliance. EPN Prior Authorization Confirmation. Requested chiropractic therapy for cervical and lumbar spine was approved.

04/04/19 Dr. Stanley G. Katz/Jose Serrato, P.A. Healthpointe Medical Group, Inc. Primary Treating Physician's Progress Report (PR-2). Examinee reported improvement in neck mobility since last visit; increased burning pain to mid back constantly, 8/10; difficulty trying to sleep due to mid to low back pain. Review of systems was significant for joint pain. Vitals: BP: 115/74. Pulse: 70. Lumbar spine examination revealed moderate paravertebral tenderness over thoracic region to lower back on lumbar flexion. Lower back pain on bilateral straight leg raise test. Cervical spine examination improved but he continued with paracervical tenderness extending to both upper trapezii. Diagnoses: Other cervical disc displacement. Other intervertebral disc displacement. Plan: Continue Celebrex 200 mg. Schedule certified Chiropractic trial x 6. Work Status: Modified duty on 04/04/19. Restrictions: No lifting, pushing, pulling over 10 lbs. Follow up on 05/02/19.

04/09/19 Soheila Ghaziaskar, Chiropractic Medicine. Healthpointe Medical Group, Inc. Initial Chiropractic Therapy Evaluation. Date of Injury: 07/03/18. Present Complaints: Examinee complained of burning neck pain at 5-6/10 and midback at 7-8/10; constant 6/10 pain level to mid back aggravated by repetitive movements of back and neck. Pain affected his ability to pray and yoga. Medication helped neck pain but not the mid back. Examinee has completed 16 sessions of therapy with benefit but when he was sent back to work, he started having more pain again. Review of systems was significant for joint pain. Cervical spine examination revealed tenderness to palpation over cervical paravertebral musculature and over C5-C7; PVM. Cervical Range of Motion: Left Lateral Flexion: 35. Right Lateral Flexion: 32. Extension: 32. Flexion: 30. Rotation Right: 63. Left: 62. Thoracolumbar flexion: 70. Extension: 30. Left Lateral Flexion: 28. Right Lateral Flexion: 29. Thoracolumbar spine examination revealed tenderness over T3-T12 and L4-L5. Positive for Patrick Fabere's on left. Type 2 end plate changes in lumbar spine per MRI report dated 01/29/19. Assessment: Examinee tolerated the treatment well. Follow up on 04/11/19.

05/02/19 Dr. Stanley G. Katz/Jose Serrato, P.A. Healthpointe Medical Group, Inc. Primary Treating Physician's Progress Report (PR-2). Examinee complained of 8/10 pain to lower back: no change to lower back pain since last visit. Neck pain was intermittent and improving, 5/10. Examinee has been attending chiropractic therapy with not much benefit longer than 3 days. Review of systems remains the same as previous visit. Vitals: BP: 104/67. Pulse: 74. Lumbar spine examination revealed improvement with chiro x 5.

Paravertebral muscle tenderness on lumbar flexion to 60 degrees. Low back pain on bilateral Straight Leg Raise has decreased but he continued with pain. Thoracic spine examination revealed slight T8-T12 Paravertebral muscle tenderness on forward reaching. Complained of increased pain on prolonged sitting. Cervical spine examination revealed much improvement with chiro. Minimal discomfort to both upper trapezii on cervical range of motion. Diagnoses: Other cervical disc displacement. Other intervertebral disc displacement. Plan: Requested authorization for additional chiropractic 2 x/weeks for 3 weeks. Work Status: Modified duty on 05/02/19. Restrictions: No lifting, pushing, pulling over 10 lbs. Follow up on 06/27/19.

05/03/19 Dr. Stanley G. Katz. Healthpointe Medical Group, Inc. Request for Authorization DWC Form RFA. Authorization requested for chiropractic therapy for cervical, thoracic and lumbar spine.

05/07/19 CarolLynn Machado, R.N. Comp Alliance. Approval Letter. Requested authorization for additional chiropractic therapy 2 x/weeks for 3 weeks for cervical spine was approved.

06/27/19 Dr. Stanley G. Katz. Healthpointe Medical Group, Inc. Primary Treating Physician's Progress Report (PR-2). Examinee's pain level rated as 5-6/10 and described as constant burning and sharp. Cervical spine pain radiates to the thoracic spine. Examinee finished chiropractic therapy with no benefits. Cervical spine examination revealed reduced range of motion; right-sided radicular pain with rotation and right lateral bending; could also reproduce right upper radicular pain with forward bending. Lumbar spine examination revealed reduced and painful range of motion, but no radicular pain. Diagnostic Data: MRI of lumbar spine showed small disc bulges. MRI of cervical spine showed right central and foraminal stenosis. Diagnoses: Other cervical disc displacement. Other intervertebral disc displacement. Plan: Recommended spine surgery consult for possible ACDF and chiropractic therapy 2 x/weeks for 6 weeks. Refilled Celebrex. Work Status: Modified duty on 06/27/19. Restrictions: No lifting, pushing, pulling over 10 lbs. Follow up on 08/22/19.

06/28/19 Dr. Stanley G. Katz. Healthpointe Medical Group, Inc. Request for Authorization DWC Form RFA. Authorization requested for chiropractic therapy for cervical spine; referral to spine surgeon for possible anterior cervical discectomy and fusion.

07/10/19 Comp Alliance. Approval Letter. Requested authorization for additional chiropractic therapy 2 x/weeks for 3 weeks for cervical spine was approved.

07/11/19 Comp Alliance. Approval Letter. Requested authorization for specialist referral to a spinal surgeon was approved.

08/22/19 Jose Serrato, P.A. Healthpointe Medical Group, Inc. Primary Treating Physician's Progress Report (PR-2). Examinee has been attending chiropractic therapy for the cervical spine with no benefits but not attending for the thoracic spine. Examinee

complained of constant spasms and burning sensations to the thoracic spine, especially in the morning. Took Celebrex for the pain with little benefits, requested refill. Review of systems remains the same as previous visit. Vitals: BP: 116/75. Pulse: 76. Cervical Spine examination revealed painful and restricted range of motion. Lumbar spine examination revealed restricted lumbar range of motion with pain on bilateral Straight Leg Raise. Diagnoses: Cervical disc herniations with radiculopathy. Lumbar spine disc herniation with discogenic back pain. Plan: Examinee has spine consult on 08/28/19 for possible anterior cervical discectomy and fusion. Recommended chiropractic therapy 3 x/weeks for 4 weeks for cervical, thoracic and lumbar spine. Work Status: Modified duty on 08/22/19. Restrictions: No lifting, pushing, pulling over 10 lbs. Follow up on 10/03/19.

08/23/19 Healthpointe Medical Group, Inc. Chiropractic Therapy Session. Examinee participated in chiropractic therapy session on 04/11/19, 04/16/19, 04/18/19, 04/25/19, 05/03/19, 05/14/19, 05/16/19, 05/23/19, 05/24/19, 05/28/19, 05/30/19, 07/19/19, 07/25/19, 07/26/19, 07/30/19, 08/01/19, 08/08/19, 08/09/19, 08/15/19, 08/16/19 and 08/23/19.

08/23/19 Dr. Stanley G. Katz. Healthpointe Medical Group, Inc. Request for Authorization DWC Form RFA. Authorization was requested for chiropractic therapy for cervical and lumbar spine.

08/24/19 Dr. Kamran Aflatoon, Orthopedic Surgery. Work Status: Modified duty until 09/25/19. Restrictions: No lifting/carrying more than 10 lbs. Follow up on 09/25/19.

08/28/19 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Secondary Treating Physician's Initial Orthopedic Consultation and Report. Date of Injury: 07/03/18. History of Injury: Examinee was pulling out a turkey from the freezer. The turkey was very heavy. Examinee experienced discomfort in his body when pulling it. The following day, he felt pain in his neck. Examinee reported the injury to his employer and was referred to Cast Health Center where he was examined, and x-rays of the neck were taken. Examinee was provided with physical therapy and Celebrex. The therapy was helpful. Examinee continued working with restrictions. Examinee states that every time when his pain surfaces, he usually stays home two or three days to prevent it from getting worse. Examinee does not recall having received any additional treatment and continued to experience pain in his neck. Present Complaints: Examinee complained of 4/10 neck pain with radiation down the arm and associated with weakness, numbness and tingling in the arm. Examinee had been dropping objects. Examinee experienced difficulty with neck movement and pain with looking up or down for a long period of time. Examinee had limitation with repeated bending, carrying, pushing and pulling. Examinee also had some difficulty with sleeping at night due to the pain. Examinee had been frustrated with the neck pain. Pain was better with rest and increased with activities. Examinee was currently not attending physical therapy but performing exercises at home as recommended per physician. Job Description: Examinee had been employed by Disneyland Park for 7 1/2 years. Examinee's position was that of food prep person. Examinee typically worked 5 days per week, 8 hours per day, plus overtime. Examinee's

job responsibilities entailed prepping food, cutting vegetables, meats, and fruits, and chopping turkey for the soup. Past Medical History: High cholesterol. Usual Childhood diseases. Current Meds: Celebrex and high cholesterol medication. Review of system was significant for history of stomach issues, and high cholesterol. Vitals: Height: 5'3". Weight: 160 lbs. Neurological exam revealed Motor Exam of biceps 4/5 bilaterally. Light touch in C5 decreased. Diagnostic Data: MRI of cervical spine dated 08/16/18 revealed moderate stenosis at C4-C5. Diagnoses: Disc herniation C4-C5. Radiculopathy. Plan: Recommended cervical epidural steroid injection at C4-C5 (Bilateral). Continue with therapy and medications. Requested authorization for chiropractic therapy to cervical spine. Work Status: As per Primary Treating Physician (Recommended no lifting or carrying over 10 lbs).

08/29/19 CompAlliance. Denial Letter. Requested authorization for additional chiropractic therapy 3 x/weeks for 4 weeks for cervical, thoracic and lumbar spine was denied.

08/29/19 Dr. Stanley Katz. Application for Independent Medical Review DWC Form IMR. Requested authorization for additional chiropractic therapy, 3 x/weeks for 4 weeks for cervical, thoracic and lumbar spine.

08/29/19 Dr. Gracia Goade, General Surgery. CompAlliance. Physician Advisor Recommendation Document. Requested chiropractic therapy additional 3 x/weeks for 4 weeks for cervical, thoracic and lumbar spine was denied.

09/16/19 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic. Request for Authorization DWC Form RFA.
Authorization was requested for cervical epidural steroid injection at C4-C5.

09/18/19 CompAlliance. Approval Letter. Requested authorization for steroid cervical epidural steroid injection at C4-C5 was approved.

09/25/19 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Secondary Treating Physician's Initial Orthopedic Consultation and Report Request for Authorization. Examinee continued to experience neck pain with radiation down the arm. Had pain with looking up or down for a long period of time. Pain level rated as 4-5/10. Pain was better with rest and increased with activities. Epidural injection was authorized. Rest of the complaint remains the same as previous visit. Review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Cervical spine examination revealed increased pain towards the terminal range of motion; paraspinal musculature tenderness to palpation. Spurling's Test was positive. Neurological exam remains the same as previous visit. Diagnoses: Disc herniation C4-C5. Radiculopathy. Treatment plan remains the same as previous visit. Work Status: Modified duty. Restrictions: No lifting or carrying over 10 lbs. Temporarily totally disabled only 10/01/19 (Due to cervical epidural steroid injection procedure).

10/01/19 Dr. Kamran Aflatoon. Doctors Surgery Center. Operative Report. Pre/Post-operative Diagnoses: Stenosis at C4-C5. Disc herniation. Radiculopathy. Operation Performed: Transforaminal myelography at C4-C5. Transforaminal epidural steroid injection at C4-C5. Nerve block of C5. Interpretation of myelographic images. Needle localization under fluoroscopic guidance.

10/16/19 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow-up Evaluation and Report Request for Authorization. Examinee had an epidural injection in the neck a couple of weeks ago. Examinee has had a great deal of improvement in the symptoms. Examinee complained of mild neck pain with radiation to the shoulders and also continued to have some numbness and tingling in the arm and also in leg. Examinee had been having lower back pain. Examinee' back pain was worse with activities and better with rest. Pain level rated as 4-5/10. Examinee had been working. Limited with prolonged walking. Review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Lumbar spine exam revealed increased pain toward terminal range of motion. There was paraspinal spasm. Sciatic notch was tender. Straight Leg Raise was positive. Neurological exam remains the same as previous visit. Diagnoses: Disc herniation C4-C5. Spinal stenosis L4-L5 and L5-S1. Radiculopathy. Plan: Recommended lumbar epidural steroid injection at L4-S1 (bilateral) and perform home exercises and stretching. Prescribed Voltaren Gel. Work Status: Regular duty.

10/18/19 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic. Request for Authorization DWC Form RFA. Authorization requested for lumbar epidural steroid injection at L4-S1 (bilateral) under fluoroscopy guidance.

10/24/19 CarolLynn Machado, R.N. Comp Alliance. Approval Letter. Requested lumbar epidural steroid injection at L4-S1 (bilateral) under fluoroscopy guidance was approved.

10/30/19 Dr. Kamran Aflatoon. Doctors Surgery Center. Operative Report. Pre/Post-operative Diagnoses: Stenosis at L4-L5 and L5-S1. Radiculopathy. Operation Performed: Transforaminal myelography at L4-L5 and L5-S1. Transforaminal epidural steroid injection at L4-L5 and L5-S1. Nerve block of L4. Nerve block of L5. Interpretation of myelographic images. Needle localization under fluoroscopic guidance.

11/07/19 Dr. Stanley G. Katz. Healthpointe. Maximum Medical Improvement Report. Date of Injury: 07/03/18. History of Injury: Examinee was injured at work while doing his usual duties as food prep for Disneyland. Examinee reported that due to repetitive movement of mixing large pot, he developed pain. Present Complaints: Examinee complained of upper, mid, and low back pain; bilateral shoulder pain; upper arm and right fingers pain; numbness and tingling in arms and hands; tingling in legs and feet. The pain was minimal and rated as 1-2/10 in both neck and back with radiations to the upper and lower extremities. Pain was worse at the end of long day's work. Job Description: Examinee was employed as a food prep for Disneyland. The job reportedly involves lifting, cutting, mixing, and standing. Examinee normally worked 8 hours per day and 40 hours per

week. Examinee was currently employed with the same employer but is no modified duty. Past Medical History: Arthritis and diabetes. Review of system was significant for arthritis, joint pain due to injury. Vitals: Height: 5'3". BP: 122/70. Pulse: 69. Cervical spine exam revealed decreased range of motion. Thoracic-Lumbar Spine exam revealed decreased range of motion. Diagnoses: Other cervical disc displacement, unspecified cervical region. Other intervertebral disc displacement, lumbar region. Disability Status: Examinee had reached Maximum Medical Improvement. Impairment Rating: 10% Whole Person Impairment as he is DRE Category II for both his neck and back, meriting 5% Whole Person Impairment for each. Causation: Examinee's current symptoms and objective findings were a direct result of the industrial injury of 07/03/18. Apportionment: Examinee had some degenerative changes in his neck and back which were non-significantly symptomatic prior to his work injury, 20% of his disability was there due to the natural history of his pre-existing condition, and remainder to his work injury of 07/03/18 Future Medical Care: Continue with over-the-counter medication and may benefit from repeat injections if his current improvement last longer after meet the criteria for injection repetition. Examinee would therefore need access to an orthopedic surgeon or interventional pain management physician on a as needed basis.

11/13/19 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow-up Evaluation and Report Request for Authorization. Examinee had an epidural injection in the lumbar spine two weeks ago which provided a great deal of improvement in the symptoms. Examinee does not have the back and leg pain that he used to have in the past. Examinee had been very happy with the pain reduction. Examinee rated the pain to be 1-2/10. Neck pain also doing very well. Examinee does not have any radiating symptom down the arm but has minimal radiation to the shoulders. Examinee continued to have some numbness and tingling in the arm. Review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Cervical spine examination revealed paraspinal musculature tenderness to palpation; decreased range of motion with increasing pain toward terminal ranges of motion. Spurling test positive. Lumbar spine exam revealed paraspinal spasm; sciatic notch tenderness; positive Straight Leg Raise; decreased range of motion with increasing pain toward terminal ranges of motion. Neurological exam remains the same as previous visit. Diagnoses: Disc herniation C4-C5. Spinal stenosis L4-L5 and L5-S1. Radiculopathy. Plan: Prescribed Voltaren Gel. Work Status: Regular work.

12/11/19 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow-up Evaluation and Report Request for Authorization. Examinee complained of increasing neck pain with right arm heaviness; numbness and tingling in the right arm. Examinee had moderate stenosis at the right C4-C5. Also had therapy and acupuncture treatment. Examinee rated his pain as 4-5/10. Examinee also reported having some lower back pain, 5-6/10 with some numbness and tingling. Examinee had an injection in the lumbar spine two months ago and has had over 50% improvement in the symptoms. Examinee's pain was exacerbated with repeated bending lifting and carrying. Vitals: Height: 5'3". Weight: 160 lbs. Exam remains the same as previous visit. Diagnoses: Disc herniation C4-5. Spinal stenosis L4-

5 and L5-S1. Radiculopathy. Plan: Prescribed Voltaren Gel. Recommended lumbar epidural steroid injection, L4-S1. Work Status: Regular duty until 01/08/20.

12/16/19 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic. Request for Authorization DWC Form RFA. Authorization requested for second lumbar epidural steroid injection at L4-S1 (bilateral) under fluoroscopy guidance.

12/18/19 Nancy Gee, R.N. Comp Alliance. Approval Letter. Requested second lumbar epidural steroid injection at L4-S1 (bilateral) under fluoroscopy guidance was approved.

01/08/20 Dr. Kamran Aflatoon. Doctors Surgery Center. Operative Report. Pre/Post-operative Diagnoses: Stenosis at L4-L5 and L5-S1. Disc herniation. Radiculopathy. Operation Performed: Transforaminal myelography at L4-L5 and L5-S1. Transforaminal epidural steroid injection at L4-L5 and L5-S1. Nerve block of bilateral L4. Nerve block of bilateral L5. Interpretation of myelographic images. Needle localization under fluoroscopic guidance.

01/22/20 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Progress Report (PR-2). Examinee complained of cervical spine 5/10 pain that radiates to right shoulder and lumbar spine pain at 3/10. Lumbar epidural steroid injection helped. Examination of lumbar spine revealed increased range of motion. Diagnoses: Lumbar region disc herniation other intervertebral disc displacement. Spinal stenosis lumbar region with neurogenic claudication. Radiculopathy lumbar region. Rx: Celebrex 200 mg. Plan: Recommended home exercise; surgery. Work Status: Regular duty until 01/29/20.

01/29/20 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow Up Evaluation and Report Request for Authorization. Examinee reported continued worsening of the neck and arm symptoms. He was frustrated with the constant pain and lack of sleep. Examinee had a cervical epidural injection with good short-term improvement. He has had therapy and medications and continued to remain symptomatic. Examinee continued to have numbness and tingling in the right arm with moderate stenosis at the right C4-5. Pain level rated as 6/10. Lower back pain has improved since the injection. Review of systems was significant for history of stomach issues and high cholesterol. Vitals: Height: 5'3". Weight: 160 lbs. Exam remains the same as previous visit. Diagnoses: Disc Herniation C4-5, radiculopathy. Spinal Stenosis L4-5 and L5-S1, radiculopathy. Plan: Requested anterior cervical decompression and fusion at C4-5. Work Status: Regular duty.

02/03/20 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for anterior cervical discectomy and fusion, plate fixation, iliac crest bone graft at C4-C5; pre-operative examination; ECG; urine dipstick; x-ray of chest; labs including PT, PTT, complete blood count and comprehensive metabolic panel.

02/12/20 Dr. Gracia Goade. CompAlliance. Physician Advisor Recommendation Document/Utilization Review Decision. Authorization requested for anterior cervical discectomy and fusion, plate fixation, iliac crest bone graft at C4-5, pre-operative examination, ECG, urine dipstick, x-ray of chest, PT, PTT, complete blood count and comprehensive metabolic panel were approved.

09/16/20 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow Up Evaluation and Report. Examinee continued to experience neck pain with radiation down the arm. He has been receiving medical treatment from India. He feels frustrated with the neck pain and lack of sleep. He had a cervical epidural injection with good short-term improvement. Rest of the complaints remains the same as previous visit. Review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Exam remains the same as previous visit. Diagnoses: Disc Herniation C4-5, radiculopathy. Spinal Stenosis L4-5 and L5-S1, radiculopathy. Plan: Requested Transfer of care for second opinion orthopedic evaluation and treatment. Work Status: Regular duty.

09/24/20 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for transfer of care second opinion, orthopedic evaluation and treatment.

10/08/20 Rebecca Segal, R.N. CompAlliance. Approval Letter. Authorization requested for transfer of care second opinion orthopedic evaluation and treatment was approved.

10/08/20 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for transfer of care, second opinion orthopedic evaluation and treatment.

11/25/20 Dr. Hamid R. Mir, Orthopedic Surgery. Hamid Mir, MD., Inc. Telehealth Progress Note. Date of Injury: 07/03/18. Examinee complained of neck, right arm and middle back pain rated as 5/10. Current Meds: Multi Vitamin, Vitamin B12 100 mcg, Atorvastatin 20 mg, Aspirin, Vitamin D 50 mcg and Magnesium 300 mg. Review of systems was significant for sleep disturbance and headaches in the morning. Vitals: Height: 5'3". Weight: 163 lbs. BMI: 28.87 kg/m2. Allergies: Examinee could not take pain killer more than 200 mg. Examination of the right shoulder revealed limited motion with loss on internal rotation and forward flexion. Diagnostic Data: MRI of the cervical spine showed degeneration in the spine but with no severe stenosis. Diagnoses: Shoulder pain, unspecified chronicity, unspecified laterality. Radiculopathy of cervical region. Lumbar radiculopathy. Plan: Recommended to see Shoulder Specialist.

12/14/20 Rebecca Segal, R.N. CompAlliance. Approval Letter. Authorization requested for Consultation with Shoulder Specialist, Dr. Ghalambor was approved.

12/28/20 Dr. Navid Ghalambor, Orthopedic Surgery. Restore Orthopedics and Spine Center. Initial Consult. Date of Injury: 07/03/18. History of Injury: Examinee was employed as

a food preparer for Disneyland Resort. On 07/03/18, he began experiencing right shoulder pain. He denied any traumatic events but attributed the onset of his shoulder pain to his work activities. To date, he has undergone treatment consisting of approximately 36 sessions of therapy and the usage of Celebrex. He has been under the care of Dr. Mir. Current Complaints: Examinee complained of nocturnal right shoulder pain that often awakens him. Lying on the right shoulder was painful. Overhead activity was painful. Daily activities such as washing and combing his hair were painful. Past Medical History: Prediabetes and cervical spinal issues. Examination of the right shoulder revealed right bicipital groove tenderness to palpation. He complained of right shoulder pain with all ranges of active motion. Provocative testing of the right shoulder was limited secondary to his complaints of pain and discomfort. Impingement, Hawkins and cross-adduction maneuvers caused right shoulder pain. Diagnostic Data: X-ray of the right shoulder revealed no evidence of acute fractures or dislocations. The acromioclavicular joint views revealed no evidence of acute fractures or dislocations. Diagnosis: Right shoulder impingement syndrome/subacromial bursitis. Plan: Ordered MRI scan of the right shoulder. Requested follow up visit after completion of the MRI scan. Recommended follow up with Primary Treating Physician in the interim.

12/29/20 CompAlliance. EPN Prior Authorization Confirmation. Authorization was requested for MRI of the right shoulder and follow up visit.

02/02/21 Dr. Joy Foster, Radiology. Open System Imaging. MRI of the Right Shoulder revealed Osseous acromion outlet: The undersurface of the acromion has a flat type 1 configuration. There is an AC joint effusion. There is a 2-3 mm spur formation along the undersurface of the clavicle at the acromioclavicular joint which mildly effaces the supraspinatus muscle at the level the musculotendinous junction. Rotator Cuff: There is moderate thickening with heterogeneity of the signal within the distal supraspinatus tendon compatible with tendinopathy rerated change. Mild tendinopathy related changes involving the infraspinatus tendon are demonstrated. Biceps Tendon Anchor: There is a small fluid collection within the tendon sheath compatible tenosynovitis. Capsular Structures and Glenoid Labrum: There is a tear of the superior glenoid labrum anterior to posterior. The findings are compatible to a slap tear. Osseous structures and soft tissues: Foci of subcortical cystic degenerative change are present superiorly within the bony glenoid. There is a small glenohumaral joint effusion. Mild changes of chondral degeneration are demonstrated involving the glenohumeral articulation. Fluid extends into the subcoracoid bursa compatible with bursitis. Mild heterogeneity of the fluid collection suggesting mild changes of synovial hyperplasia with a possible loose body is demonstrated.

Impression: Abnormal glenoid labrum. Findings compatible with a slap tear. Mild-moderate tendinopathy related changes involving the supraspinatus and infraspinatus tendons. Findings most pronounced involving the distal supraspinatus tendon. No evidence of rotator cuff tear. Biceps tenosynovitis. Mild changes of chondral degeneration involving the glenohumeral articulation. Sub coracoid bursitis. Superimposed heterogeneity of the fluid compatible with regions of synovial hyperplasia. Suspect superimposed loose body.

02/02/21 Rebecca Segal, R.N. CompAlliance. Approval Letter. Authorization requested for Valium 5 mg was approved.

02/09/21 Dr. Navid Ghalambor. Restore Orthopedics and Spine Center. Primary Treating Physician's Progress Report (PR-2). Examinee complained of right shoulder pain, overhead pain and pain at night. Right shoulder examination revealed positive Impingement, and Hawkin's test. Diagnoses: Right shoulder SLAP tear. Right shoulder impingement/subacromial bursitis. Plan: Recommended right subacromial steroid injection. Follow up on 02/19/21. (There is illegible information on this page for review).

02/10/21 CompAlliance. EPN Prior Authorization Confirmation. Authorization was requested for Topical Voltaren gel with 2 refills.

02/12/21 Rebecca Segal, R.N. CompAlliance. Approval Letter. Authorization requested for Right subacromial steroid injection and follow up visit in 2 weeks were approved.

02/19/21 Dr. Navid Ghalambor. Restore Orthopedics and Spine Center. Primary Treating Physician's Progress Report (PR-2). Examinee complained of right shoulder pain. History of steroid injection x2. Right shoulder examination revealed supraspinatus with -5/5 motor strength. Rest of the exam remains the same as previous visit. Diagnoses: Right shoulder SLAP tear. Right shoulder impingement/subacromial bursitis. Rx: Celebrex 200 mg. Plan: Examinee had consented to right subacromial space steroid injection. Work Status: Per Primary Treating Physician. Follow up on 03/18/21. (There is illegible information on this page for review).

02/23/21 Rebecca Segal, R.N. CompAlliance. Approval Letter. Authorization requested for Celebrex 200 mg was approved.

03/18/21 Dr. Navid Ghalambor. Restore Orthopedics and Spine Center. Primary Treating Physician's Progress Report (PR-2). Examinee has undergone treatment consisting of approximately 36 sessions of therapy, usage of Celebrex, and one steroid injection along the right shoulder, which alleviated his symptoms by approximately 25 percent. His right shoulder remains symptomatic. Rest of the complaints remains the same as initial visit. Examination of the right shoulder revealed provocative testing of the right shoulder was limited secondary to his complaints of pain and discomfort. Rest of the exam remains the same as initial visit. Examinee's diagnostic studies were reviewed. Diagnoses: Right shoulder impingement syndrome/subacromial bursitis superimposed on rotator cuff tendinosis. Probable right shoulder SLAP lesion. Right shoulder proximal biceps tenosynovitis. Probable right shoulder synovitis with possible loose body. Plan: Recommended right shoulder arthroscopic subacromial decompression/partial acromioplasty, evaluation of the superior labrum with debridement versus proximal biceps tenodesis as indicated, glenohumeral joint synovectomy and loose body removal as indicated. Instructed to follow up with his Primary Treating Physician. If he decides

to proceed with surgery, Dr. Ghalambor would be happy to re-evaluate him and request authorization for surgery.

06/21/21 Dr. Navid Ghalambor. Restore Orthopedics and Spine Center. Permanent and Stationary Report. Examinee continued to complain of right shoulder and contralateral left shoulder pain. At that time, he declined surgical intervention, but he would like to leave that option open as part of his future medical care. Therefore, his condition with respect to the right shoulder has reached a Permanent and Stationary status and Maximum Medical Improvement. Examination of the right shoulder revealed decreased range of motion. Positive Impingement sign and Hawkins sign. Diagnoses: Right shoulder impingement syndrome/subacromial bursitis superimposed on rotator cuff tendinosis. Probable right shoulder SLAP lesion. Right shoulder proximal biceps tenosynovitis. Probable right shoulder synovitis with possible loose body. Plan: Recommended right shoulder surgery. Work Status: With respect to the right shoulder, Examinee does not require work restrictions. Examinee would return to the open labor market without any restrictions. Disability Status: Right shoulder has reached a Permanent and Stationary status and Maximum Medical Improvement. Impairment Rating: 6 % upper extremity impairment converts to 4% Whole Person Impairment. Causation: Examinee's right shoulder condition has been accepted as being industrial in causation. Therefore, the issue of causation would not be formally discussed in this report. Apportionment: not indicated. Future Medical Care: In the event that Examinee experiences a flare-up of his right shoulder symptoms in the future, he should be afforded evaluation by an orthopaedic surgeon. In that setting, he would require treatment consisting of nonsteroidal anti-inflammatory medications, short courses of therapy and/or a local anesthetic/steroid injection along the right shoulder subacromial space. Provisions for an MRI scan of the right shoulder should be included as part of his future medical care. Provisions for surgical treatment in the form of a right shoulder arthroscopic subacromial decompression/partial acromioplasty, loose body removal and proximal biceps tenodesis should also be included as part of his future medical care.

09/15/21 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Secondary Treating Physician's Final Orthopedic Evaluation and Report. Date of Injury: 07/03/18. Examinee complained of neck pain at 3-4/10 with radiation down the arm and has numbness and tingling in the arm. He has difficulty with neck movement, some difficulty with sleeping at night due to the pain. He has pain with looking up or down for a long period of time. He has limitation with repeated bending, carrying, pushing, and pulling. Examinee has been frustrated with the neck pain. Pain was better with rest and increased with activities. Review of systems was significant for difficulty sleeping due to pain, history of stomach issues and high cholesterol. Vitals: Height: 5'3". Weight: 160 lbs. Examination of the cervical spine revealed decreased range of motion and increased pain toward terminal range of motion. Motor exam with decreased at biceps 4/5 bilaterally. Sensory examination revealed light touch at C5 was decreased. Diagnoses: Disc Herniation C4-5. Radiculopathy. Cervical stenosis. Plan: Recommended to perform home exercises and stretching. Released from care. Examinee would have future medical care. Work Status: Regular duty. Causation: Work related

injury. Impairment Rating: DRE III with 10% due to radiculopathy. Future Medical Care: Cervical decompression and fusion.

03/23/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Re-Evaluation and Report. Examinee continued to have persistent pain in the neck. E's neck and shoulder pain were worsening. Examinee reported limited neck motion with numbness and tingling in the arm. Pain level was rated as 5/10. Rest of the complaints remains the same as previous visit. Review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Examination of the cervical spine revealed paraspinal musculature tenderness to palpation. Examination of the right shoulder revealed decreased range of motion and increased pain toward terminal range of motion. Positive Hawkin's in right shoulder. Rest of the exam remains the same as previous visit. Diagnoses: Disc Herniation C4-5. Radiculopathy. Cervical stenosis. Rx: Celebrex 200 mg. Plan: Ordered MRI of the cervical spine without contrast. Work Status: Modified duty until 04/20/22. Restrictions: No lifting or carrying over 25 lbs.

03/24/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for Celebrex 200 mg and MRI of the cervical spine without contrast.

03/30/22 Nancy Gee, R.N. CompAlliance. Approval Letter. Authorization requested for Celebrex 200 mg and MRI of the cervical spine without contrast were approved.

04/18/22 Dr. Damon Sacco, Diagnostic Radiology. National Orthopedic Imaging Associates. MRI of the Cervical Spine without contrast revealed at C2-C3, there is disc desiccation. At C3-C4, there is slight narrowing of the disc space with disc desiccation slight annular bulging. There is mild uncinate remodeling. There is mild facet arthropathy. There is mild foraminal stenosis with the central canal noted to be at the lower limits of normal in size. At C4-C5, there is evidence of disc degeneration with disc space narrowing, disc desiccation, and diffuse annular bulging. Mild disc osteophyte complex is present this extends greater to the right. Mild facet arthropathy is present. Findings contribute to moderate right and mild left foraminal stenosis. The central canal is mildly stenotic. At C5-C6, there is evidence of disc degeneration with disc space narrowing, disc desiccation, and diffuse annular bulging. There is mild uncinate remodeling. There is mild facet arthropathy. Findings contribute to mild central canal and bilateral foraminal stenosis. At C6-C7, there is evidence of disc degeneration with disc space narrowing, disc desiccation, and diffuse annular bulging. Uncinate remodeling is present, slightly worse to the right with findings compatible with mild broad-based posterior disc osteophyte complex. There is mild facet arthropathy. There is mild central canal stenosis with mild-to-moderate right and mild left foraminal narrowing. At C7-T1, there is moderate left and mild to moderate right-sided facet arthropathy. Mild (1.5 mm) anterolisthesis at this level is noted. There is disc desiccation with annular bulging and a small 2.5 mm central herniation. Findings resultant effacement of the thecal sac with slight caudal migration of disc material noted. There is mild central canal stenosis.

Impression: Annular bulging with uncinate remodeling at the C3-C4 level. There is mild foraminal stenosis. Mild disc osteophyte complex extending greater the right at the C4-C5 level. There is mild facet arthropathy. There is moderate right and mild left foraminal stenosis. Mild central canal stenosis at these levels present. Annular bulging with uncinate remodeling at the C5-C6 level. There is mild facet arthropathy. There is mild central canal and bilateral foraminal stenosis. Annular bulging at the C6-C7 level with mild broad-based posterior disc osteophyte complex. There is mild facet arthropathy. There is mild-to-moderate right and mild left foraminal stenosis. The central canal this level is mildly stenotic. Facet arthropathy worse to the left at the C7-T1 level with mild anterolisthesis and annular bulging. A small localized central herniation is present with slight caudal migration of disc material. There is mild central canal stenosis at this level. Mild straightening of the normal cervical lordosis.

04/20/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow Up Evaluation Report. Examinee continued to complain of neck and arm pain rated 5-6/10. Rest of the complaints remains the same as previous visit except for arm weakness. Review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Exam remains the same as previous visit. Diagnoses: Disc Herniation C4-C5. Radiculopathy. Cervical stenosis. Rx: Mobic 15 mg #30. Plan: Requested cervical epidural steroid injection at C5-C6. Prescribed Voltaren gel. Work Status: Modified duty until 05/18/22. Restrictions: No lifting or carrying over 15 lbs. Follow up on 05/18/22.

04/26/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for cervical epidural steroid injection at C5-C6 under fluoroscopy guidance.

04/27/22 Carollynn Machado, R.N. GSG Associates, Inc. Notice of Incomplete Request for Authorization. Authorization requested for Topical Diclofenac/Voltaren 1 % x 50 days was returned because it was incomplete.

04/28/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for Mobic 15 mg 30# and Voltaren gel 1% 5.3 oz.

05/02/22 Rebecca Segal, R.N. Genex. Approval Letter. Authorization requested for Mobic 15 mg 30# and Topical Voltaren gel 1% 5.3 oz were approved.

05/03/22 Nancy Gee, R.N. Genex. Approval Letter. Authorization requested for cervical epidural steroid injection at C5-C6 under fluoroscopy guidance was approved.

05/25/22 Dr. Kamran Aflatoon. Ocean One Surgery Center. Operative Report. Pre/Post-operative Diagnoses: Disc herniation at C4-C5. Radiculopathy at C4-5. Procedure Performed: Transforaminal myelography at bilateral C4-C5. Transforaminal epidural steroid

injection at bilateral C4-C5. Nerve block of C5. Interpretation of myelography images. Needle localization under fluoroscopic guidance.

06/01/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow Up Evaluation and Report. Examinee's complaints and review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Exam remains the same as previous visit. Diagnoses: Disc Herniation C4-5. Radiculopathy. Cervical stenosis. Plan: Refilled Celebrex 200 mg #30. Recommended anterior cervical discectomy and fusion at C4-C5. Work Status: Regular duty. Follow up on 06/29/22.

06/03/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for anterior cervical discectomy and fusion, plate fixation, iliac crest bone graft at C4-C5; pre-operative examination; ECG; urine dipstick; x-ray of chest; PT, PTT, complete blood count and comprehensive metabolic panel.

06/08/22 Dr. Gracia Goade. Genex. Approval Letter. Authorization requested for anterior cervical discectomy and fusion, plate fixation, iliac crest bone graft at C4-C5; pre-operative examination; ECG; urine dipstick, x-ray of chest, PT, PTT, complete blood count and comprehensive metabolic panel were approved.

06/28/22 Dr. Navid Ghalambor. Restore Orthopedics and Spine Center. Initial Consult. Date of Injury: 07/03/18. History of Injury: Examinee reported a three to four-year history of left shoulder pain but he does not recall the exact date of the onset of left shoulder pain. He attributed the pain to his work activities including repetitive lifting of turkey and beef. Approximately four to five months after the onset of left shoulder pain, Examinee noted the onset of pain in the contralateral right shoulder. He was currently performing modified work duties with restrictions pertaining to both shoulders. To date, Examinee has undergone treatment consisting of therapy for both shoulders. Current Complaints: Examinee complained of nocturnal left shoulder pain, which often awakened him. Lying on the left shoulder was painful. Daily activities such as washing and combing his hair were painful. Overhead activity was painful. Examination of the left shoulder revealed left bicipital groove was tender to palpation. Decreased range of motion. Provocative testing of the left shoulder was limited secondary to his complaints of pain and discomfort, as he complains of left shoulder pain with the Impingement, Hawkins and cross adduction maneuvers. Diagnostic Data: X-ray of the left shoulder dated 06/28/22 revealed no evidence of acute fractures or dislocations. The acromioclavicular joint views reveal no evidence of acute fractures or dislocations. Diagnosis: Left shoulder impingement syndrome/subacromial bursitis. Plan: Ordered MRI of the left shoulder. Work Status: Modified duty. Disability Status: At this point, it was probable that his left shoulder condition has reached a Permanent and Stationary status and Maximum Medical Improvement. Causation: Left shoulder symptoms were industrial. Work Restrictions: With respect to the left shoulder, Examinee was precluded from lifting,

pushing or pulling greater than 15 pounds with the left upper extremity. These restrictions would most likely be permanent.

06/29/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow Up Evaluation and Report Request for Authorization.Examinee's complaints and review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Exam remains the same as previous visit. Diagnoses: Disc Herniation C4-C5. Radiculopathy. Cervical stenosis. Plan: Examinee was authorized to have an anterior cervical discectomy and fusion at C4-C5. Work Status: Regular duty. Follow up on 09/21/22.

07/01/22 Rebecca Segal, R.N. Genex. Approval Letter. Authorization requested for MRI of left shoulder was approved.

07/11/22 Dr. Robert Clark, Diagnostic Radiology. Open System Imaging. MRI of the Left Shoulder revealed the supraspinatus tendon demonstrates tendinosis and thickening without tear. There is impingement by the inferior acromial spur on the superior aspect of the musculotendinous junction. The subscapularis tendon demonstrates tendinosis and thickening without tear. The rotator interval fat is preserved. The anterior and posterior cartilaginous labral tissue is aligned appropriately. The acromioclavicular joint demonstrates moderate degenerative change. Longitudinal tear of the biceps tendon in the bicipital groove. Moderate amount fluid from tenosynovitis. Edema subacromial subdeltoid bursa.
Impression: Moderate degenerative change in acromioclavicular joint. Type 3 acromion with inferior spur impinging on the musculotendinous junction of the supraspinatus. Tendinosis and thickening subscapularis tendon. Longitudinal tear of the biceps tendon in the bicipital groove but moderate amount fluid from tenosynovitis. Edema subacromial subdeltoid bursa. SLAP lesion.

08/02/22 Dr. Navid Ghalambor. Restore Orthopedics and Spine Center. Permanent and Stationary Report. Examinee has undergone treatment to date consisting of therapy. He underwent one steroid injection along the right shoulder, which alleviated his symptoms temporarily. At that time, he complained of persistent bilateral shoulder pain. He wishes to hold off on steroid injections and/or surgery, but he wishes to keep these options open as part of his future medical care. Examination of the bilateral shoulders revealed decreased range of motion and positive impingement sign and a Hawkins sign. Examinee's diagnostic studies were reviewed. Diagnoses: Right shoulder impingement syndrome/subacromial bursitis superimposed on rotator cuff tendinosis. Probable right shoulder SLAP lesion. Right shoulder proximal biceps tenosynovitis. Probable right shoulder synovitis with possible loose body. Left shoulder impingement syndrome/subacromial bursitis superimposed on rotator cuff tendinosis. Left shoulder SLAP lesion per MRI scan dated 07/11/22. Left shoulder moderate acromioclavicular joint degenerative changes per MRI scan dated 07/11/22. Left shoulder longitudinal tear of the proximal biceps tendon within the bicipital groove per MRI scan dated 07/11/22. Disability Status: With respect to the bilateral shoulders, Examinee has reached a

Permanent and Stationary status and Maximum Medical Improvement. Impairment Rating: 11% upper extremity impairment converts to 7% Whole Person Impairment. Causation: Industrial in causation. Work Restrictions: With respect to the right and left shoulders, Examinee was precluded from lifting, pushing or pulling greater than 15 lbs with either upper extremity. Future Medical Care: In the event, that Examinee experienced a flare-up of his right and/or left shoulder symptoms in the future, he should be afforded evaluation by an orthopaedic surgeon. In that setting, he would require treatment consisting of nonsteroidal anti-inflammatory medications, short courses of therapy and/or a local anesthetic/steroid injection along the right and/or left shoulder subacromial space. Provisions for an MRI scan of the right and/or left shoulder should be included as part of his future medical care. Provisions for surgical treatment in the form of a right shoulder arthroscopic subacromial decompression/partial acromioplasty, loose body removal and proximal biceps tenodesis should also be included as part of his future medical care. In addition, provisions for surgical treatment in the form of a left shoulder arthroscopic subacromial decompression/partial acromioplasty, proximal biceps tenodesis and distal clavicle excision should be included as part of his future medical care.

08/11/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for anterior compression decompression fracture C4-C5.

09/21/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow Up Evaluation and Report. Examinee continued to report persistent neck pain. Neck surgery has been authorized and Examinee would like to have it done. Rest of the complaints and review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Exam remains the same as previous visit. Diagnoses: Disc Herniation C4-5. Radiculopathy. Cervical stenosis. Rx: Norco 5/325 mg. Work Status: Regular work duty until 10/05/22. Temporary totally disabled from 10/06/22 through 10/12/22.

09/26/22 Dr. Alex Zand, Internal Medicine. Zand Medical Partners. Pre-Operative Risk Assessment. Examinee complained of chronic severe neck pain since 2018. He initially hurt himself with repetitive lifting of heavy objects at Disneyland. His pain has gradually worsened, and he has radiating pain down his right upper extremity with numbness and weakness, especially in his right hand. Examinee has failed outpatient conservative therapy. Pain level rated as 6/10. Here for pre-operative risk assessment for anterior cervical discectomy and fusion C4-C6 scheduled with Dr. Kamran Aflatoon at Orange Coast Memorial on 10/06/22. Exercise Tolerance: Examinee reported fair to good exercise tolerance but was limited due to his left knee pain. Examinee could walk 30 minutes and climb 6-8 flights of stairs without any cardiac symptoms or problems, but his major limitation was his left knee pain. ECG was stable for surgery. Labs and Chest x-ray were not available at that time. Past Medical History: Hypercholestrolemia. Social History: Former Smoker. Current Meds: Aspirin 81 mg and Celebrex 200 mg. Vitals: BP: 128/72. Height: 5'2". Weight: 163 lbs. Pulse: 76. RR: 16. BMI: 28.87 kg/m2.

Examination of the abdomen revealed overweight. Diagnoses: Cervicalgia. Overweight (BMI 2.5.0-29.9). Body Mass Index 28.0-28.9, adult. Plan: Post Operative deep vein thrombosis prophylaxis and Incentive Spirometry recommended. Advised to hold Aspirin 81 mg and Celebrex 200 mg. Continue other medications. Also avoid Omega Fish Oils, Vitamin E, and all other non-steroidal anti-inflammatory drugs 7 days prior to surgery but not limited to over-the-counter Ibuprofen, Motrin, Aleve, Advil, and Excedrin, etc.). Ordered ECG, x-ray of chest, HgbA1c%, comprehensive metabolic panel, complete blood count with differential, coagulation study, urine culture and urinalysis with microscopic. Follow up as needed.

09/26/22 Dr. Elizabeth Jane Cambray-Forker, Neuroradiology. Providence St. Joseph Hospital. X-ray of the Chest revealed no acute cardiopulmonary disease.

09/26/22 Providence St. Joseph Hospital. Laboratory Report. Comprehensive Metabolic Panel.
Total Bilirubin: 0.2. AST: 11. Globulin: 3.7.
Complete Blood Count with Differential. %Monocytes: 8.4. %Eosinophils: 7.4.
Coagulation Study. Prothrombin Time: 13.3. INR: 1.0. aPTT: 31.
Urine Culture. Source: Urine, clean catch. Result: No growth at 1 day.

Urinalysis with microscopic was performed and the values were found to be within normal range.

09/26/22 Illegible Signature. ECG revealed sinus rhythm. Left axis deviation consistent with LAFB. ECG without significant abnormalities.

09/27/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for Soft Collar, Miami J and Norco 5/325 mg for post-operative pain.

09/27/22 Linh Yang, R.N. Genex. Approval Letter. Authorization requested for Soft collar, Miami J cervical collar and Norco 5/325 mg were approved.

09/28/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Order. Requested Soft cervical collar and Miami J cervical collar. Surgery scheduled on 10/06/22.

10/06/22 Illegible Signature. Ocean One Surgery Center. Anesthesia Record. Operations Performed: Anterior cervical discectomy fusion iliac crest bone graft with plate fixation, C4-C5. ASA class I.

10/06/22 Dr. Kamran Aflatoon. Ocean One Surgery Center. Operative Report. Pre/Post-operative Diagnosis: Disc herniation, cervical spine at C4-C5. Operations Performed: Anterior cervical partial corpectomy and decompression at C4. Anterior cervical partial corpectomy C5. Bilateral neural foraminotomy, C4-C5. Microdecompression at C4-5 and arthrodesis at C4-5. Insertion of biomechanical cage at C4-C5. Instrumentation at

C4-C5 iliac crest bone graft. Exploration of fusion C4-C5. Interpretation of fluoroscopic images. Needle localization under fluoroscopic guidance.

10/10/22 Genex Services. Review Withdrawn by Client. Authorization requested for Norco 5/325 mg was cancelled.

10/12/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Post-Operative Orthopedic Evaluation and Report. Examinee was status post anterior cervical decompression and fusion at C4-C5. He was doing well. Cervical spine examination revealed clean and dry incision. Vitals: Height: 5'3". Weight: 160 lbs. Diagnoses: Disc Herniation C4-5. Cervical stenosis. Radiculopathy. Status post anterior cervical discectomy and fusion C4-5. Plan: Suture removal in one week. Work Status: Temporarily totally disabled until 10/21/22. Follow up on 10/21/22.

10/21/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Post Operative Orthopedic Evaluation and Report. Examinee came in for suture removal. Cervical spine examination revealed healed incision. Vitals: Height: 5'3". Weight: 160 lbs. Diagnoses: Disc Herniation C4-5. Cervical stenosis. Radiculopathy. Status post anterior cervical discectomy and fusion C4-C5. Treatment: Sutures removed. Work Status: Temporarily totally disabled until 11/16/22. Follow up on 11/16/22.

11/10/22 Genex Services. Utilization Review Report. Authorization requested for Cyclobenzaprine HCL 10 mg #30 was not complete as the required DWC form RFA and supporting medical documents were not submitted for that treatment plan.

11/14/22 Dr. Gary Taff, Emergency Medicine. Genex Services. Utilization Review Report. Authorization requested for Flexeril 10 mg #30 was non-certified.

11/16/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Post-Operative Orthopedic Evaluation and Report Request for Authorization. Examinee was about five weeks since the anterior cervical decompression and fusion at C4-C5. Examinee reported some post operative neck pain. Vitals: Height: 5'3". Weight: 160 lbs. Exam remains the same as previous visit. Diagnoses: Disc Herniation C4-C5. Cervical stenosis. Radiculopathy. Status post anterior cervical discectomy and fusion C4-C5. Plan: He has been wearing the brace despite Dr. Aflatoon recommendation to remove the brace on the last visit. Start therapy, 2 x/week x 4 weeks. Recommended some exercises. Work Status: Temporarily totally disabled until 12/14/22. Follow up on 12/14/22.

11/17/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for post operative physical therapy, 2 x/week x 4 weeks.

11/18/22 Carollynn Machado-Guarino RN. Genex Services. Utilization Review Report. Authorization requested for post operative physical therapy 2 x/week x 4 weeks between 11/17/22 and 03/18/23 was certified.

11/21/22 Genex Services. Utilization Review Report. Authorization requested for Meloxicam 15 mg #30 was not complete as the required DWC form RFA and supporting medical documents were not submitted for that treatment plan.

12/14/22 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Post Operative Orthopedic Evaluation and Report. Examinee was two months since the anterior cervical decompression and fusion at C4-C5. He was feeling better then. Vitals: Height: 5'3". Weight: 160 lbs. Cervical spine examination revealed increasing range of motion. Diagnoses: Disc Herniation C4-C5. Cervical stenosis. Radiculopathy. Status post anterior cervical discectomy and fusion C4-C5. Plan: Recommended to perform home exercises. Work Status: Temporarily totally disabled through 01/11/22. Follow up on 01/11/22.

01/11/23 Genex Services. In Progress Notification. Authorization was requested for Flexeril 10 mg #30.

01/11/23 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Post Operative Orthopedic Evaluation and Report Request for Authorization. Examinee was then three months post anterior cervical decompression and fusion at C4-C5. Examinee continued to improve. He felt that therapy causes some neck pain. Examinee reported having mild headaches and mild paraspinal spasms. Review of systems was significant for diabetic. Rest of them remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Examination of cervical spine revealed decreased range of motion and mild paraspinal spasm. Diagnoses: Disc herniation C4-C5. Cervical stenosis. Radiculopathy. Status post anterior cervical discectomy and fusion C4-C5. Rx: Flexeril 10 mg. Plan: Recommended Acupuncture 2 x/week x 4 weeks. Work Status: Temporarily totally disabled for 4 weeks. Follow up on 02/22/23.

01/12/23 Genex Services. Incomplete RFA Notification. Authorization requested for Flexeril 10 mg #30 was not complete as the required DWC form RFA and supporting medical documents were not submitted for that treatment plan.

01/13/23 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for Acupuncture, 2 x/week x 4 weeks.

01/13/23 Carollynn Machado-Guarino, R.N. Genex Services. Utilization Review Report. Authorization requested for Flexeril 10 mg #30 and Acupuncture 2 x/week x 4 weeks between 01/11/23 and 05/13/23 were certified.

01/23/23 Illegible Signature. Rapha Acupuncture, Inc. Initial Acupuncture Evaluation. Examinee complained of neck pain radiating to shoulders, headache (back) and more pain at nighttime. Vitals: BP: 136/91. Height: 5'3". Weight: 162 lbs. Plan: Recommended Acupuncture 2 x/week x 4 weeks. (There is illegible information on this page for review).

02/22/23 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow Up Evaluation and Report Request for Authorization. Examinee has been gradually improving in his symptoms. He has been attending acupuncture sessions with some reduction in his symptoms. Examinee reported having moderate difficulty with therapy and it was causing more pain. Examinee had to stop the sessions. Review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Cervical spine examination revealed decreased range of motion and mild paraspinal spasm. Diagnoses: Disc Herniation C4-C5. Cervical stenosis. Radiculopathy. Status post anterior cervical discectomy and fusion C4-C5. Plan: Recommended additional acupuncture, 2 x/week x 4 weeks. Work Status: Temporarily totally disabled through 04/15/23. Follow up on 04/15/23.

02/23/23 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for Acupuncture, 2 x/week x 4 weeks.

02/23/23 Genex Services. In Progress Notification. Authorization was requested for Acupuncture 2 x/week x 4 weeks.

02/24/23 Genex. Utilization Review. Authorization requested for Acupuncture 2 x/week x 4 weeks between 02/23/23 and 06/23/23 was certified.

04/05/23 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Primary Treating Physician's Orthopedic Follow Up Evaluation and Report. Examinee was six months status post anterior cervical decompression and fusion at C4-C5. He has been gradually improving in his symptoms. Felt that acupuncture has helped. Examinee has less spasms in the cervical spine and would like to have some therapy then. Review of systems remains the same as previous visit. Vitals: Height: 5'3". Weight: 160 lbs. Exam remains the same as previous visit. Diagnoses: Disc Herniation C4-C5. Cervical stenosis. Radiculopathy. Status post anterior cervical discectomy and fusion C4-C5. Plan: Requested physical therapy, 2 x/week x 4 weeks. Work Status: Temporarily totally disabled through 05/03/23. Follow up on 05/03/23.

04/10/23 Dr. Kamran Aflatoon. Southern California Spine and Orthopedic Oncology Institute. Request for Authorization DWC Form RFA. Authorization was requested for physical therapy, 2 x/week x 4 weeks.

04/12/23 Linh Yang, R.N. Genex Services. Utilization Review Report. Authorization requested for Physical therapy 2 x/week x 4 weeks between 04/10/23 and 08/09/23 was certified.

REVIEW OF SYSTEMS:

General	Positive for fever, chronic fatigue, unexplained weight changes, or anxiety. The Claimant denies having recently had psychiatric problems, depression, difficulty or pain in swallowing.
Head and Neck	Positive for headaches, dizziness, neck pain, excessive thirst, difficulty or pain in swallowing. There is no history of dizziness, hearing difficulties, rhinitis, ear infections, dental problems, loss of vision, double or blurred vision, or throat infections.
Lungs	Positive for shortness of breath. The Claimant denied having chronic coughing, sputum production, hemoptysis, or frequent respiratory infections.
Cardiovascular	Positive for arrhythmias and pedal edema. There is no history of heart murmurs, chest pain, or recent Myocardial Infarction.
Gastrointestinal	Positive for abdominal pain. The Claimant denied having had dark or tarry stools, hematemesis, jaundice, diarrhea, constipation, heartburn, \or chronic vomiting.
Urinary	The Claimant denied frequent urinary infections, blood in the urine, difficulty or pain while urinating.
Neurological	Positive for difficulty walking. The Claimant denied seizures, loss of consciousness, or head injuries.
Muscles and Joints	Positive for joint swelling and joint pain. The Claimant denied having had recent bone fractures, or effusion.

PHYSICAL EXAMINATION:

The Claimant was examined on the Date of Evaluation shown on the first page of this report.

Vital Signs:

Weight, pounds	Height, inches	BP, mm Hg	HR bpm	RR/min	Temp., °F	Neck Circum., inches
173	63	134/85 sitting left 129/78 sitting right 137/84 supine left 136/80 supine right	83 sitting left 75 sitting right 80 supine left 81 supine right	Not taken	98.1	15

Claimant is right handed. Body Mass Index is 30.6.

Date of Exam: May 5, 2023

Head & Neck:

The conjunctivae were found to be clear. The pupils reacted equally to light and accommodation (PERLA).
Hearing was found to be grossly normal. Postnasal drip noted. Mallampati 4.
Well hydrated mucosa. Supple neck. No thyroid enlargement. No carotid bruits.

Lungs:
Clear to auscultation.

Cardiovascular:
Auscultation of the cardiac sounds showed normal heart sounds, without evidence of clicks or gallops. A grade II/IV was noted along the apex and left sternal border.

The peripheral pulses were present and of normal intensity in the upper and lower extremities.

Abdomen:
The abdomen was found to be soft and depressible. Normal peristalsis, no bruits in the mid-abdominal area.

Extremities: Examination of the extremities was negative for edema distally.

Neurological: CNS normal, without obvious deficits.

Motor function: The Claimant was observed while walking from and about the examiner's room. The gait was found to be normal with balance maintained throughout.

Sensation: Sensation was found to be adequate.

Reflexes: Deep tendon reflexes were found to be of normal intensity and symmetrical bilaterally.

Skin: The skin was found to be warm and dry. No prominent skin lesions.

Genitalia/Rectal: Deferred.

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

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

CBC WITH DIFFERENTIAL
METABOLIC 20
COLLAGEN PROFILE

LIPID PANEL
HBA1C
TSH, T3, T4
URINALYSIS
URIC ACID
EKG
CXR PA/LAT
H. PYLORI BREATH
POLYSOMNOGRAM
ECHO

Epworth Sleepiness Score: 10/24

DIAGNOSTIC IMPRESSION:

1. Lipid disorder
2. Chronic pain.
3. Headaches

SUMMARY and DISCUSSION:

Pertinent findings from the medical records:

The chronology of the medical records dates back to July 3, 2018. The examinee was evaluated by the Disneyland Health Services Nurse. He had developed the gradual onset of upper and mid back pain as well as bilateral shoulders over the previous 8 months. The pain radiating to both sides of his chest. He explained that the pain was due to repetitive motion of his upper extremities while cutting fruits and vegetables along with the constant bending over and lifting of heavy boxes. The pain was constant and was rated as a 7-9/10 in a visual analog scale. The examinee has a past medical history significant for diabetes and high cholesterol.

The examinee continued to treat with the occupational medicine specialist, Dr. Hinkson at Disneyland. Mr. Shah complained of constant/intermittent/tingling pain of the right hand not involving his fingers. His lower extremities felt tight if he stood for too long. He also complained of headaches with pain radiating to both shoulders. The examinee had seen his PMD 7 weeks prior to this encounter, mainly for his diabetes, but also complained of back pain. He had x-rays and saw a specialist who ordered an MRI. The study was completed on July 17, 2018. He was apparently diagnosed with degenerative changes and prescribed meloxicam. The examinee went back to see Dr. Hinkson on 7/13/18. He was taking ibuprofen 600 mg. His cervical range of motion was compromised and for flexion of the low back was also limited. Ibuprofen was discontinued and naproxen 500 mg twice daily was prescribed. He was referred to physical therapy, and when he went back to see the Disneyland health providers on 7/27/18, he felt somewhat better.

An MRI of the cervical spine without contrast was completed on August 16, 2018. Multilevel degenerative disc changes were noted. He had mild left lateral recess stenosis with a disc osteophyte

complex at C3-C4, bilateral uncovertebral joint hypertrophy with moderate foraminal stenosis at C4-C5, a broad-based disc osteophyte complex with uncinate spurring on the left and mild left foraminal stenosis causing central narrowing of the spinal canal at C5-C6. At C6-C7 he had mild-moderate right lateral recess stenosis and a 2 mm central and right lateral disc bulge. T1 images showed bone marrow findings suggestive of anemia and a complete blood count was recommended.

The imaging results were discussed by Disneyland health services providers on August 20, 2018. He was still on Naprosyn 500 mg and was diagnosed with degenerative disease. He was returned to modified work with restrictions limiting bending and twisting at the waist as well as no lifting in excess of 10 pounds.

The examinee went back to work and came back to see Dr. Hinkson on September 5, 2018. He complained of flareups of pain when he was required to prepare pickles. He was prescribed Celebrex 200 mg and returned to modified work. When he went back to see Dr. Hinson on September 28, 2018 his condition was unchanged.

The examinee went back to see the Disneyland providers on 10/12/18. He was not doing well. He was complaining of pain in the mid back radiating to the right lower extremity. He was referred (care was transferred) to an orthopedic specialist. He was still on modified work.

The examinee saw Dr. Katz, an orthopedic surgeon on November 29, 2018. He was complaining of neck, shoulder and back pain. Blood pressure was 124/84 with a pulse of 70. He was diagnosed with "other cervical disc displacement, other intervertebral disc displacement". His next visit took place on January 10, 2019. At the time his blood pressure was 106/66. The examinee persisted with constant moderate midback pain and was on Celebrex and Prilosec. His symptoms had not improved. Dr. Katz ordered an MRI of the lumbar spine. The examinee went back to modified work.

The MRI of the lumbar spine without contrast was completed on 01/29/19. It showed a developmentally small central canal, and multilevel annular bulging, with mild bilateral facet arthropathy causing mild central canal stenosis. At the lower lumbar levels, he had facet arthropathy, thickening of the ligamentum flavum, minimal bilateral foraminal stenosis and mild central canal narrowing.

The examinee returned to see Dr. Katz on February 14, 2019. He was not doing better. He continued to complain of neck and thoracic spine pain. He also had back pain. His shoulder joints felt tight. He was referred to a chiropractor. He started receiving chiropractic care on April 9, 2019. When he went back to see Dr. Katz on May 2, 2018, he was not doing better. His examination as of June 2019 revealed cervical spine Rotation. Dr. Katz referred him to a spinal surgeon for consideration of a possible anterior cervical discectomy and fusion.

The examinee saw Dr.Aflatoon, a spinal orthopedic surgeon in August 2019. On the day of the injury, July 3, 2018, the examinee was pulling out a very heavy turkey from the freezer when he felt neck pain. The review of systems was significant for history of stomach issues and high cholesterol. The examinee's weight was 160 pounds and his height was 63 inches. He was diagnosed with a disc herniation C4-C5 with radiculopathy. Epidural cervical injections were recommended. The examinee received the initial epidural injection to C4-C5 on 10/1/19. The 2nd one was administered to the lumbosacral spine on

10/24/19 (L4-S1). On 10/30/19 the examinee had a transforaminal myelography at L4-L5 and L5-S1 as well as an epidural injection at these levels and a nerve block at L4 and L5.

On November 7, 2019 the examinee went back to see Dr. Katz. The examinee was complaining of upper, mid and low back pain, bilateral shoulder pain, upper arm and right finger pain with numbness and tingling in arms and hands, legs and feet. The pain was worse at the end of a long day's work. Blood pressure was 122/70 with a pulse of 69. Dr. Katz provided a rating.

The examinee went back to see Dr. Aflatoon on December 9, 2019. The lumbosacral epidural injection had improved the Examinee's symptomatology. The pain was now 1-2/10. His weight was 160 pounds. He was diagnosed with disc herniation C4-C5 and spinal stenosis at L4-5 and L5-S1. The examinee was returned to regular work. Another lumbar epidural injection was administered on 12/18/19. The examinee also received additional lumbosacral epidural injections on January 8, 2020.

On January 22, 2020 the examinee saw Dr.Aflatoon. He was complaining of moderate cervical spine pain radiating to the right shoulder and lumbar spine pain which was rated at 3/10. He was prescribed Celebrex 200 mg and he returned to regular work. An anterior cervical decompression and fusion at C4-C5 was recommended. In October 2020 Dr. Aflatoon requested a transfer of care, 2nd opinion orthopedic evaluation.

On November 25, 2020 the examinee saw Dr. Mir, an orthopedic surgeon. At the time his weight was 163 pounds for a BMI of 29. Current medications included multivitamins, atorvastatin, aspirin, magnesium and vitamin D. Dr. Mir recommended a referral to a shoulder specialist. The examinee was referred to Dr. Ghalambor.

The examinee saw Dr. Ghalambor on December 28, 2020. He was complaining of right shoulder pain. Past medical history was significant for prediabetes. He was diagnosed with right shoulder impingement/subacromial bursitis. An MRI of the right shoulder was requested.

The MRI of the right shoulder was completed on February 2, 2021. It showed an abnormal glenoid labrum consistent with a SLAP tear. There was mild to moderate tendinopathy in the supraspinatus and infraspinatus tendons. No evidence of rotator cuff tear was noted and biceps tenosynovitis was present. The examinee also had subcoracoid bursitis and regions of synovial hyperplasia. A right subacromial steroid injection was recommended.

Examinee went back to see Dr.Ghalambor on March 18, 2021. Right shoulder arthroscopic subacromial decompression/partial acromioplasty, glenohumeral joint synovectomy and loose body removal was recommended. When the examinee went back to see this provider on June 21, 2021, the examinee opted to wait and not have the surgery. He was then declared Permanent & Stationary. The examinee was rated for an upper extremity impingement syndrome and a WPI of 4%. He was returned to regular work and had no permanent restrictions.

The examinee returned to Dr. Aflatoon on September 15, 2021. At the time his weight was 160 pounds. He was complaining of mild to moderate neck pain, radiating down his arm causing numbness and tingling. Review of systems was significant for difficulty sleeping due to pain, history of stomach issues

and high cholesterol. He was diagnosed with C4-C5 disc herniation with radiculopathy and cervical stenosis. The examinee was released from his medical care. A rating (DRE III with a WPI of 10%) was prepared.

On March 23, 2022 the examinee saw Dr. Aflatoon for a reevaluation. He ordered an MRI of the cervical spine without contrast and sent the patient back to modified work (no lifting/carrying over 25 pounds).

The MRI of the cervical spine without contrast was completed on 4/18/2022. It showed multilevel facet arthropathy with foraminal stenosis and mild central canal stenosis at multiple levels.

The examinee went back to see Dr. Aflatoon on April 20, 2022. The examinee's weight was 160 pounds. He was diagnosed with disc herniation at C4-C5 with radiculopathy and cervical stenosis. Epidural injections were requested. The epidural was administered on 5/25/2022. During his follow-up visit, on 6/1/2022, Dr. Aflatoon requested approval for anterior cervical discectomy and fusion at C4-C5. The surgery was scheduled for oh 2/6, 2022. The proposed procedure was: Anterior cervical discectomy fusion iliac crest bone graft with plate fixation, C4-C5.

The examinee saw Dr. Ghalambor on June 28, 2022. The examinee was complaining of a 4-year history of left shoulder pain and subsequently had developed bilateral shoulder pain. He had shoulder impingement syndrome. An MRI of the left shoulder was completed on July 11, 2022. It showed impingement and supraspinatus/subscapularis tendinosis. There was a longitudinal tear of the biceps tendon within the bicipital groove. Dr. Ghalambor opined the examinee was at MMI as of August 2, 2022. His impairment rating was a 7% WPI for the left shoulder. Future medical care was provided. He had permanent work restrictions, including surgery.

On September 26, 2022 the examinee saw Dr. Zand, an internist for a preoperative clearance. The EKG was "stable for surgery", the rest of the labs and the chest x-ray were not available for review. The examinee was a former smoker and was on low-dose aspirin as well as Celebrex 200 mg. Blood pressure was 128/72 with a weight of 163 pounds and a height of 62 inches. BMI was 29. Laboratories were ordered. A chest x-ray was unremarkable. The urinalysis was within normal limits. A CMP showed normal electrolytes, glucose at 95, BUN at 12 and creatinine at 0.94. Calcium was 9.6, with normal albumin and total protein. Liver enzymes were normal. Alkaline phosphatase was 89. Globulin fraction was slightly elevated at 3.7 (normal 2.5-3.5). A CBC and differential showed WBCs at 6200 with elevated monocytes and eosinophils. Hematocrit was 46.9% with normal MCV and MCH. Platelets were 232,000. Coagulation parameters were within normal limits. Urine culture was negative.

The examinee underwent the anterior cervical discectomy/fusion with iliac crest bone graft and plate fixation (C4-C5 level) uneventfully. He saw Dr. Aflatoon for follow-up on 10/21/2022. Sutures were removed, and the examinee was kept off work through 11/16/2022.

When the examinee saw Dr. Aflatoon on 11/16/2022, he was still wearing the neck brace on his last visit which Dr. Aflatoon had recommended be removed during his last visit. He was referred to physical therapy. The Examinee remained off work through January 11, 2023.

The examinee returned to see Dr.Aflatoon on January 11, 2023. He was complaining of mild headaches and mild paraspinal spasms. Dr. Aflatoon recommended acupuncture. He extended his disability 202/22/23.

Vital signs from the acupuncture provider as of January 23, 2023 were as follows: Weight = 162 pounds, blood pressure = 136/91. When Dr. Aflatoon saw him on follow-up on February 22, 2023 he extended the Examinee's off work time through April 15, 2023. When the examinee was seen in April 2023, he was referred to physical therapy and his disability was extended to May 3, 2023.

COMMENTS:

I appreciate opportunity of reviewing the evolution of this Examinee's musculoskeletal injury treatment, however, the information does not assist or support my Internal Medicine determinations. There is no information on his prediabetes or diabetes, and the only pertinent findings from the gastrointestinal side was excess gas and constipation, symptoms that are very common in the general population and generally not associated to the use of NSAIDs. The Examinee is a vegetarian and has been for a long time. His weight is stable.

The examinee is taking lansoprazole and naproxen. The medical records do not reflect a prescription for lansoprazole, so I do not know if this was prescribed because he was symptomatic or it was prescribed as a preventative, since he was taking naproxen.

The examinee appears to be a diabetic, however, when I asked about this condition, the examinee, through his interpreter denied his being a diabetic. When I started my evaluation, the examinee had not listed his medications, as he was waiting for somebody at home to provide him with a list, and therefore, I did not have the opportunity of reviewing his list because it had not arrived at the completion of my interview.

There is also some conflicting evidence in the paperwork he provided. He stated that he had never smoked, however, the medical records state that he was a former smoker.

Of note is the fact that aside from a long standing history of constipation that happens from time to time, and occasional abdominal pain due to gas, the examinee did not complain of any gastrointestinal conditions when he was evaluated at my office. At the time of my evaluation the examinee was not working, and therefore I cannot evaluate how he would do when he goes back to his job.

The examinee has a primary medical provider which I assume treats his prediabetes/diabetes and prescribes his glipizide, lansoprazole, etc. I would appreciate opportunity of reviewing those files in order to better ascertain this examinee's claims.

This report is submitted in compliance with Labor Code Section 139.2 (j) (I) and Rule 38(a), which requires this Evaluator to submit a report within 30 days of the examination date. Extensive testing has been requested to prove or disprove this applicant's Workers' Compensation claim; the results are not available for inclusion with this report, but I will be glad to prepare a supplemental report if the parties so desire as soon as the results are available for my review. ***If a supplemental report with the final***

causation and rating is desired, I would appreciate the parties sending me a formal written request. I will provide definitive opinions regarding causation and other compensability issues at that time.

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

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

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

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

DISCLAIMER

Declaration Pursuant Title 8, CCR § 10606

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

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

Claimant: Barghav Shah

Exam Date: 5/1/2023

Location of the Examination: **N. Betancourt, MD, Inc. – Anaheim**
947 S. Anaheim Blvd., Suite 280
Anaheim, CA 92805
(951) 666-0706

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

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

Qualifications: **Diplomate, American Board of Internal Medicine, Certificate No: 121664**
Qualified Medical Evaluator Certificate Number: 915187
American Board of Independent Medical Examiners, re-certified 2020
Diplomate, American Board of Toxicology, 2012, 2017, 2022
Medical College of Wisconsin, MPH Degree, 1998
Master's Degree in Public Health - Occupational Medicine

Board Certified Health Care Quality Management
Physician Advisor, Workers' Compensation
Medical Director, Occupational and Environmental Health Program, OccMed, Inc.
Occupational Medicine Consultant

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

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

Pursuant to Section 5703

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

Limited scope of this evaluation

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

Pursuant to Labor Code Sec. 3208.3 (h)

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

Signed this 22nd day of May, 2023 at City of Irvine, Orange County, California.

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