West Coast Orthopedics, Inc.
3325 Palo Verde Avenue, Suite 205 • Long Beach, CA 90808 • (562) 425-1802

January 10, 2020

Honorable Judge
Workers' Compensation Appeals Board
1065 North Link, Suite 170
Anaheim, CA 92806

RE:	JAMES YOUNG, Benetia
EMP:	Star View Adolescent Center
OCC:	Youth Counselor
DOI:	04/18/2019
CASE#:	ADJ12213522
CLAIM#:	19006760

To Whom It May Concern:

Ms. James Young was seen in this office for orthopedic examination on January 10, 2020 in my capacity as Agreed Medical Evaluator. This is a basic evaluation, and as such, this report will be billed at the ML102 level. In accordance with CCR Title 8, Section 9795, time spent in face to face, review of medical records, medical research, or report preparation, will not be specified.

Mailing Address: 18102 Irvine Boulevard, Suite 107 • Tustin, CA 92780
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DATE AND LOCATION OF EXAMINATION:

The patient was examined on January 10, 2020, at 3325 Palo Verde Avenue, Suite #205, Long Beach, California 90808.

HISTORY OF INJURY AS RELATED BY THE PATIENT:

The patient began working for Star View Adolescent Center on December 10, 2018, as a shift lead. Her job duties consisted of writing up a treatment plan daily for 16 clients, which she did on a computer. She was required to check on clients every 7 minutes as some were suicidal. When outside with the clients, she had to make sure they did not escape. She had to separate males and females from each other, supervise hygiene, bedtime and do laundry. She processed and had to "pro-act" 14-15 clients' behavior daily. At times she had to take down clients so they would not harm themselves. She would restrain clients in order to allow the nurses to give them injections to calm them down. She made sure the clients would eat dinner. She would collect forks after a meal. She basically monitored the clients so they did not engage in self-harm. She monitored family visits and other visitors. She also had to pat down clients to check for contraband or anything that could be used to harm themselves. She worked 12-16 hours per day, 6-7 days per week. She did undergo a pre-employment physical examination.

The patient denies having concurrent employment. Physically, the job required constant walking and sitting, as well as frequent bending at the waist, kneeling, squatting, reaching, pushing and pulling. Occasionally, she would have to sit, crawl, grip, grasp and jump or run. She occasionally had to lift and carry up to about 125 pounds. She states that the facility was a locked facility. She denies having concurrent employment.

On April 18, 2019, Ms. James Young was making her rounds and that she was walking by two clients. One of the clients snatched her by the back of her hair, and dragged her about 15 feet. This individual then beat her with closed fists with impact to her head and face. Another client came to her assistance and got the assailant off her. A colleague dragged her away from the area and that she had lost consciousness. That night she was evaluated at the Concentra Medical

<u>HISTORY OF INJURY AS RELATED BY THE PATIENT (Cont'd)</u>:

Clinic in Torrance and she was given medications. She subsequently attended physical therapy for her left shoulder and left shoulder blade, her left arm, the left side of her neck, and low back.

In approximately June 2019, the patient presented to the Kaiser facility on Long Beach and was evaluated by Dr. Cho, her private doctor, for complaints involving her neck, left shoulder and lower back. She was having difficulty sleeping due to pain. She was provided with medication only.

The patient continued working for the above employer until October 25, 2019, when she resigned. She denies subsequent employment.

In approximately November 2019, the patient came under the care of Dr. Eric G. of Los Angeles for neck and low back adjustments. This chiropractor requested an evaluation with a neurologist as she was having ringing in her left ear which was related to the April 18, 2019, incident. The patient believes she has been approved for this and is waiting for an appointment to be scheduled. She will be seeing a chiropractor in the near future.

<u>WORK LOSS HISTORY</u>:

After the April 18, 2019, incident, the patient continued to work until October 25, 2019, when she resigned from her job. She denies subsequent employment.

<u>PAST MEDICAL HISTORY</u>:

Prior Similar Injuries: None.

Other Industrial Injuries: None.

Recreational/Sports Injuries: When she was younger, the patient played baseball, tennis, ran track, and swam but denies injuries. She has not played sports as an adult and denies injuries.

Automobile/Motorcycle Accidents: None.

PAST MEDICAL HISTORY (Cont'd):

Fractures:	None.
Surgeries:	In the past, the patient underwent a cesarean section.
Major Illnesses:	The patient has hypertension, which is controlled with medication.
Allergies:	None.
Current Medications:	The patient utilizes amlodipine, ibuprofen, trazodone, zolpidem and Buspirone.

CURRENT COMPLAINTS:

The patient reports constant pain of her **CERVICAL SPINE** which is left-sided and radiates to the left shoulder and the top of her left ear. There is numbness and tingling. She has increased pain when she wakes up in the morning. There is some relief of pain with the use of medication.

In the **LEFT SHOULDER** there is constant pain that radiates into the top of her left ear and down the spine to the lower back. The pain increases when she raises her arm, walks and is more intense when she wakes in the morning. There is some relief of pain with the use of medication.

In the **LOWER BACK** there is intermittent left-sided pain with radiation to the hip and waistline. There is tingling of her low back. She has increased pain with standing and arising from a seated position. The pain is worse when she wakes up in the morning. There is some relief of pain with the use of medication.

ACTIVITIES OF DAILY LIVING:

The patient reports moderate pain with self-care activities including brushing or washing her hair, showering, preparing meals, brushing her teeth and swallowing food. There is moderate pain with lifting or carrying of more than 10 pounds with

ACTIVITIES OF DAILY LIVING (Cont'd):

the pain becoming moderate to severe with more than 20 pounds, as well as with pushing and pulling. There is moderate pain with bending or twisting of her neck or back, lifting her arms overhead, kneeling, squatting, climbing stairs and typing/writing. There is moderate pain with sitting for more than one hour and she is unable to tolerate this activity for longer than 2-3 hours due to severe pain. There is moderate to severe pain with standing or walking for more than 1 hour and she is unable to tolerate these activities for longer than 2-3 hours due to severe pain. She sleeps 4-5 hours per night and reports interrupted sleep due to pain, depression and anxiety. She feels tired during the day due to lack of sleep and takes naps. She also has difficulty with sexual function and urination, dental/jaw problems, speech problems, stomach upset, weight gain or loss, depression and anxiety. She has ringing of her left ear. She has had to increase her medication for hypertension.

REVIEW OF MEDICAL RECORDS:

Please see attached addendum.

OCCUPATIONAL HISTORY:

October 15, 2013 - the patient worked 8 years for Kedren Community. From November 2, 2017 or 2018 - the patient worked 6-9 months for Early Stride.

EDUCATIONAL HISTORY:

The patient has a college degree.

FAMILY HISTORY:

The patient's father is 80 years old and has no reported health problems. Her mother is 75 years of age and has no reported health problems. She has 5 sisters and 5 brothers with no reported health problems. She is widowed and is the mother of 1 child.

SOCIAL HISTORY:

The patient denies smoking cigarettes and denies consuming alcoholic beverages. She denies illegal drug usage.

PHYSICAL EXAMINATION:

The patient is a 55-year-old female, who stands 5'8" in height and weighs 145 pounds. The patient is ambidextrous. Blood pressure is 180/125. Respiration is 22. Pulse is 71. Temperature is 98.1.

The patient was very guarded in movement today. I was unable to obtain reliable range of motion.

Examination of the **CERVICAL SPINE** reveals a normal attitude of comfort, with the shoulders level. No cervical collar is being worn. The skin is clear, and no scars are present. There is tenderness to palpation over the bilateral upper trapezius musculatures left greater than right. There is also tenderness over the left levator scapula and rhomboid musculature. There is no muscle spasm.

Orthopedic Testing:

Spurling test:	Negative
Axial Compression test:	Negative
Shoulder Abduction test:	Negative

Range of Motion of the Cervical Spine: Please see attached Inclinometer chart; 3 separate readings were obtained for consistency, per the AMA Guides (5th Edition).

Examination of the **BILATERAL SHOULDERS** reveals no evidence of gross deformity. The skin is clear, and no scars are present. There is tenderness to palpation over the anterior aspect of the left shoulder. She has difficulty with usage of the left shoulder.

Orthopedic Testing:

Neer test:	Positive on left

PHYSICAL EXAMINATION (Cont'd):

Hawkins test:	Positive on left
O'Brien test:	Negative
Jobe test:	Positive on left
Speed test:	Negative
Cross Arm test:	Negative

Range of Motion of the Bilateral Shoulders: Please see attached Inclinometer chart; 3 separate readings were obtained for consistency, per the AMA Guides (5th Edition).

The grip JAMAR dynamometer reading on the 2nd notch reveals 5/5/5 on the right, per kilograms force. She declined to grasp the Jamar dynamometer on the left due to pain. Pinch testing reveals 4/4/4 on the right and 2/2/2 on the left.

Circumferential Measurements of Upper Extremities:

Biceps:	R/29.0 cm	L/29.0 cm
Forearms:	R/25.5 cm	L/25.0 cm
Wrists:	R/15.5 cm	L/15.5 cm
Hands:	R/19.0 cm	L/19.0 cm

Neurological examination reveals the deep tendon reflexes to be symmetrical in the biceps (1+), triceps (1+), and brachioradialis (1+). Sensation utilizing the Wartenberg wheel is intact.

The patient walks with a normal gait. The patient is able to squat. Heel and toe walking are performed satisfactorily. Rising from a sitting position is accomplished in a normal manner.

The patient does not use a cane/brace/walker/wheelchair.

Examination of the **LUMBAR SPINE** reveals the patient stands with increased lumbar lordosis. The skin is clear, and there are no scars in the midline of the low back. There is tenderness to palpation over the lumbosacral spine at the midline bilaterally. There is no muscle spasm.

PHYSICAL EXAMINATION (Cont'd):

Orthopedic Testing:

Babinski sign:	Negative
Lasègue sign:	Negative
Fabere maneuver:	Negative

Range of Motion of the Lumbar Spine: Please see attached Inclinometer chart; 3 separate readings were obtained for consistency, per the AMA Guides (5th Edition).

Neurological examination reveals the deep tendon reflexes to be absent in the patellar and Achilles tendons bilaterally. Sensation utilizing the Wartenberg wheel is intact. Motor strength testing is within normal limits.

Circumferential measurements of the lower extremities:

Thighs (10 cm above patella):	R/51.5 cm	L/51.0 cm
Midcalves:	R/36.0 cm	L/36.0 cm

Circulation into both lower extremities remains intact. The length of both legs is equal from the anterosuperior iliac spines to the tips of the medial malleoli bilaterally.

X-RAY EXAMINATION:

X-ray examination of the **CERVICAL SPINE** (2 views) reveals degenerative changes with osteophytes and disc changes at C5-6. Prevertebral soft tissue shadows are within normal limits.

X-ray examination of the **BILATERAL SHOULDERS** (6 views, including external, internal and outlet views) reveals the overall osseous density to be normal. The joint spaces are well maintained. The acromioclavicular joint appears normal. There is no evidence of fracture, dislocation or subluxation.

X-ray examination of the **LUMBAR SPINE** (3 views) reveals mild diffuse osteopenia. Lumbar lordosis is maintained. Degenerative changes are present,

X-RAY EXAMINATION (Cont'd):

most notable at L3-4 where there is sclerosis of the superior endplate of L4 and some disc space narrowing. Facet hypertrophic changes are present.

DIAGNOSES:

1. Cervical trapezial strain with degenerative disc disease, per x-rays.

2. Left shoulder strain; rule out internal derangement.

3. Lumbosacral sprain/strain with degenerative disc disease, lumbar spine; per x-rays.

DISCUSSION:

Ms. Benetia James Young presents for evaluation of her orthopedic complaints. According to submitted correspondence, this is an accepted injury sustained on April 18, 2019, however, the nature and extent are at issue. The cover letter has captioned dates of injury which include April 18, 2019, through October 10, 2019, which appears to be a cumulative trauma.

Examination of the cervical spine reveals areas of tenderness and decreased range of motion.

The patient was quite guarded on inclinometer testing and reliable range of motion could not be obtained.

Examination of the shoulders reveals tenderness over the anterior aspect of the left shoulder joint. The patient had difficulty with usage and movement of her left shoulder. Neer, Hawkins and Jobe testing were positive.

Examination of the lumbar spine reveals the patient stands with increased lumbar lordosis. There is tenderness of the lumbar spine and bilateral hamstring tightness. Reflexes are absent in the patellar and Achilles tendons bilaterally.

X-rays were taken of the cervical spine, bilateral shoulders and lumbar spine. In the cervical and lumbar spine, the patient has degenerative disc disease.

DISCUSSION (Cont'd):

Following evaluation, I recommended she undergo MRI studies of the cervical spine, left shoulder and lumbar spine. Unfortunately, these were not done as the patient canceled the appointments and has not responded to re-scheduling of these studies. If she does go on to have the MRI studies, I will review them and provide additional commentary in a supplemental report.

In addition to her orthopedic complaints, the patient describes sleep difficulties, issues with sexual function and urination, ringing of her left ear, stomach upset. She also states she has had to increase her high blood pressure medication. Her blood pressure readings were elevated and she was advised of this.

At this juncture, I have not received any medical records. I am recommending the above-noted MRI studies. I would like to review the recommended MRI studies and the records before commenting further.

CAUSATION AND APPORTIONMENT:

The patient sustained a specific injury on April 18, 2019, when she was assaulted by a client. From her history, the injury involved her cervical spine, left shoulder and lumbar spine, however, she also describes ringing of her left ear, psychological complaints and other non-orthopedic issues, which are deferred to the appropriate specialists.

In the cover letter, there is another date of injury, April 18, 2019 through October 10, 2019, which suggests a cumulative trauma injury has been filed on this case. I was not provided with any paperwork or medical records on this case, nor did the patient specifically describe cumulative trauma. I will gladly review outstanding medical records and other documents in order to address this possible second date of injury.

Based on present information, the patient's cervical spine, left shoulder and lumbar spine complaints are consistent with the industrial injury of April 18, 2019, as described by the patient. This date of injury has been accepted, however, it appears that nature and extent are at issue.

CAUSATION AND APPORTIONMENT (Cont'd):

X-rays show degenerative disc disease of both the cervical and lumbar spine. The patient denied any prior injuries to the cervical spine, left shoulder or lumbar spine. Apportionment may be an issue and will be readdressed at the time of my final assessment of this patient.

If there are any further questions, please feel free to contact this office.

CERTIFICATION:

Initial base history by Yvonne C. Summers. X-rays taken by Elias Gonzalez, X-ray Technician, Permit #RHF00096714. Review of report for structural content performed by Randy Chelwick. Review of history with the patient, physical examination, interpretation of x-rays, review of medical records, dictation/review of final report by **SOHEIL M. AVAL, M.D.**

DECLARATION UNDER PENALTY OF PERJURY:

I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation inducement for any referred examination or evaluation. Also, pursuant to Section LC 4628 (b), the time spent performing the above evaluation was in compliance with the guidelines established by the Administrative Director.

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,

DECLARATION UNDER PENALTY OF PERJURY (Cont'd):

except as to the information that I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Very truly yours,

Soheil M. Aval, M.D.
Diplomate, American Board
Of Orthopaedic Surgery
CA Lic#A67928

Signed and dated in Orange County on 3-2-2020.

SMA:ls/7/gac/9
0224bjamlp

State of California

DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

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

Case Name: Benetia James Young *(employee name)* v ATHENS ADMINISTRATORS CONCORD *(claims administrator name, or if none employer)*

Claim No.: 002740 013707 WC 01 **EAMS or WCAB Case No. (*if any*):** ADJ12213522

I, April Christine Valle *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My business address is: 18102 Irvine Boulevard, Suite 107, Tustin, California 92780
3. On the date shown below, I served the attached original, or a true and correct copy of the original comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:
   a. Depositing the sealed envelope with the U.S. Postal Service with the postage fully prepaid.
   b. Placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
   c. Placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
   d. Placing the sealed envelope for pick up by a processional messenger service for service (Messenger must return to you a completed declaration of personal service.)
   e. Personally delivering the sealed envelope to the person or firm named below at the addresses shown below.

Means of Service *(For each addressee, enter A-E as appropriate)*	**Date Served**	**Addressee and Address Shown on Envelope**
B	3/2/2020	Workers' Compensation Appeals Board, 1065 North Link, Suite 170, Anaheim, CA 92806
B	3/2/2020	Natalia Foley, Esq., WORKERS DEFENDERS ANAHEIM, 8018 East Santa Ana Canyon Road, Suite 100 215, Anaheim, CA 92808
B	3/2/2020	Timothy Chapin, ATHENS ADMINISTRATORS CONCORD, Post Office Box 696, Concord, CA 94522
B	3/2/2020	Bethe C. Barkley, Esq., STANDER REUBENS EL SEGUNDO, 200 North Pacific Coast Highway, Suite 1550, El Segundo, CA 90245-4359

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

Date: 3/2/2020

April Valle
(signature of declarant)

April Christine Valle
(print name)

QME Form 122
Rev. February 2009

ACV 115430

Orthopedic Medical Group of Santa Ana
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Tustin, California 92780

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WORKERS DEFENDERS ANAHEIM
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<u>Packing List</u>
Address Sheet
First Page
Report
Proof Of Service