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Internal Medicine, Rheumatology and Geriatrics

July 28, 2022

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Department of Industrial Relations
Subsequent Injuries Benefits Trust Fund
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Sacramento, CA 95825-3367

SUBSEQUENT INJURIES BENEFITS TRUST FUND EVALUATION

RE:	BOUDRINE, DMITRI
Case #:	21753072
DOB:	June 26, 1962
Date of Injury:	April 11, 2012
Claim #:	SIF8345007

Dear Counselor and Interested Parties:

As requested, Mr. Dmitri Boudrine, was evaluated at our Glendale office located at 425 W. Broadway, Suite 215, Glendale, CA 91204, for a Medical-Legal Evaluation on July 28, 2022.

The purpose of this assessment was to exclude internal medicine or rheumatology conditions relative to this Subsequent Injuries Benefits Trust Fund (SIBTF) and to comment on impairment in the workplace that might result from such diagnoses.

We confirmed the identification of Mr. Boudrine by photographic ID.

Under penalty of perjury, this report is submitted pursuant to 8 Cal Code of Regs. Section 9795 (b) and (c) as an ML-201-93-95, a Qualified Comprehensive Medical-Legal Evaluation.

Increased time required due to presence of interpreter: The need for a certified interpreter in (Russian) Alexandra Goldburt; Cert #: 301074, increased the time necessary for the evaluation by the amount of time it takes to communicate in two separate languages as enabled by the presence of the interpreter, reasonably doubling the average time required to complete the interview and examination and obtain an accurate history.

Time spent face-to-face with the examinee was 1.5 hour. Total pages of records received and reviewed, 7162. Declaration(s) enclosed at the end of report.

The Subsequent Injuries Benefits Trust Fund (SIBTF) evaluation is a medical evaluation focusing on pre-existing medical conditions which caused labor disablement.

My evaluation includes a retrospect review of medical records prior to the date of injury of April 11, 2012 and contemporaneous evaluation by reviewing the records of Mr. Boudrine and providing an assessment of labor disablement and AMA ratable internal medicine problems.

Readers of this report are no doubt aware that the Subsequent Injuries Benefits Trust Fund process is administered consistent with the requirements of Labor Code Section 4751 which specifies the following information:

If an employee who is permanent partially disabled receives a subsequent compensable injury resulting in additional permanent partial disability so that the degree of disability caused by the combination of both disabilities is greater than that which would have resulted from the subsequent injury alone, and the combined effect of the last injury and the previous disability or impairment is a permanent disability equal to 70% or more of total (after modification considering age and occupation) he shall be paid in addition to the compensation due under this code for the permanent and partial disability caused by the last injury compensation for the remainder of the combined permanent disability existing after the last injury as provided in this article; provided, that either (a) the previous disability or impairment affected a hand, an arm, a foot, a leg, or an eye, and the permanent disability resulting from the subsequent injury affects the opposite and corresponding member, and such latter permanent disability, when considered alone and without regard to, or adjustment for, the occupation or age of the employee, is equal to 5% or more of total, or (b) the permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or the age of the employee, is equal to 35% or more of total.

A contemporaneous and retrospective review of the medical history and medical records is performed to determine if it is medically probable that there was labor disabling impairment, which pre-existed the date of the last injury in question and whether or not the sum of the combined industrial and nonindustrial impairment rates to 70% disability or more. Prior impairment ratings for industrial injuries are reviewed for accuracy and if necessary, re-rated.

In this case, the gentleman has a broad constellation of problems including extensive orthopedic injuries resulting from a car versus pedestrian motor vehicle accident. He does not have any history of inflammatory arthritic condition that typically would be considered rheumatological. Therefore, most of his disability falls under the rubric of internal medicine or orthopedic surgery. I will focus upon the internal medicine-related conditions.

Please note that I reviewed the cover letter, dated June 20, 2022, from Workers Defenders Law Group, dated June 20, 2022, and signed by Irina Palees, Legal Assistant to attorney Natalia Foley.

I was assisted in this evaluation by Medical Assistant Genieva. This individual checked height, weight, initial blood pressure, pulse, respirations, temperature, pulse oximetry and hand preference. I performed all aspects of the actual subsequent physical examination.

Please note that a Russian-English-English-Russian interpreter was also provided telephonically in the form of a certified specialist in this respect. I note however that Mr. Boudrine is an educated man, he once served as an Adjunct Professor in the New York University. Therefore, although, Alexandra, Court Certification #301074, was on stand-by during the interview. The gentleman preferred to perform most of the answering of questions himself in the English language. I believe I was able to obtain the detail and adequate history.

Date of injury is April 11, 2012. Therefore, the focus in this case will be upon the conditions that might have impaired competitiveness in the workplace prior to that specific date consistent with the SIBTF process.

OCCUPATIONAL HISTORY

The job duties at the time of date of injury included those of property manager. In that capacity, he was responsible for maintaining the safety and security of rental property location, dealing with leases and contracts for other rental property, leasing, taking care of minor

repairs, collecting rent and documents, and responding to resident concerns. His employer was called Roberts Company. The job involved working 80% of the time in an office environment and 20% of the time outdoors, walking back and forth from various locations. Up to one-third of the workday involved walking on irregular terrain and twisting the torso as well as reaching hands overhead; up to two-thirds of the workday involved walking on flat terrain such as office floors or outside walkways. The remainder of the time included sitting, typing, precision gripping and lifting office documents weighing up to 20 pounds.

In addition to his career as an office manager at the time of his date of injury, Mr. Boudrine has also been an actor of some renown, having appeared in various Hollywood movies over the years. Since Hollywood movies did not require his attention on a full-time basis, he also was able to maintain outside employment. He indicates that the movie Exiles in Paradise, it is movie that he is associated with. He feels that it was loosely based on his own life in fact. He has worked with numerous famous actors over the years as well as well-known directors and producers. He has been unable to pursue acting since his date of injury of cumulative trauma of April 28, 2011 through April 11, 2012 due to pain in his back, right knee, left knee, sleep disorder, obesity, and possible secondary injury to psyche. As noted above, he has, in the past, served as an Adjunct Professor, NYU in Acting Instruction Courses, I believe prior to his date of injury.

MILITARY HISTORY:

No reported history of military service or service-connected disability.

CHIEF COMPLAINT:

"Problems."

HISTORY OF INJURY OR ILLNESS:

This pleasant 60-year-old male reports a variety of problems dating from two dates of injury. The first is cumulative trauma of April 28, 2011 through April 11, 2012involving pain in his back, right knee, left knee, sleep, neurologically, he has injury to psyche. He also has a date of injury of January 28, 2008. Against that backdrop, he has suffered numerous internal medicine related problems, which are summarized in this report as follows:

1. Obesity:

He indicates that prior to the date of injury, his body weight was in the range of 200 pounds. He has gained over 200 pounds and now weighs 420 pounds. He indicates that this is weight gain associated with impaired mobility. Consequently, he has decreased capacity for burning calories. He did have a gastric sleeve placed a number of years ago. This was removed subsequently for poor tolerance. He did lose 90 pounds, but gained it back. He admits that his caloric intake is excessive. He has seen dieticians and attempted to moderate his caloric intake. Complications relative to the so called "metabolic syndrome" have included hypertension, diabetes, and sleep apnea, which will be discussed below. He feels the major obstacle to his ambulation and burning of calories is pain in his back and knees.

2. Restrictive lung disease:

He has a history of restrictive lung disease associated with obesity. Specifically, shortness of breath with ambulation greater than 50 feet. I would estimate that his overall capacity to exercise is markedly diminished, certainly no greater than 5.7 to 7.1 METs. Indeed, it may well be lower than that. He is adherent to any treatment protocol that has been offered to him. He has not been treated with lung biopsy or suggestion that he required any other major intervention.

3. Essential hypertension:

He indicates that he has been on medications for this for a long time, perhaps 10-20 years. When he was busy acting, he was covered with health insurance by the Screen Actors Guild, and received excellent treatment. In recent years, his membership with the Guild may have dropped off in some respect, because he no longer has easy access to this medication. He does indicate, however, that he tries to follow up with treating physicians. He has had diagnostic studies that show left ventricular hypertrophy. Blood pressure tends to run between a normal levels noted at this visit to levels as high as 150/100 on other occasions.

4. Cardiac arrythmia:

He has a history of premature ventricular contractions with subjective palpitations. This has become more of a problem with weight gain. He has not had a pacemaker surgery

of any kind. There is no history of Wolff-Parkinson-White Syndrome. There is no history of atrial fibrillation to his knowledge.

5. Microcytic anemia:

The medical records indicate that at Cedars-Sinai Medical Center, he was noted to have a low mean corpuscular volume (MCV). He has had slightly decreased hemoglobin and hematocrit over the years with hemoglobin in the range of 10 to 12 mg/dL. There is no history of inherited thalassemia to his knowledge.

6. Traumatic brain injury:

The medical records reviewed indicate that he sustained a traumatic brain injury when he was struck by an automobile, which also caused orthopedic trauma to lower extremities including tibia-fibula fracture and an ankle bimalleolar fracture contralaterally. He does not have seizure disorder or significant residual neurological impairment to his knowledge. There is documentation of this traumatic event in his medical records, which will be described below.

7. Tobacco dependence:

He has a history of being a cigarette smoker from 30 to 10 years ago. I believe, he has currently quit smoking. He has residual mild wheezing at times. He does not routinely use an asthma inhaler, but has on occasion used inhalers. There is no history of cystic fibrosis or alpha-1 antitrypsin deficiency.

8. Diabetes mellitus type 2:

He has a history of adult-onset diabetes mellitus. Treatment has been largely conservative. He has also been placed on medication for this in the past. There is no history of diabetic ketoacidosis or diabetic hyperosmolar state.

9. Gastroesophageal reflux disease and gastritis:

He has a history of these conditions treated with proton-pump inhibitors on an intermittent basis. The symptoms were made somewhat worse when he had the gastric sleeve placed. Typically, when he experiences symptoms, he will experience retrosternal discomfort and burning. There is no history of Barrett's esophagus.

10. Peripheral vascular disease:

Due to his lower leg injury, he has swelling of his legs bilaterally. He has not had significant ulcerations. He does have some chronic pain and discomfort associated with this condition and feels more comfortable elevating his legs. In the past, he in fact had deep vein thrombosis and had a filter placed in his inferior vena cava, which was subsequently removed.

Treatment for these conditions has been undertaken by various physicians in primary care and other specialties. He indicates that he does attend a number of doctor's appointments although he has had some problems with his healthcare coverage that has rendered his situation challenging in terms of accessing healthcare on occasion. He feels that he cannot return to any of his previous activities such as working as an actor or property manager due to the severity and multiplicity of his medical problems. He is hopeful that perhaps in the future if his condition could improve, some of these options would perhaps be open to him, but at present, he is not optimistic about that possibility.

PAST MEDICAL HISTORY:

Past Medical History: Conditions as outlined above.

Current Medications:

1. Antihypertensive.
2. Proton pump inhibitor.
3. Low-dose aspirin therapy.
4. History of use of analgesics and muscle relaxers for treatment of musculoskeletal conditions.

Allergies: None reported.

FAMILY HISTORY:

He is originally from Eastern Europe and is a native Russian speaker.

SOCIAL HISTORY:

Substance Use: He admits to drinking alcohol on occasion.

He has had, to most of his adult life, rich social interactions with other individuals in the entertainment industry. He does not engage in significant physical exercise at present. He has tried to perform bicycle riding without success using a stationary bicycle.

REVIEW OF SYMPTOMS

Positive for the following symptoms in the past: Chronic joint pain, gastrointestinal discomfort, low back pain, poor circulation, daytime sleepiness.

Positive for the following symptoms at present: Chronic joint pain, gastrointestinal discomfort, low back pain, poor circulation, daytime sleepiness.

Positive for the following symptoms, past and present: Chronic joint pain, gastrointestinal discomfort, low back pain, poor circulation, daytime sleepiness.

PHYSICAL EXAMINATION:

General:

The examinee is a pleasant, elderly male, in no acute distress. Height 6 feet 4 inches tall, weight 419 pounds (BMI of 50 constituting extreme obesity), right handed, blood pressure initially checked by staff 106/80, followup manual blood pressure 152/102, pulse 80, respirations 18-26, pulse oximetry 95%, temperature 97%.

HEENT

Normocephalic and atraumatic. Pupils equally round and reactive to light and accommodation. Extra ocular muscles intact. Fundi reveal no papilledema, exudates or hemorrhages. No malar rash is noted. Oropharynx reveals prominent soft tissue consistent with obesity with partial obstruction of soft palate. Salivary flow is adequate. External ears are intact.

Neck

Neck is supple without jugular venous distention or thyromegaly. Carotids, upstrokes equal and brisk bilaterally. Trachea midline. No supraclavicular lymphadenopathy.

Cardiovascular

Heart sounds are distant due to large body mass index. Regular rate and rhythm. An occasional ectopic beat is noted, possibly a PVC one every 30 seconds at most. There is no indication of the irregularly irregular rhythm seen with atrial fibrillation. No S3 or S4 is noted though S1 and S2 are audible. No precordial heave is appreciated.

Lungs

He becomes tachypneic with respiratory rate increasing from 18 to 24 with ambulation greater than 50 feet. A few scattered faint wheezes are audible in the apical lungs, the bases reveal decreased air entry. There is no dullness to percussion. No use of accessory muscles of inspiration is noted. No E to A changes are appreciated.

Abdomen

Protuberant due to obesity. No overt organomegaly is noted on examination though examination is limited by abdominal girth. No renal artery bruits are detected. Punctate scar is consistent with cholecystectomy are barely visible in the right upper quadrant.

Genitourinary Exam

Deferred.

Rectal Exam

Deferred.

Extremities

The legs bilaterally have +1 pretibial brawny edema. There are punctate scars in the left pretibial area consistent with open reduction internal fixation surgery and a longitudinal scar

over the right ankle extending anteriorly in a cephalo-caudad manner for 20 cm hyperpigmented and depressed. Pulses are 1+ popliteal and 1+ dorsalis pedis bilaterally. Range of motion is diminished in both ankles with the right ankle having dorsiflexion 0 degrees, plantar flexion 20 degrees, inversion 10 degrees, eversion 0 degrees; left ankle dorsiflexion 10 degrees, plantar flexion 30 degrees, inversion 24 degrees, eversion 12 degrees by goniometer.

Circumferential Measurements

	Right	Left
Upper arms	43 cm	43 cm
Forearms	30 cm	30 cm
Legs	50 cm	50 cm
Calves	44 cm	44 cm

Jamar Dynamometer Hand Strength Measurement

Right	Left
40 kg	40 kg
40 kg	38 kg
40 kg	38 kg

Neurological Examination

Alert and oriented x3. Affect does not appear depressed at this time. Speech, comprehension and expression appear fluent in English. Long-term, short-term and intermediate-term memory intact. The examinee room members particularly anecdotes of his acting career and his medical history in detail. He remembers recent activities as well. Cranial nerves reveal no overt deficits of II through XII.

Deep tendon reflexes are 2+ and symmetric at biceps, triceps, brachioradialis, knees and ankles. Babinski is absent bilaterally. Gait is broad-based and somewhat unsteady. Romberg test is positive. He does at times appear minimally somnolent.

REVIEW OF RECORDS:

The following records were reviewed in conjunction with this evaluation:

1. Deposition of Jan Merman, MD, taken in Los Angeles, California, dated 09/26/2018. Pages 1 through 26.
2. State of California Division of Workers' Compensation Workers' Compensation Appeals Board Notice and Request for Allowance of Lien. (Incomplete Report)
3. State of California Division of Workers' Compensation-Medical Unit - QME/AME Appointment Notification Form. Dated: Unknown Date. Employee: Dmitri Boudrine - DOI: 01/26/08. Employer: The Roberts Company.
4. Worker's Compensation Claim Form (DWC-1). Dated: 01/28/08. DOI: 01/26/08. Employee sustained injury to left knee.
5. State of California Division of Workers' Compensation Disability Evaluation Unit - Employee Disability Questionnaire. Dated: 06/30/09. Employer: The Roberts Companies - Property Manager.
6. DWC/WCAB Application for Adjudication of Claim. Dated: 04/05/12. DOI: CT: 04/28/11-04/11/12. Employer Name and Designation: The Roberts Companies and Property Manager. Body Part 1: 420 Back. Body Part 2: 513 Knee. Body Part 3: 880 Body SMS. Body Part 4: 100 Head. Body Part 5: 842 Psych. Patient was injured while performing job duties as required by employer.
7. DWC/WCAB Application for Adjudication of Claim. Dated: 04/05/12. (DOI: 01/26/08) Employer Name and Designation: The Roberts Companies - Property Manager. Body Part 1: 420 Back. Body Part 2: 513 Knee. Body Part 3: 880 Body SMS. Body Part 4: 100 Head. Patient was injured while performing job duties as required by employer.
8. Worker's Compensation Claim Form (DWC 1). Dated: 04/05/12. (DOI: 01/26/08) Employee sustained injury to back, right knee, left knee, sleep and neuro while performing duties in the course and scope of his employment.
9. Worker's Compensation Claim Form (DWC 1). Dated: 04/11/12. DOI: CT: 04/28/11-04/11/12. Employee sustained injury back; right knee; left knee: sleep neuro: and psych.
10. DWC/WCAB Application for Adjudication of Claim. Dated: 05/22/12. (DOI: CT 04/28/11 - 04/11/12) Employer's Name and Designation: The Roberts Companies - Property Manager. Body Part 1: 420 Back - including back muscles. Body Part 2: 513

Knee patella. Body Part 3: 880 Other body systems. Body Part 4: 100 Head - not specified. Other Body Parts: 842 Nervous system - Psychiatric/psych. Employee was injured while performing job duties as required by employer.

11. DWC/WCAB Application for Adjudication of Claim. Dated: 05/22/12. DOI: 01/26/08. Employer Name and Designation: The Roberts Companies - Property Manager. Body Part 1: <420> Back including back muscular. Body Part 2: <513> Knee patella. Body Part 3: <880> Other body systems. Body Part 4: <100> Head, not specified. Worker was injured while performing job duties as required by employer.

12. DWC/WCAB Declaration of Readiness to Proceed. Dated: 07/11/12. Case Number: ADJ8345019. Employer: The Roberts Companies.

13. State of California Department Of Industrial Relations Divisions Of Worker's Compensation Minutes of Hearing. Dated: 08/20/12. Employer: The Roberts Companies.

14. DWC/WCAB Declaration of readiness to proceed. Dated: 09/19/12. Case Number: ADJ8345019, ADJ8345007. Employer: The Roberts Companies.

15. State of California Division of Workers' Compensation Workers' Compensation Appeals Board Notice and Request for Allowance of Lien.. Dated: 10/01/12. Case No: ADJ8345007. The Robert Companies Vs Employers Comp Glendale.

16. State of California Division of Workers' Compensation Workers' Compensation Appeals Board Notice and Request for Allowance of Lien.. Dated: 10/26/12. Case No: ADJ8345007. Dmitri Boudrine Vs The Roberts Companies.

17. DWC/WCAB Stipulations with Request for Award. Dated: 12/05/12. DOI: 01/26/08. Employer: The Roberts Companies. . Employee injured back, sleep, hand, psych and knee while performing job duties

18. State of California WCAB Minutes of Hearing. Dated: 12/06/12. Employer: SK Former, LLC

19. State of California Division of Workers' Compensation Workers' Compensation Appeals Board Notice and Request for Allowance of Lien.. Dated: 12/10/12. Case No: ADJ8345019. Patient Name: Dmitri Boudrine. Employer: Schlossberg Umholtz Los Angeles.

20. State of California Division of Workers' Compensation Workers' Compensation Appeals Board Notice and Request for Allowance of Lien.. Dated: 12/20/12. Case No: ADJ8345019. Patient Name: Dmitri Boudrine.

21. State of California WCAB Minutes of Hearing. Dated: 01/07/13. (Incomplete).

22. State of California WCAB Minutes of Hearing. Dated: 02/25/13. Employer: The Roberts Companies.

23. Employee's Claim for Worker's Compensation Benefits. Dated: 04/24/13. (DOI: CT 04/28/11-04/11/12) Employee sustained injury to head, back, left knee, other body systems due to repetitive physical work while performing duties in the course and scope of his employment.

24. Employee's Claim for Worker's Compensation Benefits. Dated: 04/24/13. (DOI: 01/26/08) Employee sustained injury to head, back, left knee, other body systems due to fall while performing duties in the course and scope of his employment.

25. DWC/WCAB Application For Adjudication of Claim. Dated: 04/24/13. DOI: 01/26/08. Employer Name and Designation: The Roberts Co - Laborer. Body Part 1: 100 Head. Body Part 2: 420 Back. Body Part 3: 513 Knee. Body Part 4: 880 Body SMS. Employee sustained injury due to fall.

26. DWC/WCAB Application For Adjudication of Claim. Dated: 04/24/13. DOI: CT 04/28/11-04/11/12. Employer Name and Designation: The Roberts Co - Laborer. Body Part 1: 100 Head. Body Part 2: 420 Back. Body Part 3: 513 Knee. Body Part 4: 880 Body SMS. Due to repetitive physical work.

27. Workers' Compensation Claim Form (DWC 1). Dated: 04/24/13. (DOI: 01/26/08) Employee sustained injury to head, back, left knee and other body systems due to fall.

28. Workers' Compensation Claim Form (DWC 1). Dated: 04/24/13. (DOI: CT 04/28/11-04/11/12) Employer sustained injuries to head, back, left knee, other body systems, due to repetitive physical work.

29. State of California Division of Workers' Compensation Workers' Compensation Appeals Board Notice and Request for Allowance of Lien.. Dated: 05/06/13. Case No: ADJ8345019. Dmitri Boudrine Vs The Roberts Companies.

30. State of California WCAB Minutes of Hearing. Dated: 03/07/17. Employer: The Roberts Companies.

31. DWC/WCAB Amended Application for Adjudication of Claim . Dated: 04/25/17. DOI: 01/26/08. Employer Name and Designation: The Roberts Company - Property Manager. Body Part 1: 100 - Head. Body Part 2: 420 - Back. Body Part 3: 513 - Knee. Body Part 4: Body SMS. Employee sustained injury due to fall, amend to include lumbar spine, weight gain, high blood pressure, hypertension, asthma and sleep dysfunction.

32. State of California WCAB Minutes of Hearing. Dated: 12/21/17. Employer: The Roberts Company.

33. State of California Division of Workers' Compensation Disability Evaluation Unit - Employee Disability Questionnaire.. Dated: 02/22/18. DOI: 2008. Employer: The Robert Companies and Apartment Management.

34. Declaration of Readiness to Proceed. Dated: 03/22/19. Case Number: ADJ8345019; ADJ8345007. Employer: The Roberts Companies.

35. State of California WCAB Minutes of Hearing. Dated: 05/09/19. Employer: The Roberts Co.

36. State of California Division of Workers' Compensation-Medical Unit - QME Appointment Notification Form. Dated: 05/09/19. Employee: Dmitri Boudrine - DOI: 01/26/18. Employer: The Robert's Company.

37. DWC/WCAB Declaration of readiness to proceed.. Dated: 03/24/20. Case Number: ADJ83450l9; ADJ8345007. Employer: The Roberts Company.

38. DWC/WCAB Declaration of readiness to proceed.. Dated: 12/08/20. Case Number: ADJ8345019. Employer: The Roberts Company.

39. State of California WCAB Minutes of Hearing. Dated: 01/04/21. Employer: The Roberts Company.

40. State of California WCAB Minutes of Hearing. Dated: 03/01/21. Employer: The Roberts Company.

41. State of California DWC/WCAB Compromise & Release. Dated: 08/27/21. DOI: 04/28/11-04/11/12. Employer Name and Designation: The Roberts Company - Laborer.

42. DWC/WCAB Declaration of Readiness to Proceed. Dated: 09/27/21. Case Number: ADJ8345019. Employer: The Roberts Company.

43. Unknown Date Job Description. Job Description: Property manager for RHB management company. Frequency of activity required of the employee to perform the job: No squatting, climbing, kneeling, crawling, twisting (waist), power grasping (right and left). Bending (waist), twisting (neck), fine manipulation (right and left), pushing and pulling (right and left), reaching above shoulder (right and left) less than one hour. Standing - one hour per day. Walking, keyboarding, mouse use - 2 hours per day. Bending (neck) - 3 hours per day. Sitting, simple grasping (right and left), reaching below shoulder (right and left) - 4 hours per day. Lifting/carrying - up to 10 lbs less than one hour per day. Driving- requires. Operation of foot controls or repetitive foot movement - requires. Permanent Modified Task List: The following tasks are required patient's light duty position: 1) Meet with prospective tenants to show apartments (both vacant units and units on a 30-day notice), take applications and deposits and

bring the same to the office immediately during business hours. 2) Posts checks and collections and bring the same to the office immediately during business hours. 3) Report every Monday morning between 9:00 a.m. to 10:00 a.m., by calling the Leasing Department, traffic activities (rental, showing, calls) for this building for the last weekend. 4) Serves notices regarding late rents, 3-day notices and rent increases etc. 5) Answers phones, tenant requests and complaints. Maintain tenant relations. 6) Place free advertisements (i.e. on the internet and other places and establishments). 7) Take care of basic/minor maintenance outside the walls of an apartment unit (within the work restrictions i.e., No more than occasionally squatting, kneeling, and ladder climbing. No very prolonged standing and walking on uneven grounds), including light plumbing, electrical, and if possible stoves, refrigerators, dishwashers and air conditioner. 8) Do move-in and move-out reports and forward the same to the Accounting Department. 9) Report and coordinate and schedule with the Maintenance Department for work that he cannot do inside the apartments units due to work restrictions. 10) Report, coordinate and schedule with the Maintenance Department for major repair needs. 11) Monitor cleaning staff. Monitor handymen and outside vendors performing repairs and maintenance on the property. 12) Keep grounds, steps, walkways, garage areas and pool area clean at all times (within the work restrictions). 13) Maintain laundry room facilities (clean dryer vents, empty trash cans etc.) 14) Keep outside lights in working order (within the work restrictions). 15) Water plants/trees around building. Modifications to Accommodate Permanent Work Restrictions: The following tasks have been eliminated from Injured Worker's usual and customary position to accommodate the permanent work restrictions imposed: 1) Patient has been instructed to only perform duties within the work restrictions of no more than occasionally squatting, kneeling and ladder climbing, no very prolonged standing and no prolonged walking on uneven ground. 2) He is not to perform any major repairs what so ever. All duties fall within the lighter duty capacity.

44. Unknown Date Description Of Employee's Job Duties. Job Title: Property Manger. Physical Demands: No sitting, standing, bending (neck), bending (waist), squatting, climbing, kneeling, and lifting 100 plus lbs. Occasionally walking, crawling, and lifting 100 lbs up to 3 hours.

45. 11/02/09 Job Description. Property Manager for RHB Management Company. Duties: Up to 4 hours of sitting, simple grasping right, simple grasping left, reaching below right and left shoulder. Up to 2 hours of walking, keyboarding, mouse use right and left. Standing up to 1 hour. No squatting, climbing, kneeling, crawling, waist twisting, power grasping right and left. Less than 1 hour of waist bending, neck twisting, fine manipulation right, left, pushing and pulling right, left, reaching above right and left

shoulders. Bending of neck up to 3 hours. No lifting or carrying from 11-75 lbs. One hour of lifting or carrying up to 10 lbs. Job requires driving, own vehicle as needed. Job requires operation of foot controls or repetitive foot movement, own vehicle as needed.

46. 07/03/12 Job Description. Employer Job Title: Resident Manager for RHB management. Description of Job Responsibilities: Showing units, fielding inquiries (calls, emails) minor cleaning (i.e. picking up litter or wrappers). Job Requires: No driving cars, forklifts, and other equipment and working around equipment and residency. Walking on uneven ground. No exposure to excessive noise, exposure to extremes to temperature, humidity, or wellness, exposure to dust, gas, flames, or chemicals, working on heights, operation of foot controls or repetitive foot movement, use of special visual or auditory protective equipment, and working with bio-hazards such as sewage and hospital waste etc.

47. Unknown Date Orthopaedic Evaluation. Patient fell down a slippery surface trying to fix the entrance gate. Next day went to UCLA Medical Center, and they ran tests. (Illegible Handwritten Note).

48. Illegible Date Unknown Provider Progress Note. CC: Patient reports he feels somewhat better. Exam: BP: 139/88. WT: 338 lbs. HT: 6"4". HR: 108. RR: 12. Temp: 97.8 degrees F. SpO2: 98. Assessment/Plan: Acute low back pain. Recommended referral to Orthopedic consultation and Physical Therapy.

49. Illegible Date Bert R. Mandelbaum, MD PTP's Progress Report (PR-2). CC: Patient reports left knee postop 02/18/08. He is doing much better at this time. He still has not had any significant therapy. Dx: 1) Left knee ACL injury. 2) Left knee medial meniscal tear. 3) Left knee bone bruise with 2+ edema. Tx plan: Continue postop PT 2-3x/week for 4 weeks. Incompletely rehabilitated knee. He will keep the present program to get fit, lose weight and optimize the overall functional levels. Work Status: RTW/modified duty. Restrictions: Light duty only. He will not be able to stand on his left leg more than 4 hours. F/u in 2 months.

50. Unknown Date Julian Girod, MD PTP's Progress Report (PR-2). CC: Patient presents with left knee pain. He state that he cannot squat. Squatting increases pain. It is tabbing and tingling sensation. Dx: 1) Left knee injury with ligament injury. 2) Status post AVS. Tx plan: Advised to loose weight first until surgery. Recommended weight loss program. Work Status: Deferred to PTP. F/u in 4-6 weeks. (Illegible Handwritten Note)

51. Illegible Date Maria R. Leynes, MD STP's Progress Report (PR-2). (Illegible Handwritten Note).

52. Unknown Date Cedars-Sinai Medical Center Radiology/Diagnostics. Vascular Ultrasound Preliminary Report. Indication: Pain. Impression: Left within normal limits. Right, subacute thrombus was seen in one of the posterior tibial veins. (Illegible Handwritten Note).

53. Unknown Date EDD - Physician's Supplementary Certificate. Patient is still being treated. Current conditions continue to make him disabled are, internal derangement of knee not otherwise specified; lumbosacral neuritis, not otherwise specified; sprain of lumbar region. Conditions prevent him from his duties - severe lower back pain radiating to lower extremities causing numbness and tingling. Current estimated date patient will be able to perform his regular or customary work - 07/17/13. (Illegible Handwritten Note).

54. 07/22/05 Cedars-Sinai Medical Center History and Physical. HPI: Patient presents for right upper quadrant abdominal pain, cholelithiasis on ultrasound. PMH: Cigarette smoker and history of hepatitis. Vitals: BP: 124/84. HR: 72. RR: 16. Temp: 98.2 degrees F. Dx: Cholelithiasis. Tx plan: Patient was scheduled for laparoscopic cholecystectomy.

55. 07/22/05 David E. Fermelia, MD -Cedars-Sinai Medical Center Operative Report. Preop/Postop Dx: Cholelithiasis. Procedure Note: Laparoscopic cholecystectomy with intraoperative cholangiography.

56. 07/22/05 Juan Lechago, MD Laboratory. Surgical Pathology: Specimen: Gallbladder, laparoscopic cholecystectomy. Impression: 1) Chronic cholecystitis, mild. 2) Cholelithiasis, mixed, single.

57. 05/03/07 Avrom Gart, MD - Cedars-Sinai Medical Center Operative Report. Procedure Performed: 1) Lumbar facet syndrome. 2) Lumbar disc herniation. 3) Lumbar radiculitis. Procedure Performed: 1) Bilateral L4-L5 facet injection. 2) Bilateral L5-S1 facet injection. 3) L4-5 lumbar epidural steroid injection. 4) Fluoroscopic imaging. 5) Intraoperative epidurogram.

58. 01/27/08 Santa Monica Orthopedic and Sports Medicine Group, Inc. ED Summary. CC: Left leg injury. HPI: Patient slipped and fell on wet pavement last night and had (illegible) left knee. Currently knee is swollen and more painful. There was no direct trauma to the knee. PMH: Hypertension. Exam: BP: 166/99. HR: 98. RR: 17. Temp: 36.7 degree C. SpO2: 99%. Extremities: Patient has large effusion on his left knee. The knee is stable to stress. He is able to bear weight. He walks but with obvious discomfort. Neuro: Antalgic gait. ED Course: Patient refused knee immobilizer and

crutches. Dx: Knee injury with acute hemarthrosis. Tx plan: Patient needs referral to Orthopedics. Disposition: Discharged. (Illegible Handwritten Note)

59. 01/28/08 Tower Saint John's Imaging Radiology/Diagnostics. MRI of Left Knee. Indication: pain. Impression: 1) Deformity and foreshortening of the posterior horn of the medial meniscus compatible with a bucket handle tear. Anterior horn appears intact. 2) Degenerative tear of the anterior horn of the lateral meniscus. Posterior horn appears intact. 3) Tear of the anterior cruciate ligament. Post cruciate ligament appears intact. 4) Moderate joint effusion. Approximately 1 x 2.5 cm popliteal cyst. 5) Mild partial thickness chondromalacia lateral facet of the patella.

60. 02/11/08 Bert R. Mandelbaum, MD Correspondence. Patient was seen in followup. Once again reviewed the MRI which demonstrates the ACL tear, medial meniscus tear, and bone bruise. Overall, talked about options one, two, and three. Think that arthroscopy with meniscus only management should be appropriate as he has a film coming up in March. Think this is the most efficient way to go. Will ask him to see you in preoperative history and physical.

61. 02/11/08 Bert R. Mandelbaum, MD Correspondence. Seeing patient in followup. MRI: Once again reviewed the MRI, which demonstrates the ACL tear, medial meniscus tear, and bone bruise. Recommendations: Overall, have talked about options one, two, and three. Think that arthroscopy with meniscus only management should be appropriate as he has a film coming up in 03/2008. Think this is the most efficient way to go. Will ask him to see Dr. Solomon in preoperative history and physical.

62. 02/11/08 Bert R. Mandelbaum, MD Progress Note. CC: Patient presents for followup. Assessment/Plan: Once again reviewed the MRI which demonstrates the ACL tear, medial meniscus tear, and bone bruise. Overall, have talked about options one, two, and three. Think that arthroscopy with meniscus only management should be appropriate as he has a film coming up in March. Think this is the most efficient way to go in preoperative history and physical.

63. 02/11/08 Bert R. Mandelbaum, MD PTP's Progress Report (PR-2). CC: Patient complains of left knee pain. He slipped while on a filming set injuring his left knee. Since this time he has had pain that is severe. It is constant. He was seen at UCLA. Dx: 1) Left knee ACL injury. 2) Left knee medial meniscus tear. 3) Left knee bone bruise with 2 + edema. Tx plan: Scheduled arthroscopy medial meniscectomy for now on 02/18/08. Recommended to take ice and crutches. Recommended post op PT 2-3x/week for 4 weeks. Will ask him to see in preoperative history and physical. F/u in 4 weeks.

64. 02/11/08 Bert R. Mandelbaum, MD PTP's Progress Report (PR-2). CC: Patient states he slipped while on a filming set injuring his left knee. Since this time he has had pain that is severe. It is constant. He was seen at UCLA. Dx: 1) Left knee ACL injury. 2) Left knee medical meniscus tear. 3) Left knee bone bruise with 2+ edema. Tx plan: Recommended arthroscopy medial meniscectomy for now; surgery date will be 02/18/08. DME, ice, crutches. Postop physical therapy 2-3x/week x 4 weeks.

65. 02/18/08 Bert R. Mandelbaum, MD - Surgery Center Of The Pacific Procedure Report. Pre-op Dx: 1) Left knee ACL tear. 2) Medial meniscus tear. Procedures Performed: 1) Left knee arthroscopy. 2) Partial medial and lateral meniscectomy. 3) Debridement of articular cartilage defects. Post-op Dx: 1) Left knee ACL tear. 2) Medial and lateral meniscus tears. 3) Articular cartilage defects. 4) Medial femoral condyle, 1x1 grade III. 5) Lateral femoral and tibial condyle, 2x2 cm grade III.

66. 02/22/08 Los Angeles Fire Department Emergency Medical Service Report. (Illegible Handwritten Note)

67. 02/22/08 Nathan J. McNeil, MD - Cedars Sinai Medical Center ED Note. CC: Patient is a 49-year old male who was brought in by paramedics from an auto versus pedestrian who is complaining of right leg, tibia/fibula swelling as well as lacerations of the right side of the face. He had a positive loss of consciousness at the tine of the accident. Apparently he was crossing the street and his wife was able to get out of the way. He was taken to Queen of the Valley Hospital. The paramedics reported that they were able to get pedal pulses. His abdomen was otherwise soft. He was transported secondary to mechanism here and was able to recall his name. He was talking and complaining of right leg and right-sided head pain. He denied any chest discomfort, abdominal pain or shortness of breath. PMH: Otherwise negative except for a recent left knee meniscal arthroscopy (meniscal surgery). Exam: HEENT: Head demonstrates a large, about 10 cm, laceration slightly superior to the left ear with what appears to be some laceration of the temporal artery. Musculoskeletal: Back: The left lower extremity demonstrates a TED hose stocking in place. The right lower extremity shows clear swelling of the tibia/fibula area. The pulse is somewhat difficult to palpate but 1+ dorsalis pedis and posterior tibia. ED Course: Patient was placed on cardiac monitoring, continuous pulse ox and IV was started. Oxygen was administered with saturations of 95%. The trauma Attending, Ali Hahn, MD, will admit he and Tina Mg, MD has relayed that they will admit he to the floor at this time. They have notified Orthopedics and apparently, he does not have any clear signs of compartment syndrome, although he is high risk in the right lower extremity. He has significant soft tissue swelling there and the bone may have already punctured some of the fascia, possibly loosening both the

anterior and lateral compartments and deep compartments. He is currently stable for disposition to the surgical floor. Dx: 1) Blunt head trauma. 2) Scalp laceration. 3) Tibia/fibula fracture of the right lower extremity. 4) Observation for compartment syndrome. Disposition: Admitted to surgery in stable condition.

68. 02/22/08 Justin D. Saliman, MD - Cedars Sinai Medical Center Operative Report. Preop/Postop Dx: 1) Left medial malleolar shear fracture. 2) Right tibia and fibula fracture. Operations Performed: 1) Right tibia intramedullary nailing. 2) Left ankle open reduction and internal fixation.

69. 02/22/08 Tina Ng, MD/Ali Salim, MD - Cedars-Sinai Medical Center Trauma Surgery Consultation. HPI: Patient was brought in by paramedics, and information was obtained by paramedics on him. He was hit by a car. He has palpable pulses and is breathing spontaneously. He was amnestic to the event and lost consciousness. He quickly regained consciousness and had a reported GCS of 15 subsequently. He presented with pain on the right head with obvious laceration and bleeding from the site, as well as right leg pain. Past Surgical Hx: Recent left medial meniscus repair, cholecystectomy and also appendectomy. Exam: BP: 99/56. HR: 91. RR: 27. SpO2: 100%. Impression: 1) Status post auto versus pedestrian. 2) Head laceration. 3) Right tibial-fibular closed fracture. Tx plan: Recommended admission to the floor. Orthopedic surgery has been consulted. The head laceration will be closed at bedside in the emergency room. The leg has already been splinted. The trauma team will follow closely.

70. 02/22/08 Cedars Sinai Medical Center Laboratory. **High** RDW of **17.3**, WBC of **17.3**, RDW of **17.4**, absolute polys of **10.4**, lymphocytes of 6.4 and glucose of 118. **Low** RBC of **3.61**, hemoglobin of **8.1**, hematocrit of **25.0**, MCV of **69.3**, MCH of **22.5**, MPV of **7.3** and potassium of **3.4**. Ethanol, blood of ethanol level of **0.030**.

71. 02/22/08 Ashley M. Wachsman, MD - Cedars Sinai Medical Center Radiology/Diagnostics. CT of Abdomen and Pelvis with Contrast. Indication: Head injury, trauma. Impression: 1) Mild dependent atelectasis both lung bases. 2) Status post cholecystectomy. 3) No CT evidence of visceral or vascular injury in the abdomen or pelvis. 4) Direct inguinal hernia on the right side.

72. 02/22/08 Navid Mehrpoo, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Pelvis. Indication: Injury. Trauma. Findings/Impression: Overlying objects obscure some of the radiographic detail. No definitive evidence of a displaced pelvic fracture or dislocation is shown.

73. 02/22/08 Navid Mehrpoo, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Left Tibia and Fibula. Indication: Trauma. Findings/Impression: Slightly displaced fracture of the medial malleolus is noted. Nondisplaced fracture is seen at the lateral malleolus. Correlation with ankle series is suggested.

74. 02/22/08 Navid Mehrpoo, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Right Tibia and Fibula. Indication: Trauma. Findings/Impression: Comminuted fractures of the mid shaft of the right tibia and fibula are noted with moderate displacement.

75. 02/22/08 Navid Mehrpoo, MD - Cedars-Sinai Medical Imaging Group Radiology/Diagnostics. X-ray of Chest. Indication: Injury. Trauma. Findings/Impression: Overlying objects obscure some of the radiographic detail. There is no evidence of pulmonary consolidation, pleural effusion, pneumothorax or pulmonary vascular congestion. The cardiomediastinal structures and visualized skeleton appear grossly intact.

76. 02/22/08 Navid Mehrpoo, MD - Cedars-Sinai Medical Imaging Group Radiology/Diagnostics. X-ray of Right Knee. Findings/Impression: No evidence of a displaced fracture or dislocation is seen at the right knee. Mild degenerative changes are evident.

77. 02/22/08 Ashley M. Wachsman, MD - Cedars Sinai Medical Center Radiology/Diagnostics. CT of Abdomen and Pelvis. Indication: Head injury, trauma. Impression: 1) Mild dependent atelectasis at both lung bases. 2) Status post cholecystectomy. 3) No CT evidence of visceral or vascular injury in the abdomen or pelvis. 4) Direct inguinal hernia on the right side.

78. 02/22/08 Barry D. Pressman, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Right Tibia and Fibula. Indication: Intraoperative right tibia and fibula fixation, tibia and fibula fracture. Impression: Operative views of placement of tibial fixation; fracture site is not well-evaluated on this examination.

79. 02/23/08 Cedars Sinai Medical Center Laboratory. **High** direct bilirubin of **0.4**, indirect bilirubin of **0.8**, AST of **57**, ALT of **65**, WBC of **14.4**, RDW of **20.7**, ProTime of **15.8**, INR of **1.5**, PTT of **106**, and glucose of **128**. **Low** serum calcium of **7.9**, total protein of **4.5**, albumin of **2.6**, free calcium of **1.07**, RBC **3.54**, hemoglobin of **8.6**, hematocrit of **25.6**, MCV of **72.2**, and MCH of **24.2**. Peripheral blood culture showed no growth. Urinalysis showed high specific gravity of 1.030.

80. 02/23/08 Cindy E. Kallman, MD - Cedars Sinai Medical Center Radiology/Diagnostics. CT of Abdomen and Pelvis without Contrast. Indication: Evaluation for intra-abdominal

hemorrhage. Trauma. Impression: No evidence for intra-abdominal hemorrhage or fluid collection.

81. 02/23/08 Willis Wagner, MD - Cedars-Sinai Medical Imaging Group Radiology/Diagnostics. Vascular Leg Vein Duplex DVT Bilateral. Indication: Pain in limb. Impression: Right: Imaging revealed patency of the deep venous system of the lower extremity without evidence of thrombosis. The peroneal veins were not well visualized due to edema, however they did not appear dilated as would be seen with an acute deep venous thrombus. Doppler: A normal phasic Doppler signal is noted in the common femoral vein. There is no evidence of iliac obstruction. Left: Imaging: Subacute thrombus was seen in one of the paired posterior tibial veins. The tip of the thrombus was seen in the upper calf. The remainder of the deep venous system is patent and without evidence of thrombus. The peroneal veins were not well visualized due to edema, however they did not appear dated as would be seen with an acute deep venous thrombus. Doppler: A normal phasic Doppler signal is noted in the common femoral vein. There is no evidence of iliac obstruction.

82. 02/23/08 Cindy E. Kallman, MD - Cedars-Sinai Medical Center Radiology/Diagnostics. CT Scan of Chest, Pulmonary Artery Angiogram with IV Contrast. Indication: Post trauma with lower extremity fractures. Pulmonary embolism, fat embolism. Impression: Multiple right-sided pulmonary emboli. Findings have been discussed with the covering surgical service.

83. 02/23/08 Daniel Lee, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Chest. Indication: Trauma. Comparison: 02/22/08. Findings/Impression: This is a limited portable examination with the left costophrenic angle cut off from the field of view. The remainder of the lungs are grossly unremarkable. No evidence for pneumothorax or infiltrates. Heart is normal in size. Visualized osseous structures are intact. No right pleural effusion identified.

84. 02/24/08 Cedars Sinai Medical Center Laboratory. **High** PTT of **75**, WBC of **12.2**, platelet count of **146000**, WBC of **12.2**, RDW of **20.6**, glucose of **112**, patient protime of **14.3**, creatine kinase of **715**, INR of **1.4**, absolute polys of **8.5**, absolute monocytes of **1.2** and absolute eosinophils of **0.4**. **Low** RBC of **3.17**, hemoglobin of **7.8**, hematocrit of **23.5**, MCV of **73.9**, MCH of **24.4**, serum calcium of **7.7**, potassium of **3.4**, phosphorus of **2.3** and free calcium of **1.09**.

85. 02/24/08 Navid Mehrpoo, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Left Tibia and Fibula. Indication: Trauma. Impression: Slightly displaced fracture of the medial malleolus is noted. Non-displaced fracture is seen at the lateral malleolus. Correlation with ankle series is suggested.

86. 02/24/08 Navid Mehrpoo, MD - Cedars Sinai Medical Center Radiology/Diagnostics. CT of Cervical Spine without Contrast. Indication: Trauma. Impression: 1) No CT evidence of acute fractures or subluxation. 2) No hemorrhage is seen within the spinal canal. 3) These findings were communicated to the surgical resident Dr. Ng.

87. 02/24/08 Navid Mehrpoo, MD - Cedars Sinai Medical Center Radiology/Diagnostics. CT of Brain without Contrast. Indication: Trauma. Impression: 1) No CT evidence of acute fracture, hemorrhage, or mass. 2) Extensive right-sided scalp laceration. 3) Fluid in the left maxillary sinus, and mucoperiosteal thickening of the right maxillary sinus. 4) A CT of the face may be of benefit if a facial fracture is suspected clinically.

88. 02/25/08 Illegible Medical Provider Progress Note. (Illegible Handwritten Note)

89. 02/25/08 Cedars Sinai Medical Center Laboratory. **High** WBC of **15.5**, RDW of **22.8**, PTT of **92**, glucose of **119**, monocytes absolute of **0.9**, eosinophils absolute of **0.4**, absolute polys of **8.2**, and basophils absolute of **0.2**. **Low** RBC of **3.29**, hemoglobin of **8.3**, hematocrit of **24.8**, MCV of **75.2**, MCH of **25.3**, calcium of **8.0**, platelet count of **146000**, free calcium of **1.11**, and absolute monocytes of **1.1**.

90. 02/25/08 Rick Sukov, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Left Ankle. Indication: Trauma. Impression: Soft tissue swelling and a nondisplaced bimalleolar fracture.

91. 02/25/08 Rick Sukov, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Chest. Indication: Cardiopulmonary evaluation. Impression: Interval development of bilateral mid-lung zone subsegmental atelectasis.

92. 02/25/08 Richard J. Van Allan, MD - Cedars Sinai Medical Center Radiology/Diagnostics. IR IVC Filter Placement. Indication: Right leg tibial DVT with trauma with multiple lower extremity fractures and post-operative day #3 status post open reduction and internal fixation of left ankle fracture and intra-medullary rod placement of right ankle as a contraindication to anticoagulation. Impression: Successful uncomplicated fluoroscopy-guided placement of a retrievable Cook-Tulip inferior vena cave filter. Although this filler is approved for permanent use. If it is no longer indicated within 60 days of placement removal can be scheduled with the interventional radiography service at 310-423-4125.

93. 02/26/08 Illegible Medical Provider Progress Note. (Illegible Hand Written Note)

94. 02/26/08 Cedars Sinai Medical Center Laboratory. **High** RDW of **23.2**, monocytes absolute of **1.2**, absolute eosinophils of **0.4**, and WBC of **11.2.** **Low** RBC of **3.21**, hemoglobin of **7.9**, hematocrit of **24.2**, MCV of **75.4**, MCH of **24.8**, and calcium of **8.1**. MRSA screen - Negative.

95. 02/26/08 Cedars Sinai Medical Center Laboratory. **High** RDW of **23.2**, absolute monocytes of **1.2**, and absolute eosinophils of **0.4**. **Low** RBC of **3.21**, hemoglobin of **7.9**, hematocrit of **24.2**, MCV of **75.4**, and MCH of **24.8**.

96. 02/27/08 Illegible Medical Provider Progress Note. (Illegible Handwritten Note).

97. 02/27/08 Cedars Sinai Medical Center Laboratory. **High** WBC of **13.6**, and RDW of **23.6. Low** RBC of **3.42**, hemoglobin of **8.6**, hematocrit of **25.8**, MCV of **75.4**, and MCH of **25.3.**

98. 02/27/08 Cedars Sinai Medical Center Laboratory. **High** WBC of **13.6** and RDW of **23.6**. **Low** RBC of **3.42**, hemoglobin **8.6**, hematocrit of **25.8**, MCV of **75.4**, and MCH of **25.3**.

99. 02/28/08 Shirley Chi, MD/Srikanth S. Rao, DO - Cedars Sinai Medical Center Consultation. CC: Patient was unfortunately struck by a car on 02/22/08. He lost consciousness during the event and does not recall being hit by the car. His last recollection is getting into a car with his wife and his first recollection after the accident is being taken to the hospital by paramedics. In the emergency department, he was found to have a right comminuted fracture of the mid shaft of the tibia and fibula, as well as left bimalleolar fractures. As a result, he was taken to the operating room on 02/22/08 for intramedullary nailing of the right tibiofibular fracture and ORIIF of the left bimalleolar fracture. Postoperatively, he developed sudden tachycardia and a CT chest angiogram was performed which displayed evidence of pulmonary embolism. A bilateral lower extremity Doppler displayed a deep venous thrombosis in the left posterior tibia. As a result, he was started on a heparin drip, however, unfortunately, while on heparin drip, he evidenced acute bleeding and needed multiple transfusions. As a result, heparin drip was stopped and an IVC filter was placed on 02/25/08. He is currently on prophylactic doses of Fragmin. He was subsequently transferred to the floor on 02/27/08 after stabilization and patient is currently being evaluated for comprehensive rehabilitation and consideration of transfer to the acute rehabilitation unit. PMH: Hypertension. Past Surgical Hx: Left meniscal repair. Meds: Polysporin, Fragmin 5000 units subcutaneous daily, and Zantac 150mg oral BID. Vitals: BP: 130/70. HR: 92. RR: 20. Temp: 98.8 degrees F. Dx: 1) Mild traumatic brain injury secondary to pedestrian versus auto accident. 2) Right tibiofibular fracture, status post intramedullary nailing on 02/22/08. 3) Left bimalleolar fracture, status post open reduction and internal fixation on 02/22/08. 4) Pulmonary embolus, currently not on therapeutic anticoagulation due to acute bleeding with anticoagulation. 5) Left lower extremity deep venous thrombosis, status post inferior vena cava filter placement, 02/25/08. Tx plan: Continue with supportive care. Recommend air-flow mattress to prevent any skim breakdown, turn patient Q2 hours while in bed, continue with Fragmin for DVT prophylaxis, as well as ranitidine for GI prophylaxis. Incentive spirometry as

able. 3) Out of bed to chair for all meals as able. 4) Progressive mobilization, with physical therapy for bed mobility, transfers and wheelchair training, as well as occupational therapy for bed and wheelchair-level activities of daily living. 5) Given patient's hypoalbuminemia, may consider nutrition evaluation to optimize patient's nutritional intake, to optimize wound healing. Currently too low level functionally for ARC level of care. If function improves and able to tolerate three hours of acute level therapies, he may be a candidate in that instance.

100. 02/28/08 Illegible Medical Provider Progress Note. (Illegible Handwritten Note)

101. 02/28/08 Cedars-Sinai Medical Center Laboratory. **High** WBC of **14.1** and RDW of **23.7**. **Low** RBC of **3.76**, hemoglobin of **9.4**, hematocrit of **28.9**, MCV of **77.0** and MCH of **25.0**. MRSA Screen. Source: Nasal. Result: No methicillin resistant Staphylococcus aureus isolated, cultured and examined for this organism only.

102. 02/28/08 E. James Tourje, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Left Ankle. Indication: Trauma, postoperative. Comparison: 02/22/08. Findings/Impression: Metallic plate and multiple screws are seen fixing distal tibial fracture. One of the screws extends into the distal fibula. The ankle mortis is normally aligned on this study. Distal fibular fracture is still identified. Medial malleolus is now well aligned.

103. 02/28/08 E. James Tourje, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Right Tibia and Fibula. Indication: Trauma. Findings/Impression: Intramedullary rod is in place fixing a fracture of the tibia in good alignment. Fracture fragments seen protecting anteriorly. Soft tissue swelling anterior is noted. Fractures of the fibula are seen in several locations. Intramedullary rod is fixed proximally by two screws and distally with two screws.

104. 03/04/08 Illegible Medical Provider Progress Note. (Illegible Handwritten Note).

105. 03/04/08 Franklin Westhout, MD/Ali Salim, MD - Cedars Sinai Medical Center Discharge Summary. (Date of Admission: 02/22/08) Hospital Course: Patient was brought in by paramedics after sustaining an auto-versus-pedestrian accident. He came in complaining of right leg pain and also had tibiofibular swelling as well as lacerations on the right side of the face. Of note is that patient just had received left knee surgery. Apparently patient was crossing the street, and his wife had been able to get out of the way but he was hit by a car. He was taken to Queen of the Valley Hospital and subsequently was then transferred to Cedars-Sinai for a higher level of care. His right leg was reduced in the ER, imaging obtained showed comminuted fractures of the midshaft of the right tibia and fibula with moderate displacement. CT of the C-spine

was negative. He was taken to the OR by Dr. Justin Saliman for open reduction and internal fixation. He tolerated the procedure well and was transferred to the ICU in stable condition. His ICU course was further complicated by the development of deep vein thrombosis for which he then underwent an IVC filter placement. Discovered a PE on the following day, on 02/23/08. As such, he then had an IVC filter placed on 02/25/08. Unfortunately, this patient has now become non weightbearing in both lower extremities due to the fact of the previous knee surgery and the latest above mentioned open reduction and internal fixation of the right tibia and fibula. He progressed appreciably and was transferred to the floor. An acute rehab consult was obtained. He was too low level due to his non weightbearing status in both extremities. As such, he cannot be started in acute rehab at this time. Patient will, more than likely, receive weightbearing status in his left extremity on the 03/07/08. There are no surgical orthopedic interventions to be done at this time. Discharge Medications: Discharge home on Fragmin. Home health nurse will administer dose injections. Also discharge home on Vicodin. Disposition: On 03/04/08, patient is ready for discharge home. Will receive home health aid nurse to assist with ADL.

106. 03/07/08 Justin D. Saliman, MD - Cedars-Sinai Medical Center Office Visit. CC: Patient presents status post left ankle ORIF and right tibia IM nailing 2 weeks ago. He was discharged from the hospital last week and was sent home with six hours of assistance and, apparently, no physical therapy. He has been non-weightbearing bilateral lower extremities. He states that his pain is well controlled but he is having difficulties with activities of daily living, as he has no one nearby to assist him except for his girlfriend whom 10 unavailable for most of the day. Assessment/Plan: Patient is 2 weeks status post left ankle ORIF and right tibia IM nailing, complicated by postoperative DVT and likely pulmonary embolism as well as low hematocrit. He stabilized during his stay in the hospital and was discharged last week. He has been taking Fragmin subcutaneous since discharge. Will advance his weightbearing to weightbear as tolerated on the right lower extremity and maintain non-weightbearing on the left lower extremity. Taught him how to use a standard walker this day, however, will send him home in a wheelchair with a prescription for physical therapy three times a week at his home, and a standard walker, which he can pick up at Lerman & Sons. Advised that he not begin weightbearing on his right leg by himself until he has had time to work with a therapist to regain his balance. If he is unable to do this in the next several days, he may return to a rehab facility, which believed is appropriate given his lack of help at home. Asked him to call over the weekend and at any time with any significant problems that he may encounter. He will otherwise followup in 3 weeks for repeat examination and evaluation.

107. 03/07/08 Justin D. Saliman, MD - Cedars-Sinai Medical Center Progress Note. CC: Patient presents status post left ankle ORIF and right tibia IM nailing 2 weeks ago. He was discharged from the hospital last week and was sent home with 6 hours of assistance and apparently, no physical therapy. He has been non-weightbearing on bilateral lower extremities. He states that his pain is well controlled, but he is having difficulties with activities of daily living, as he has no one nearby to assist him except for his girlfriend whom is unavailable for most of the day. Assessment/Plan: Two weeks status post left ankle ORIF and right tibia IM nailing, complicated by postoperative DVT and likely pulmonary embolism as well as low hematocrit. He was stabilized during his stay in the hospital and was discharged last week. Will advance his weightbearing to weight-bear as tolerated on the right lower extremity and maintain non-weightbearing on the left lower extremity. Taught him how to use a standard walker currently, however, will send him home in a wheelchair with a prescription for physical therapy 3 times a week at his borne, and a standard walker, which he can pick up at Lernan and Sons. Advised that he not begin weightbearing on his right leg by himself until he has had time to work with a therapist to regain his balance. If he is unable to do this in the next several days, he may return to a rehab facility, which believe is appropriate given his lack of help at home. Asked him to call over the weekend and at any time with any significant problems that he may encounter. He will otherwise followup in 3 weeks for repeat examination and evaluation.

108. 03/07/08 Cedars-Sinai Medical Center Radiology/Diagnostics. X-ray of Right Tibia and Fibula. Indication: History of fracture. Impression: Hardware through a tibial fracture with two fibular fractures, near anatomic alignment is seen.

109. 03/07/08 Cedars-Sinai Medical Center Radiology/Diagnostics. X-ray of Left Ankle. Indication: Postoperative evaluation. Findings: The bony detail is obscured by cast. Medial plate and screws through a distal tibial fracture is present. There is also a single screw through the tibial plafond. A distal fibular fracture cannot be excluded as well. There is near anatomic alignment seen.

110. 03/20/08 Justin D. Saliman, MD - Cedars-Sinai Medical Center Progress Note. CC: Patient presents for followup one month status post right tibia intermedullary nailing and left ankle open reduction internal fixation. He has been weightbearing as tolerated on the right and non-weight bearing on the left, which is casted. He is, as of late, doing well with home physical therapy three times a week and six-hour-per-day aid. He states that he is unable to walk long distances secondary to fatigue, but short distances do not hurt his right leg. Assessment/Plan: One month status post right tibial intramuscular nailing and left ankle open reduction internal fixation, doing well. Will advance him to

weight bear as tolerated, bilateral lower extremities, with the left ankle in a CAM walker. Will also schedule him for outpatient small open procedure to remove the spike of bone that is projecting anteriorly to prevent heterotopic ossification into the anterior compartment musculature. Extensively discussed the risks, benefits and alternatives of this procedure with patient and he requested to proceed. He will be scheduled one week from Friday, following medical clearance.

111. 03/20/08 Justin D. Saliman, MD - Cedars-Sinai Medical Center Progress Note. CC: Patient presents for followup one month status post right tibia intramedullary nailing and left ankle open reduction internal fixation. He has been weightbearing as tolerated on the right and non-weightbearing on the left, which is casted. He is as of late, doing well with home physical therapy 3 times a week and 6-hour-per-day aid. He states that he is unable to walk long distances secondary to fatigue, but short distances do not hurt his right leg. Assessment/Plan: One month status post right tibial intramuscular nailing and left ankle open reduction internal fixation, doing well. Will advance him to weight bear as tolerated on bilateral lower extremities, with the left ankle in a CAN walker. Will also schedule him for outpatient small open procedure to remove the spike of bone that is projecting anteriorly to prevent heterotopic ossification into the anterior compartment musculature. Extensively discussed the risks, benefits and alternatives of this procedure with him and he requested to proceed. He will be scheduled one week from Friday, following medical clearance.

112. 03/24/08 Norman Solomon, MD History and Physical. HPI: Patient came in for a preoperative consultation regarding an upcoming surgery. He is scheduled to have some debridement of his right tibia to be done by Dr. Jay Saliman at Cedar Sinai on Friday the 28th. He has been previously known and was cleared preoperatively for a knee surgery done by Dr. Mandelbaum for a meniscal issue back in 02/2008. At that point, he was deemed a low risk for surgery. Since that time, he was hit in a crosswalk by car. He apparently had a right tibial fracture as well as a left ankle fracture, and he had what sounds like a pin and plate placed in each leg. He is currently wearing a boot on his left ankle. According to his wife, he was in the intensive care unit for 11 days and had head trauma and there are obvious signs of that with a scar around his right ear. It was completely evaluated in the ER. He was unhappy with the care he received at Cedars. There was a Dr. Ali who sounds like he had evaluated him at same point and apparently did not diagnose the ankle fracture in his left leg which upset him. He apparently developed blood clots in his legs and a pulmonary embolus. He has been on Lovenox since he was discharged from the hospital. It is unclear what the dosage is because he says he was running out and his doctor told him when he was up and walking he did not need to take it anymore. His wife said that they put a filter in

through his neck for the blood clots. He had previously had a history of leukocytosis which had been evaluated by hematology a number of years ago. He had a history of prostadynia which had been evaluated by numerous physicians without any clearcut etiology. He has had borderline blood pressures that have not been treated with medication. Pain is rated 5/10. PSH: Gallbladder surgery, tibial plateau surgery. Exam: BP: 122/82. WT: 255 lbs. HT: 6'4". HR: 80. RR: 16. Temp: 99.1 degrees F. Dx: 1) Status post right tibial fracture. 2) Status post left ankle fracture. 3) By history, deep venous thrombosis and possibly pulmonary. 4) Meralgia paresthetica by history. Tx plan: Prescribed Neurontin. Ordered labs. F/u in 24 hours.

113. 03/24/08 Unknown Medical Provider Laboratory. **High** RDW of **19.0**, monocytes % of **10.1** and BUN of **26**. **Low** hemoglobin of **12.9**, hematocrit of **38.0**, MCV of **72.9** and MCH of **23.6**.

114. 03/24/08 Westside Health Center Radiology/Diagnostics. ECG. Impression: 1) Sinus rhythm. 2) Within normal limits.

115. 03/28/08 Justin D. Saliman, MD - Cedars-Sinai Medical Center Operative Report. Pre-Op/Post-Op Dx: Right tibia superficial bone shard. Procedures Performed: Right tibia excision of displaced superficial tibial bone shard.

116. 03/28/08 Cedars-Sinai Medical Center Laboratory. Surgical Pathology. Specimen: Right tibial bone, excision. Impression: Bone with focal osteoblastic activity.

117. 03/31/08 Cedars-Sinai Medical Center Radiology/Diagnostics. X-ray of Left Ankle. Indication: Followup. Comparison: 03/20/08. Impression: Hardware through the distal tibia and a distal fibular fracture is seen, there is near anatomic alignment without significant change.

118. 03/31/08 Cedars-Sinai Medical Center Radiology/Diagnostics. X-ray of Right Tibia and Fibula. Indication: Followup. Comparison: 03/20/08. Impression: Intramedullary rod through a tibial fracture and two mid fibular fractures are seen with evidence of healing, there is near anatomic alignment present.

119. 04/21/08 Justin D. Saliman, MD - Cedars-Sinai Medical Center Post-Operative Visit. CC: Patient presents for standard followup status post right tibia IM nailing and left ankle open reduction internal fixation on 02/22/08. He states that his right leg still aches from time to time, but he has been ambulating without crutches. He is using simply a cane at this time. He is also complaining of some anterior thigh pain and paresthesias bilaterally. His left knee is being followed by Dr. Mandal on status post a knee arthroscopy a couple of days he was struck by the vehicle. Assessment/Plan: Advised Dmitri to continue taking it easy on his right lower extremity and using the cane in his

contralateral band while weightbearing on that extremity. There is callous formation and it appears that he is doing well. Will send him to Dr. Avrom Gart for evaluation of his bilateral anterior thigh pain and paresthesias. He has a history of low back problems and has had injections from Dr. Gart in the past. Will also send Dmitri again for physical therapy as he has been having a hard time finding a therapist that can see him in a timely manner. F/u with examiner in 4 weeks for repeat examination, evaluation and x-rays.

120. 04/22/08 Hany M. Nasr, MD/Avrom Gart, MD - Institute For Spinal Disorders Progress Note. CC: Patient presents in the clinic, with Dr. Gart, for followup regarding his lower back pain. He had 2 surgeries in both lower extremities. He has been complaining recently of increasing pain shooting down from the lower back to the bilateral lower extremities, at the front of the thighs, aggravated while he was hospitalized for his surgery. He presents now for increasing pain, for further recommendation and evaluation. He has an old MRI study, which is not available at the time of the exam. He has prescription to do MRI, but he did not do it, so he does not have it done so far. He is here now for further recommendation and assessment, for followup. Impression: Lumbosacral degenerative disc disease, lumbosacral radiculitis. Tx plan: At this time, Dr. Gart and examiner discussed with him the plan of care. He should obtain the new MRI study of the lumbar spine to further evaluate his condition. He was given a prescription. He is to follow up, after having the study done, for further recommendation to follow.

121. 04/24/08 Laboratory. **High** WBC of **11.6,** RDW of **16.1,** glucose of **107,** alkaline phosphatase of **107. Low** hemoglobin of **13.3,** hematocrit of **41.3**, MCV of **69.8,** MCH of **22.5.**

122. 04/28/08 Richard J. Allan, MD - Cedars-Sinai Medical Center Radiology/Diagnostics. Ultrasound and Fluoroscopy-Guide Inferior Vena Cavogram and Percutaneous Retrieval of Intravascular Foreign Body. Indication: Status post orthopedic procedures for lower extremity fractures and now a candidate for anticoagulation for lower extremity deep vein thrombosis no longer requiring IVC filtration. Impression: Successful, uncomplicated, image-guided percutaneous retrieval of Cook-Tulip IVC filter performed.

123. 05/05/08 Bert R. Mandelbaum, MD PTP's Progress Report (PR-2). CC: Patient complains of left knee. He was involved in car motor vehicle accident sustaining left tibial fracture and right pilon fracture ORIF. Dx: 1) Left knee ACL injury. 2) Left knee medial meniscus tear. 3) Left knee bone bruise with 2+ edema. Tx Plan: Recommended postop physical therapy 2-3x4 incompletely rehabilitated knee. F/u in 6 weeks.

124. 05/06/08 Bert R. Mandelbaum, MD - Santa Monica Orthopedic and Sports Medicine Group PTP's Progress Report (PR-2). CC: Patient presents for followup. No generalized complaints of significant pain, only stiffness and soreness. He was involved in a motor vehicle accident sustaining left tibial fracture and right pilon fracture. ORIF at Cedar Sinai. Dx: 1) Left knee ACL injury. 2) Left knee medial meniscus tear. 3) Left knee bone bruise with 2+ edema. Tx Plan: Postop physical therapy 2-3 x4 - incompletely rehabilitated knee. Work Status: Off work. F/u in 6 weeks.

125. 05/08/08 Bert R. Mandelbaum, MD PTP's Progress Report (PR-2). CC: Patient reports left knee postop 02/18/08. No generalized complaints of significant pain, only stiffness & soreness. He was involved in a motor vehicle accident sustaining left tibial fracture and right pilon fracture. ORIF at Cedar Sinai. Dx: 1) Left knee ACL injury. 2) Left knee medial meniscal tear. 3) Left knee bone bruise with 2+ edema. Tx plan: Continue postop PT 2-3x/week for 4 weeks. Incompletely rehabilitated knee. Work Status: Off work. F/u in 6 weeks.

126. 05/14/08 Justin D. Saliman, MD - Cedars Sinai Medical Center Post-Operative Progress Note. CC: Patient presents for f/u. He is doing well and ambulating without assistive devices. He states he still has some mild-to-moderate discomfort in the right lower extremity at the knee and the mid-shaft regions. He states he has gained a significant amount of weight over the last several weeks and he is asking what activities he can resume to help him lose the weight. His left ankle is doing well, without any symptoms. Assessment/Plan: Patient is doing well, status post right tibia and left ankle open reduction internal fixation. He is seeing Dr. Gart to discuss ways to improve his rehabilitation. Asked him to concentrate on ambulating with a normal gait. Also released him to begin swimming, biking and non-impact-type activities to help him get himself back into shape.

127. 05/14/08 Justin D. Saliman, MD - Cedars Sinai Medical Center Progress Note. CC: Patient presents for followup. He is doing well and ambulating without assistive devices. He states he still has some mild-to-moderate discomfort in the right lower extremity at the knee and the mid-shaft regions. He states he has gained a significant amount of weight over the last several weeks and he is asking what activities he can resume to help him lose the weight. His left ankle is doing well, without any symptoms. Assessment/Plan: Doing well status post right tibia and left ankle open reduction internal fixation. He is seeing Dr. Gart on 05/15/08 to discuss ways to improve his rehabilitation. Asked him to concentrate on ambulating with a normal gait. Also released him to begin swimming, biking and non-impact-type activities to help him get himself back into shape.

128. 05/14/08 Thomas Learch, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Right Tibia and Fibula. Indication: Fracture. Comparison: 04/21/08. Impression: Progressive healing of comminuted diaphyseal fractures of the right tibia/fibula with some callus formation.

129. 05/14/08 Katherine M. Haker, MD - Cedars Sinai Medical Center Radiology/Diagnostics. CT of Chest without Contrast. Indication: Carcinoid. Comparison: 12/11/07. Impression: 1) Small cystic lesion in the medial aspect of the right upper lobe. 2) Small subcutaneous nodule in the anterior upper chest which is unchanged. 3) Small low density liver lesion which may be a cyst and is unchanged.

130. 05/14/08 Thomas Learch, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Left Ankle. Indication: Left ankle surgery. Comparison: 04/21/08. Impression: Healing medial malleolar fracture with stable hardware positioning.

131. 05/19/08 Hany M. Nasr, MD/Avrom Gart, MD - Cedars-Sinai Medical Center Progress Note. CC: Patient presents with Dr. Gart for followup of his lower back pain and bilateral lower extremity pain. He had an MRI study done of the lumbar spine and is here for further evaluation and assessment. He continues to experience pain at the lower back, occasionally shooting down to the bilateral lower extremities at the side of his leg all the way down to the foot, right more than left. Impression: 1) Lumbosacral radiculitis. 2) Lumbar degenerative disc disease. Tx plan: At this time Dr. Gart and examiner discussed his plan of care. He is to continue his home regimen/program. He is to continue to try to lose weight because this is going to help his pain. He is to continue over-the- counter medications as needed for his pain control. F/u in 4-6 weeks for further recommendations.

132. 05/19/08 Hany M. Nasr, MD/Avrom Gart, MD - Cedars Sinai Medical Center Progress Note. CC: Patient presents for followup of his lower back pain and bilateral lower extremity pain. He had an MRI study done of the lumbar spine and is here for further evaluation and assessment. He continues to experience pain at the lower back, occasionally shooting down to the bilateral lower extremities at the side of his leg all the way down to the foot, right more than left. Impression: 1) Lumbosacral radiculitis. 2) Lumbar degenerative disc disease. Tx plan: At this time Dr. Gart and myself discussed his plan of care. He is to continue his home regimen/program. He to continue to try to lose weight because this is going to help his pain. He is to continue over-the- counter medications as needed for his pain control. He is to followup with us in 4-6 weeks for further recommendations.

133. 06/12/08 Justin D. Saliman, MD - Cedars Sinai Medical Center Progress Note. CC: Patient presents for followup. He is complaining of inability to dorsiflex his left foot to

the same degree as he can dorsiflex his right foot. He also states that he has some aching over the lateral aspect of his ankle that is more profound in the morning on first getting out of bed. He has been ambulating without assistive device and states that he has gained 30 lbs as of late. Assessment/Plan: Patient is status post significant trauma to his bilateral lower extremities requiring tibial nail and an open reduction internal fixation (ORIF) to the left ankle. He continues to do physical therapy and rehab. Thinks he will continue to make gains as time goes by. He is requesting anything that can be done to increase his dorsiflexion on the left ankle, so will prescribe him a Dyna splint for dorsiflexion, will also send him for more physical therapy especially for gait training. He will follow up in 2-3 months for repeat examination and evaluation.

134. 06/23/08 Hany M. Nasr, MD/Avron Gart, MD Progress Note. CC: Patient in the clinic with Dr. Gart for follow-up of lower back and bilateral lower extremity pain. He is to start a course of physical therapy with a weight loss program. He continues to experience some pain, although he is improving at a slower rate than he expected. He had multiple trauma to the bilateral lower extremities as a result of an MVA. He is here for further recommendations and assessment. Dx: 1) Lumbosacral radiculitis. 2) Lumbar degenerative disc disease. 3) Status post open reduction, internal fixation of left knee. 4) Status post left knee arthroscopic surgery for meniscal repair. Recommendations: At this time, Dr. Gart and examiner discussed with patient the plan of care. He is to be start an aggressive course of physical therapy to help get patient back in shape improving range of motion, lumbosacral stabilization, strengthening of the core muscles, core strengthening, use of modalities as needed to control patient's pain and symptoms, and a stretching program. At the same time, patient is to contact his orthopedic surgeon to fax a prescription regarding his knee diagnosis and PT prescription. F/u in 4-6 weeks with further recommendations to follow.

135. 07/16/08 West Side Spine and Joint Rehab Physical Therapy Initial Evaluation. CC: Patient presents for PT. Dx: 1) Lumbar degenerative disc disease. 2) Myalgia paresthesia. 3) Status post left ankle ORIF and right ankle nailing. Tx plan: Recommended PT of x2/week for 4 weeks.

136. 07/17/08 Bert R. Mandelbaum, MD Correspondence. Patient are seeing back now 02/18/08 after his left knee arthroscopy where we had an ACL tear, partial medial and lateral meniscectomies. His situation was complicated by the fact that he did have his motor vehicle accident and ORIF of the his right pylon fracture and his left tibia fracture. He has also gained about 60 lbs. He presently is in physical therapy and is swimming and biking on a daily basis in a very good amount. Overall, our plan is to continue just

this program. Think in the next few months he will continue to get fit, lose weight, and optimize his overall functional levels. Will check him back in two months time.

137. 07/17/08 Bert R. Mandelbaum, MD PTP's Progress Report (PR-2). CC: Patient presents for followup. His situation was complicated by the fact that he did have his motor vehicle accident and ORIF for right pylon fracture and left tibia fracture at Cedar Sinai. He has gained 60 lbs. Currently, he is in physical therapy and is swimming and biking on a daily basis. Dx: 1) Left knee ACL injury. 2) Left knee medial meniscus tear. 3) Left knee bone bruise with 2+ edema. Tx plan: Recommended postop physical therapy. Work Status: Off work until 08/21/08. F/u in 2 months.

138. 07/21/08 Work Status Report. Work Status: Full duty.

139. 08/29/08 Bert R. Mandelbaum, MD - Santa Monica Orthopedic and Sports Medicine Group Knee Arthroscopy Postoperative Note. CC: Patient presents for followup. He has only stiffness and soreness. He is currently taking appropriate and usual pain medicines and anti-inflammatories. Dx: Incompletely rehabilitated knee. Tx plan: Recommended to stationary biking, strengthening exercises, and sports progression. F/u in 3 months.

140. 09/09/08 Gail M. Schlesinger, MD - Medical Diagnostic Associates, A Medical Corporation Radiology/Diagnostics. MRI of Left Knee. Impression: 1) Scarring identified within Hoffa's fat pad compatible with patient's history of previous surgery. 2) Abnormal appearance to the posterior horn of the medial meniscus as well as the anterior horn of the lateral meniscus possibly reflecting previous partial meniscectomies. Correlation with his previous operative report for the extent and nature of his previous surgery may be helpful for further evaluation. 3) Likely tear of the anterior cruciate ligament. 4) Mild medial compartment degenerative changes.

141. 10/03/08 Bert R. Mandelbaum, MD PTP's Progress Report (PR-2). CC: Patient presents for followup. He is doing much better at this time, rehabilitating well. Dx: 1) Left knee ACL injury. 2) Left knee medial meniscus tear. 3) Left knee bone bruise with 2+ edema. Tx Plan: Advised to continue PT. Work Status: RTW/modified duty. Restrictions: Light duty only this will includes taking parts, no action roles. He will not be able to stand on his left leg more than four hours. F/u in 2 months.

142. 10/03/08 Bert R. Mandelbaum, MD PTP's Progress Report (PR-2). CC: Patient presents for left knee. He is post op on 02/18/08. He is doing much better at this time and rehabilitating well. Dx: 1) Left knee ACL (acromioclavicular ligament) injury. 2) Left knee medial meniscus tear. 3) Left knee bone bruise with 2+ edema. Tx plan: Continue postop PT 2-3 x/week x4 weeks. Incompletely rehabilitated knee. He will keep the preset program to get fit, lose weight and optimize his overall functional levels. Work

Status: RTW/modified duty. Restrictions: Include taking parts, no action roles. He will not be able to stand on his left leg more than 4 hours. F/u in 2 months.

143. 10/06/08 Li-Der Chen, PT - Orthopedic Physical Therapy Associates PT Initial Evaluation. CC: Patient c/o pain and stiffness in both ankles, right more than left. He is status post right ankle ORIF. He presents both ankles ROM lost with stiffness for ADL functions. Aggravated by walking, loading, stairs. Eased by rest. Dx: 1) Cervical spine DDD. 2) Status post right ankle ORIF. Tx plan: Recommended PT. (Illegible Handwritten Note)

144. 11/06/08 Michon Halio, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Left Ankle. Indication: Followup left ankle fracture. Comparison: 06/12/08. Impression: Status post ORIF distal left tibia. Stable interval appearance since the prior study 06/12/08.

145. 11/06/08 Michon Halio, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Right Tibia and Fibula. Comparison: 06/12/08. Impression: Healing fractures of the right tibia and fibula status post intramedullary rod placement, right tibia. Interval healing demonstrated. Normal alignment seen.

146. 11/18/08 Bert R. Mandelbaum, MD - Santa Monica Orthopedic and Sports Medicine Group PTP's Progress Report (PR-2). CC: Patient is postop left knee on 02/18/08. He is doing much better at this time. He still has not had any significant therapy. Dx: 1) Left knee anterior cruciate ligament injury. 2) Left knee medial meniscal tear. 3) Left knee bone bruise with 2+ edema. Tx plan: Continue postop physical therapy 2-3x/week for 4 weeks. Incompletely rehabilitated knee. He will keep the present program to get fit, lose weight and optimize his overall functional levels. Work Status: RTW/modified duty. Restrictions: Taking parts, no action roles. He will be able to stand on his left leg for more than 4 hours. F/u in 2 months.

147. 12/19/08 Cedars-Sinai Medical Center History and Physical. HPI: Patient complains of painful left ankle hardware. PMH: Overweight. Assessment/Plan: ROH left ankle under local. (Illegible Handwritten Note).

148. 12/19/08 Justin D. Saliman, MD - Cedars Sinai Medical Center Operative Report. Preop Dx/Postop Dx: Left ankle retained hardware. Operations Performed. Left ankle syndesmotic screw removal.

149. 01/26/09 Orthopedic Physical Therapy Associates Patient participated in physical therapy sessions from 07/16/08 to 01/26/09.

150. 01/26/09 West Side Spine and Joint Rehab Patient participated in physical therapy sessions from 07/16/08 to 01/26/09.

151. 01/28/09 Bert R. Mandelbaum MD Procedure note. Procedure Performed: LT, KA, PMMX, PLMX, debridement of ACD. Recommended physical therapy. F/u in 6 weeks.

152. 01/28/09 Bert R. Mandelbaum, MD - Santa Monica Orthopedic and Sports Medicine Group PTP's Progress Report (PR-2). CC: Patient presents for f/u on his left knee. He is postop on 02/18/08. He does not have generalized complaints of significant pain, only soreness and stiffness. He still has not had any significant therapy. He is still taking appropriate medicines. Dx: 1) Left knee anterior cruciate ligament injury. 2) Left knee medial meniscal tear. 3) Left knee bone bruise with 2+ edema. Tx plan: Continue postop physical therapy 2-3x/week for 4 weeks. Incompletely rehabilitated knee. He will keep the present program to get fit, lose weight and optimize his overall functional levels and use stationary bike. Work Status: RTW/modified duty. Restrictions: Taking parts, no action roles. He will be able to stand on his left leg for more than 4 hours. F/u in 6 weeks.

153. 02/11/09 Justin D. Saliman, MD - Cedars-Sinai Medical Center Progress Note. CC: Patient presents for followup status post removal of syndesmotic screw on 12/19/08. He states that he did not followup previously because he was out of the country. Assessment/Plan: Doing well status post removal of syndesmotic screw. He has minimal complaints at present and is doing quite well. He had no deep calf tenderness now on examination. He is neurovascularly intact distally. He will follow up on an as-needed basis.

154. 07/27/09 Thomas W. Fell, Jr., MD Orthopedic Panel Qualified Medical Evaluation. (DOE: 06/30/09) (DOI: 01/26/08). Hx of injury: On 01/26/08, while working at a property, the sliding cite was stuck late at night. He was trying to get it back on the track when he slipped and fell on his left knee, hitting his left knee on the track. That night he noted some swelling of the left knee. The next morning when he woke up it was very swollen. The next day, he went to UCLA where he was evaluated and x-rays were taken of his knee. He decided to see an orthopedist. His primary care physician referred him to Dr. Mandelbaum. When he reported this as a work injury, he was referred to the same doctor. He had an MRI and was diagnosed with tears of the meniscus and ACL. He had surgery on the meniscus on 02/18/08. Four days later, on 02/22/08, while crossing a street, he was struck by a car, on a non-industrial basis. He spent 11 days in the ICU at Cedars. He had fractures of both the right and left legs. He had surgery on both legs 4-5 times with rods, plates and screws. There was lack of healing bilaterally that required further surgery as well as some screws to be inserted. The last time he had surgery was a few months ago when he had screws removed from the left leg. Eventually, he had PT for the left knee last summer. He has had PT from two different aspects for both the

left knee as well as the leg surgeries. He is not undergoing therapy as this time. In therapy, he had ball exercises, other exercises. However, he has some difficulty squatting in therapy due to his ankle. He is presently staying/living at the property, but is not working. CC: He is able to walk, but he has pain in both legs and in the left knee after brief walking. Particularly, the left ankle gives him pain after 5-7 minutes of walking. He has a lot of difficulty with stairs and has more trouble going down stairs than up stairs. He cannot squat because of pain in both ankle and the knee. He feels that prolonged kneeling causes pain in tie left knee. There is no swelling or locking, but the knee feels strange. He has to use his hands to arise from a chair. He feels that the therapist has never pushed him as far as his exercises are concerned. Regarding the right leg, he states that it is a "mass." He has plantar fascial pain in early morning. He feels that the screws cause pain, swelling, and numbness distally. With regards to the left leg, due to his ankle, he cannot squat fully. He has difficulty standing. After 5-7 minutes of walking, he has pain. He has limited motion of the ankle, but there is no swelling. Exam: WT: 287 lbs. HT: 6'4." Dx: 1) Sprain/strain of the left knee with meniscal tear and ACL tear. Status post arthroscopic partial medial and lateral meniscectomies. 2) Pilon fracture of left ankle, non-industrial. Status post open reduction and internal fixation with multiple surgeries. 3) Mid shaft tibia fracture on right, non-industrial. Status post open reduction internal fixation and multiple surgeries. Disability Status: With regard to the injury of his left knee of 0l/26/08 he is at MMI. Will provide restrictions and impairment for the left knee only. Restrictions for the left knee include no more than occasional squatting, kneeling, and ladder climbing. No very prolonged standing and no prolonged walking on uneven ground. AMA Impairment: Using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, Chapter 17, the left knee is rated as follows: He is rated according to Table 17-33. He has partial medial and lateral meniscectomies. This gives him a l0% lower extremity impairment. A moderate cruciate ligament instability is a l7% impairment for a total of 27% lower extremity impairment which using Table 17-3, calculates to a total 13%,whole person impairment. Causation and Apportionment: The ACL injury and, need for partial meniscectomies due to the work incident of 01/26/08 as described. The impairment rating gave above is for the left knee only. Do not feel that his subsequent accident increased his left knee disability that provided above. The ACL and meniscal injuries were due to the work incident and existed prior to him being hit by the car. However, apportionment is indicated for the left knee; as there was some degenerative tearing of the medial and lateral menisci suggesting some pre-existing pathology resulting in some of the meniscal tears. As more of his impairment is due to the ACL injury, then the meniscal tears, only a small amount can be apportioned. Therefore,

would apportion 5% to preexisting pathology and 95% to the aggravation and further injury as a result of the work incident of 01/26/08. Future Medical care: He should continue doing his exercises at home including quadriceps and hamstring strengthening exercises. He complains that be has gained 60 lbs, but this would not be due to the work incident, which was only a left knee injury. For both his knee injury and his leg injuries and his general conditioning and health, recommend he get on an aerobic conditioning program. A bicycle exercises program would be excellent for him. He has residual instability of the left knee. Allowance should be made for anterior cruciate ligament reconstruction if symptoms become significantly symptomatic in the future. With time and activity, there may be some laxity of the ligaments about the knee, which in some individuals, this results in increasing instability over time. Allowance should be made for this for further evaluation including MRIs, orthopedic visit, as well as surgical intervention.

155. 07/27/09 Thomas W. Fell, Jr., MD Orthopedic Panel Qualified Medical Evaluation. (DOE: 06/30/09) (DOI: 01/26/08) Hx of Injury: Patient reports while on 01/26/08, while working at a property, the sliding gate was stuck late at night. He was trying to get it back on the track when he slipped and fell on his left knee, hitting his left knee on the track. That night he noted some swelling of the left knee. The next morning when he woke up it was very swollen. The next day, he went to UCLA where he was evaluated and x-rays were taken of his knee. He decided to seek an orthopedist. His primary care physician referred him to Dr. Mandelbaum. When he reported this as a work injury, he was referred to the same doctor. He had an MRI and was diagnosed with tears of the meniscus and ACL. He had surgery on the meniscus on 02/18/08. Four days later, on 2/22/08, while crossing a street, he was struck by a car, on a non-industrial basis. He spent 11 days in the ICU at Cedars. He had fractures of both the right and left legs. He had surgery on both legs four to five times with rods, plates and screws. There was lack of healing bilaterally that required further surgery as well as some screws to be inserted. The last time he had surgery was a few months ago when he had screws removed from the left leg. Eventually, he had physical therapy for the left knee last summer. He has had physical therapy from two different aspects for both the left knee as well as the leg surgeries. He is not undergoing therapy as this time. In therapy, he had ball exercises, other exercises. However, he has some difficulty squatting in therapy due to his ankle. He is presently staying and living at the property, but is not working. CC: Patient is able to walk, but he has pain in bilateral legs and in the left knee after brief walking. Particularly, the left ankle gives him pain after five to seven minutes of walking. He has a lot of difficulty with stairs and has more trouble going down stairs than up stairs. He cannot squat because of pain in both ankle and the knee. He feels that prolonged

kneeling causes pain in the left knee. The knee feels strange. He has to use his hands to arise from a chair. He feels that the therapist has never pushed him as far as his exercises are concerned. Regarding the right leg, he states that it is a mess. He has plantar fascial pain in early morning. He feels that the screws cause pain, swelling, and numbness distally. With regards to the left leg, due to his ankle, he cannot squat fully. He has difficulty standing. After 5-7 minutes of walking, he has pain. He has limited motion of the ankle. Past Surgical Hx: As mentioned, one for the left knee work injury, the remaining for the non-industrial incident with the car. Exam: WT: 287 lbs. HT: 6'4". Dx: 1) Sprain or strain of the left knee with meniscal tear and ACL tear, status post arthroscopic partial medial and lateral meniscectomies. 2) Pilon fracture, left ankle, non-industrial, status post open reduction internal fixation with multiple surgeries. 3) Mid shaft tibia fracture, right, non-industrial, status post open reduction internal fixation and multiple surgeries. Disability Status: With regard to the injury of his left knee of 01/26/08, he is at Maximum Medical Improvement. Causation: The ACL injury and need for partial meniscectomies is due to work incident of 01/26/08. The impairment rating gave is for the left knee only. Do not feel that his subsequent accident increased his left knee disability that provided. The ACL and meniscal injuries were due to the work incident and existed prior to him being hit by the car. Apportionment: Apportionment is indicated for the left knee as there was some degenerative tearing of the medial and lateral menisci suggesting some pre-existing pathology resulting in some of the meniscal tears. As more of his impairment is due to the acute injury, then the meniscal tears, only a small amount can be apportioned. Therefore, would apportion 5% to pre-existing pathology and 95% to the aggravation and further injury as a result of the work incident of 01/26/08. Impairment Rating: Total WPI is 13%. Future Medical Care: Patient should continue doing his exercises at home including quadriceps and hamstring strengthening exercises. He complains that he has gained 60 lbs but this would not be due to the work incident, which was only a left knee injury. For both his knee injury and his leg injuries and his general conditioning and health, recommended he get on an aerobic conditioning program. A bicycle exercises program would be excellent for him. He has residual instability of the left knee. Allowance should be made for anterior cruciate ligament reconstruction if symptoms become significantly symptomatic in the future. With time and activity, there maybe some laxity of the ligaments about the knee which in some individuals, this results in increasing instability over time. Allowance should be made for this for further evaluation including MRIs, orthopedic visits, as well as surgical intervention. Work Status: RTW/modified duty. Restrictions: No more than occasional squatting, kneeling,

and ladder climbing. No very prolonged standing and no prolonged walking on uneven ground.

156. 10/01/09 Bert R. Mandelbaum, MD - Santa Monica Orthopedic and Sports Medicine Group Knee Arthroscopy Postoperative Note. CC: Patient complains of stiffness and soreness. Now taking appropriate and usual pain medicine and anti-inflammatories. Assessment: Patient presents with incompletely rehabilitated knee. Tx plan: Continue stationary biking and strengthening exercises. Sports progression. F/u in 3 months.

157. 10/01/09 Bert R. Mandelbaum, MD - Santa Monica Orthopedic and Sports Medicine Group PTP's Progress Report (PR-2). CC: Patient presents for followup. He has no generalized complaints of significant pain, only soreness and stiffness. He still has not had any significant therapy. He is still taking appropriate medicines. Dx: Dx: 1) Left knee ACL injury. 2) Left knee medial meniscus tear. 3) Left knee bone bruise with 2+ edema. Tx Plan: Recommended home exercises. Work Status: RTW/modified duty. Restrictions: Light duty only this will includes taking parts, no action roles. He will not be able to stand on his left leg more than four hours. F/u in 3 months.

158. 11/02/09 Work Status Report. Work Status: RTW/modified duty. Restrictions: Continue restrictions as instructed.

159. 11/02/11 Motion Picture & Television Fund Hospital Laboratory Laboratory. **High** WBC of **11.1**, RBC of **6.2**, RDW of **16,** eosinophils% of **3.4%. Low** MCV of **68,** MCH of **21.9.**

160. 04/17/12 Edward Komberg, DC PTP's Initial Comprehensive Report. Hx of Injury: Patient reports in 02/2008, he was trying to open a gate at work. He states that the gate became stuck, and he thus lost his balance and fell on his left knee. He reported the injury to his employer. Medical attention was offered. He was referred to the insurance appointment medical provider. He was eventually informed that his injury would require surgery. He proceeded with surgery in 02/2008. Approximately 1 week after the surgery, he states that he was hit by a car. He states that he underwent multiple surgeries to correct damage to the right side of his body. Therefore treatment and rehabilitation for his left knee was postponed. He explains that he had to learn to walk again. His therapy took about a year and a half to complete. By the time he was well enough to continue with his left knee treatment, the insurer told him that he had exhausted his treatment. He was offered 12-15% disability which he denied because he feels that his left knee pain is still a problem. Additionally, he states that his employer created a stressful and hostile work environment. He has been threatened with termination at least once a year since his knee injury in 2008. He has been told to gather his possessions and leave, and then told that he was okay to continue his work duties. CC: Patient c/o activity-dependent to constant minimal 1/10 achy, sharp left

knee pain becoming severe 9/10. Vitals: BP: 123/84. Wt: 289 lbs. HT: 6'4". HR: 84. Dx: 1) Status post surgery, left knee. 2) Chronic post surgical pain, left knee. Causation: His presenting complaints and examination findings are consistent with the described history. Based upon information provided on his initial visit, there were no prior complaints of pain in the affected body parts. Based upon the provided history and medical evidence as available, his injuries are believed to be attributable to, and the direct result of, the work-related trauma that occurred on 02/01/08. Tx plan: Recommended physical therapy x 24; kinetic activities. Ordered MRI of the left knee. Referred to Ortho surgeon, psych. Work Status: Temporary Total Disability through 06/01/12.

161. 04/20/12 Edward Komberg, DC - Tri-County Medical Group, Inc Work Status Report. Work Status: Unable to return to work until 06/01/12.

162. 04/25/12 Sean Johnston, MD - California Imaging Networks, Inc. Radiology/Diagnostics. MRI of Left Knee. Impression: 1) Marked thinning of the medial meniscus and anterior horn of the lateral meniscus. A tear is not excluded. May consider MR arthrogram for further evaluation if clinically indicated. 2) Joint effusion. 3) Baker's cyst.

163. 05/29/12 Edward Komberg, DC PTP's Progress Report (PR-2). CC: Patient is complains of minimal 0/10 dull left knee pain and weakness radiating to left thigh with numbness and tingling becoming severe 9/10 sharp. He also complains of difficulty sleeping and psychological complaints due to pain. Exam: BP: 116/88. WT: 295 lbs. HT: 6'4". HR: 95. Dx: 1) Status post surgery, left knee. 2) Chronic post surgical pain. 3) Meniscus thinning, left knee, per MRI. 4) Baker's cyst with joint effusion, left knee, per MRI. 5) Difficulty sleeping. 6) Psychological complaints. Tx plan: Recommended PT 2-3x/week for 6 weeks and kinetic activities. Ordered MR arthrogram of left knee. Referred to Ortho surgeon. Work Status: Off work until 07/13/12.

164. 05/29/12 Edward Komberg, DC PTP's Progress Report (PR-2). CC: Patient is complains of minimal 0/10 dull left knee pain, mid weakness radiating to left thigh with numbness and tingling becoming severe 9/10 sharp. He also complains of difficulty sleeping and psychological complaints due to pain. Exam: BP: 116/88. WT: 295 lbs. HT: 6'4." HR: 95. Dx: 1) Status post surgery of left knee. 2) Chronic post surgical pain. 3) Meniscus thinning of left knee, per MRI. 4) Baker's cyst with joint effusion of left knee, per MRI. 5) Difficulty sleeping. 6) Psychological complaints. Tx plan: Recommended physical therapy 2-3x/week for 6 weeks. Recommended kinetic activities. Ordered MR arthrogram of left knee. Referral done to ortho surgeon. Work Status: Remain off work until 07/13/12. F/u on 07/13/12.

165. 06/08/12 Julian Girod, MD Doctor's 1st Report of Occupational Injury or Illness. (DOI: 02/01/08) HPI: Patient is here for orthopedic initial consultation regarding injury sustained to his left knee at work. He slipped while trying to open a gate, which got stuck. He lost his balance and landed on his left knee. He was taken to emergency room at the UCLA, where he was evaluated and released. He continued to complain of pain and was sent to Dr. Mandelbaum for evaluation. He had left knee arthroscopic surgery soon after the injury. He was recommended physical therapy after the injury, but was involved in an auto/pedestrian accident where he suffered multiple injuries to his right lower extremity, requiring IM rodding and intensive physical therapy after the injury for nine months. Regarding the work injury to the left knee, he describes persistent symptoms. He has difficulty descending stairs more than ascending stairs. He describes weakness and an inability to squat on his left knee. He describes a rare episode of locking and giving way. He complains of activity-dependent left knee pain. PMH: He is borderline hypertensive due to weight gain. Past Surgical Hx: He underwent left knee surgery and multiple surgeries to the right side of his body following a car accident. Dx: Left knee injury with ligament injury with ACL tear, status post arthroscopic surgery. Causation: Findings and diagnosis consistent with account of injury or onset of illness. Tx Rendered: He is here for orthopedic initial consultation, and seeing him as a secondary treating physician for evaluation of his left knee. He has had surgery in the past. Unfortunately, he was involved in an auto/pedestrian accident that limits the rehabilitation capability of his left knee after surgery. He presents with residual symptoms in his knee. Examination reveals evidence of increased anterior translation. MRI reveals evidence of absent ACL with meniscal postsurgical changes. Would like get a baseline x-rays of his left knee. With regard to his further treatment, would like to see previous OP report and arthroscopic pictures to assess why the ligament was not addressed at the time. Disability status: Per the PTP.

166. 06/14/12 Ronald S. Grusd, MD - California Imaging Networks, Inc. Consultation Report. Patient admits to a work-related injury sustained to the left knee on 04/11/12. He has had previous surgery to the left knee in 2008. He complains of pain and weakness in the left knee. There is occasional popping and grinding sensation in the left knee. There is no history of buckling or locking. Pain is aggravated by rotation and motion. He is unable to flatly flex the knee and he is unable to fully squat. On examination, there is no soft tissue swelling. There is tenderness to palpation. There is decreased strength when elevating/abducting the left knee against resistance. He is referred for MRI/MR arthrographic evaluation of the left knee for internal derangements. The procedure with possible complications and side effects including possible allergic reactions to the local anesthetic and the contrast, bleeding and or infection was explained to him. The

purpose of this procedure was explained to him. He was informed that the introduction of contrast into the joint was designed to achieve possible better delineation of the joint for internal derangements. It was explained to him that this procedure was desirable although not essential. A diagnosis could possibly be achieved without the introduction of contrast; that is an MRI without contrast. However, the introduction of contrast into the joint yielded more definitive results on most occasions. The method and technique of the procedure were explained to him that a local anesthetic; that is, numbing medicine, would be placed into the superficial tissues with a small gauge needle. Thereafter, a needle would be placed into the joint and its position confirmed via the introduction of contrast under fluoroscopic guidance. A solution of Gadolinium diluted 1 in 200 would then be injected into the joint. The needle would then be withdrawn. The side effects were explained to him. It was explained to him that he would probably feel a burning sensation upon the administration of the local anesthetic. He was told that he might experience no, mild, moderate or severe pain during the procedure. He may experience a stretching feeling of the joint during or after the administration of contrast. He may experience a pinching feeling in the superficial tissues or skin upon withdrawal of the needle. The postinjection procedure was explained to him. He would be submitted to x-rays during the procedure and an MRI after the administration of the Gadolinium contrast into the joint. The possibility of allergic reaction was explained to him. He was informed that there was a possibility, albeit low, of an allergic reaction to the local anesthetic and/or the contrast. He was given the opportunity to ask any questions about the procedure. He of his own freewill agreed to undergo the procedure and signed an informed consent.

167. 06/14/12 Edward Komberg, DC Review of Records. The medical records are reviewed only and are not incorporated as in the medical record at this time unless specifically indicated otherwise.

168. 06/14/12 Ronald S. Grusd, MD - California Imaging Networks, Inc. Radiology/Diagnostics. MR of Left Knee. Impression: Satisfactory arthrography. The findings are considered to be part of the total evaluation and should be utilized as accessory information together with clinical correlation and further assessment and management of patient. Additional testing may be helpful if clinically desirable and appropriate.

169. 06/14/12 Sean Johnston, MD - California Imaging Networks, Inc. Radiology/Diagnostics. MRI of Left Knee. Impression: 1) Complex tear of the posterior horn of the medial meniscus extending to both superior and inferior articular surfaces. 2) Contrast distention of a previously described Baker's cyst.

170. 06/14/12 Ronald S. Grusd, MD - California Imaging Networks, Inc. Radiology/Diagnostics. X-ray of Left Knee. Impression: There are no fractures or dislocations.. There are no other focal bones, joint or soft tissue abnormalities identified.

171. 06/14/12 Ronald S. Grusd, MD - California Imaging Networks, Inc. Radiology/Diagnostics. X-ray of Left Knee Following Intra-Articular Administration of Contrast and Gadolinium Diluted 1/200 in Saline. Impression: Satisfactory injection of contrast into the left knee joint.

172. 06/15/12 Edward Komberg, DC - Tri-County Medical Group, Inc. PTP's Progress Report (PR-2). CC: Patient is complains of minimal 0/10 dull left knee pain and weakness radiating to left thigh with numbness and tingling becoming severe 9/10 sharp. He also complains of difficulty sleeping and psychological complaints due to pain. He is being treated in office for injuries sustained in a work-related accident on 02/01/08. He is temporarily totally disabled. He is currently involved in very specific physical therapy with office. He is only recommended to perform the exercise provided in this office and not engage in outside exercise at this time. His prognosis is expected to improve with proper rehabilitation and may be able to perform outside exercise in the future. Exam: BP: 116/88. WT: 295 lbs. HT: 6'4". HR: 95. Dx: 1) Status post surgery, left knee. 2) Chronic post surgical pain. 3) Meniscus thinning, left knee, per MRI. 4) Baker's cyst with joint effusion, left knee, per MRI. 5) Difficulty sleeping. 6) Psychological complaints. Tx plan: Recommended PT 2-3x/week for 6 weeks and kinetic activities. Recommended to obtain MR arthrogram left knee. Recommended to follow up with Ortho surgeon. He reported that he is leaving for 1 month for personal reasons. Work Status: Off work until 07/27/12. F/u on 07/21/12.

173. 07/17/12 Edward Komberg, DC PTP's Progress Report (PR-2). CC: Patient presents for followup. His situation was complicated by the fact that he did have his motor vehicle accident and ORIF for right pylon fracture and left tibia fracture at Cedar Sinai. He has gained 60 lbs. Presently he is in PT and is swimming and biking on a daily basis. Dx: 1) Left knee ACL injury. 2) Left knee medial meniscus tear. 3) Left knee bone bruise with 2+ edema. Tx Plan: Advised to continue physical therapy. He will keep present program to get fit, lose weight and optimize his overall functional levels. Work Status: Off work. F/u in 2 months.

174. 07/20/12 Julian Girod, MD PTP's Progress Report (PR-2). CC: Patient complains of left knee pain. Dx: Left knee injury with ligament injury and ACL tear. Tx plan: Recommended to weight loss program. F/u in 4-6 weeks. (Illegible handwritten scan)

175. 07/26/12 Edward Komberg, DC PTP's Progress Report (PR-2). CC: Patient presents complaining of constant severe 7-8/10 achy, sharp and throbbing left knee pain. He complains of moderate constant low back pain compensatory to his left knee pain. Exam: BP: 125/92. WT: 297 lbs. HT: 6'4". HR: 92. Dx: 1) Status post surgery, left knee. 2) Chronic post surgical pain. 3) Meniscus thinning, left knee, per MRI. 4) Baker's cyst with joint effusion left knee, per MRI. 5) Difficulty sleeping. 6) Psychological complaints. 7) Lumbar musculoligamentous injury. 8) Lumbar myospasm. Tx plan: Recommended physical therapy 2-3x/week for 6 weeks at an alternate location closer to his home. Advised kinetic activities. Ordered x-rays of lumbar spine and left knee. Referred to Internal Medicine for weight loss. Advised to followup with Ortho Surgeon. Work Status: Remain off work until 09/07/12.

176. 08/01/12 Maria R. Leynes, MD Initial Internal Medicine Evaluation Report. (DOI: 02/01/08) HPI: Patient began working for RHB Management in 2001. He states he was in a perfect state of health when he began his employment with the company. He was not taking medication prior to his injury. He was referred by his PTP, Dr. Edward Komberg, chiropractor, for an examination regarding weight loss. In 02/2008, Mr. Doudrine states he slipped while trying to open a gate which became stuck. As a result, he lost his balance and he landed on his left knee. The injury was reported to the employer. Medical attention was offered. He was referred to the insurance appointment medical provider. Mr. Doudrine was eventually informed his injury would require surgery. He proceeded with left knee surgery also in 02/2008. Approximately one week after the surgery, he states he was hit by a car on the right side of his body. He explains he underwent multiple surgeries to correct the damage on the right side of his body, therefore the treatment and rehabilitation was postponed for his left knee. Mr. Doudrine explains he had to learn how walk once again and his treatment for the right side of his body took about one year and a half. By the time he was well enough to continue with the treatment for his left knee, the insurer told him he had exhausted his treatment. He was offered a 12-15 disability which he denied because he feels his left knee is still a problem. Additionally, his employer has created a stressful and hostile work environment. He has been threatened with termination at least once a year since then. He is told he needs to gather his possessions and move out only to be told it is okay for him to continue. This causes stress, anxiety and nervousness. In 04/2012, he was referred to Dr. Edward (Illegible) in the city of Los Angeles for chiropractic treatment. He was prescribed physical therapy, but he has been scheduled. He is not aware of the reason he has not started therapy. He was referred to Dr. Girod for consultation of the left knee. He underwent an MRI and Dr. Girod recommended left knee surgery. Surgery will not take place until he is able to lose weight. He has gained

approximately 100 lbs since his injury occurred. Dr. Girod estimates he will gain another 40 lbs if he undergoes surgery at this time. He has been advised to lose weight and undergo surgery. He has borderline hypertension after gaining weight following his work injury. He does not take medication. He states his limitations in physical activity and walking increases the pain in his legs. (Incomplete).

177. 08/08/12 Maria R. Leynes, MD STP's Internal Medicine Initial Report. CC: Patient was seen in this office for an initial internal medicine examination on 08/08/12 in capacity as a secondary treating physician. As per the historian. The history was reviewed and the physical examination was done with the help of an English-Spanish interpreter. Exam: Vitals: BP: 120/85. WT: 310 lbs. HT: 6'4". HR: 94. Temp: 98.6 degrees F. Dx: 1) Obesity. 2) Weight gain secondary to orthopedic diagnoses. 3) History of increased WBC and blood count. 4) Orthopedic diagnoses. Disability Status: The disability status is as per the attending doctor. Tx plan: Advised to continue low carbohydrate, low-fat diet, 6 small meals a day and exercise regularly. Advised to get recent lab tests including thyroid tests and EKG from Lindora. Recommended UCLA weight loss program as discussed. Advised to f/u in 6 weeks or sooner if necessary.

178. 08/13/12 Biofeedback Session Note. Patient complains of left leg and lumbosacral pain. Pain level is 8-9/10. (Illegible Handwritten Note).

179. 08/17/12 Julian Girod, MD PTP's Progress Report (PR-2). CC: Patient c/o left knee (illegible) severe pain. Dx: Left knee injury with ligamental injury with ACL tear. Tx plan: Obtain OP and previous medical records. Work Status: Deferred to PTP. F/u in 6 weeks.

180. 08/24/12 Edward Komberg, DC PTP's Progress Report (PR-2). CC: Patient complains of activity-dependent to constant moderate 6/10 achy, sharp, throbbing low back pain becoming severe 8/10 radiating to bilateral legs. He has complains of activity-dependent to constant moderate 6/10 achy, sharp and throbbing left knee pain becoming severe 8/10. Exam: BP: 122/85. WT: 297 lbs. HT: 6'4". HR: 90. Dx: 1) Status post surgery, left knee. 2) Chronic post surgical pain. 3) Meniscus thinning left knee, per MRI. 4) Baker's cyst with joint effusion, left knee, per MRI. 5) Difficulty sleeping. 6) Psychological complaints. 7) Lumbar musculoligamentous injury. 8) Lumbar myospasm. 9) Complex tear medial meniscus, per MRI. Tx plan: Recommended home exercise. He would like alternate opinion for his left knee, will refer to Dr. Saliman ortho surgeon and apparently performed the first surgery. Will refer to alternate internal medicine for weight loss if there is no subjective/objective improvement. Work Status: Off work until 10/08/12. F/u on 10/08/12.

181. 08/24/12 Nayyer U. Islam, MD- United Medical Imaging of Los Angeles - Wilshire Radiology/Diagnostics. X-ray of Left Knee. Indication: Pain. History of arthroscopy. Impression: No acute osseous injury with moderate medial and mild patellofemoral compartment narrowing.

182. 08/31/12 Julian Girod, MD PTP's Progress Report (PR-2). CC: Patient reports continue severe pain. Dx: Left knee injury with ligament. Tx plan: Recommended PT, walking, bicycle exercise and weight loss. Work Status: deferred to PTP. F/u on 10/15/12. (Illegible Handwritten Note).

183. 09/05/12 Maria Ruby Leynes, MD PTP's Progress Report (PR-2). CC: Patient states he cannot loose weight because he cannot exercise because of other work injured he applied to UCLA weight loss program. Vitals: BP: 137/94. Wt: 308. HR: 99. Dx: 1) Obesity. 2) Weight gain. 3) History on increase WBC. Tx plan: Recommended weight loss program. F/u in 6 weeks. (Illegible Handwritten Note).

184. 09/26/12 Edward Komberg, DC PTP's Progress Report (PR-2). CC: Patient has complaint of activity-dependent to constant moderate 6/10 achy, sharp, throbbing low back pain becoming severe 8/10 radiating to bilateral legs. He c/o activity-dependent to constant moderate 6/10 achy, sharp, throbbing left knee pain becoming severe at 8/10. Exam: BP: 129/92. WT: 297 lbs. HT: 6'4". HR: 81. Dx: 1) Status post surgery of left knee. 2) Chronic post surgical pain. 3) Meniscus thinning, left knee, per MRI. 4) Baker's cyst with joint effusion, left knee, per MRI. 5) Difficulty sleeping. 6) Psychological complaints. 7) Lumbar musculoligarnentous injury. 8) Lumbar myospasm. 9) Complex tear medial meniscus, per MRI. Tx plan: Recommended home exercises and weight loss program. Recommended MRI of lumbar spine and lower extremity EMG/NCV. Cervical pain as compensatory to be included. F/u with Ortho surgeon. Work Status: Off work.

185. 10/03/12 Andrew Thierry, MD - United Medical Imaging of Los Angeles Radiology/Diagnostics. MRI of Cervical Spine without Contrast. Indication: Pain. Slip and fall. Impression: 1) At the C5-C6 and C6-C7 levels there are 1 mm broad-based posterior disc protrusions which does not result in central canal steno sis or neural foraminal narrowing. 2) Mild straightening of the normal cervical lordosis which may be secondary to muscle spasm. 3) Minimal spondylosis at the C5-C6 and C6-C7 levels.

186. 10/03/12 Andrew Thierry, MD - United Medical Imaging of Los Angeles Radiology/Diagnostics. MRI of Lumbar Spine without Contrast. Indication: Pain. Impression: 1) L4-L5: There is a 2 mm broad-based posterior disc protrusion which together with degenerative facet disease and redundancy of the ligamentum flavum results in mild bilateral neural foraminal narrowing and mild central canal stenosis. 2) L5-S1: There is a 1 mm broad-based posterior disc protrusion which together with

degenerative facet disease and redundancy of the ligamentum fl4vum results in mild to moderate bilateral neural foraminal narrowing and mild central canal stenosis. 3) L3-L4: There is a 1 mm broad-based posterior disc protrusion which together with degenerative facet disease and redundancy of the ligamentum flavum results in mild bilateral neural foraminal narrowing and mild central canal stenosis. 4) There is mild spondylosis at the L1-L2 and L4-L5 levels. 5) There is straightening of the normal lumbar lordosis which may be secondary to muscle spasm.

187. 10/29/12 Edward Komberg, DC PTP's Progress Report (PR-2). CC: Patient is complaining of constant moderate 6/10 achy, sharp low back pain becoming severe 9/10 sharp with tingling. He complains of constant mild 3/10 dull left knee pain and weakness becoming moderate 4/10 achy. There is complaint of loss of sleep due to pain. There are psychological complaints. Exam: BP: 134/94. WT: 307 lbs. HT: 6'4". HR: 95. Dx: 1) Status post surgery, left knee. 2) Chronic post surgical pain. 3) Meniscus thinning, left knee, per MRI. 4) Baker's cyst with joint effusion, left knee, per MRI. 5) Difficulty sleeping. 6) Psychological complaints. 7) Lumbar musculoligamentous injury. 8) Lumbar disc protrusion, per MRI. 9) Complex tear medial meniscus, per MRI. 10) Cervical musculoligamentous injury. 11) Cervical disc protrusion, per MRI. Tx plan: Recommended PT 2-3x/week for 6 weeks at alternate location close by patient's home focusing on lumbar strengthening and weight loss and balance. Kinetic activities. Pending lower EMG/NCV. Recommendation for weight loss program (UCLA or Lindora). Work Status: Off work until 12/13/12. F/u with Ortho surgeon.

188. 10/31/12 Jalil Rashti, MD Doctor's 1st Report of Occupational Injury or Illness. (DOI: 01/26/08) Hx of Injury: Patient worked as a property manager for The Roberts Company for 10 years. He indicated that on 01/26/08, he fell down on a slippery surface while trying to fix an entrance gate. He injured his left knee. The next day, he went to UCLA. He was examined and treated with Dr. Mandelbaum. He had surgery of the left knee and started rehabilitation. He was hit by a car on the street 1 week later injuring the right side of his neck, fracturing his right tib/fib and left ankle and had multiple surgeries. He was treated at the UCLA Medical Center for 1-1/2 to 2 years. He did not get rehabilitation. He has gained 100 lbs. Until 01/2012, he could not walk without a walker. He developed low back pain due to an uneven gait. He also had a period of continuous trauma date of injury from 04/28/11 to 04/11/12 injuring his back and bilateral knees, sleep, neuro, and psych. CC: Patient has constant low back pain that radiates to the leg with numbness of the thigh. HE has left knee constant pain that is aggravated with 20 minutes of walking. There is occasional swelling. There is no giving way or locking. He has headaches and depression. PMH: Hit by a car in 2008. PSH: Multiple surgeries for the legs. Dx: 1) Status post left knee surgery by history with

anterior cruciate ligament tear. 2) Status post open reduction, internal fixation of the right leg and left ankle by history. 3) Lumbar radiculitis as a compensable consequence. 4) Obesity as a compensable consequence. Tx Rendered: Will need to review the rest of the medical records. Recommended patient to attend a medical weight loss program to take some pressure off his joints. A gym exercise program was advised. Had an extensive discussion with patient regarding continuing with conservative treatment versus further surgical intervention. Pros, cons, potential risks, and complications were thoroughly discussed with him in detail. He can continue taking his medication. Causation: Based on the information obtained from patient, mechanism of injury, which are consistent with the clinical findings) the causation is industrially related. Apportionment: At present time, there is no apportionment applicable in this case. Disability Status: TTD.

189. 12/19/12 EDD Claim for Disability Insurance Benefits/Employee's Claim for Disability Insurance Benefits. Disability began on 04/17/12. Last worked on 04/17/12. Employee stopped work because doctor put him on temporary disability because of pain.

190. 12/19/12 EDD Doctor's Certificate. Patient is under medical care from 10/31/12 to present. Patient is still being treated for left knee internal derangement, lumbosacral spine radiculitis and headaches. Dx: 1) Thoracic or lumbosacral neuritis or radiculitis, unspecified. 2) Sprain of lumbar. Rx: Recommended weight loss treatment and gym program. Estimated RTW/regular duty 03/19/13.

191. 12/19/12 Jalil Rashti, MD PTP's Progress Report (PR-2). CC: Patient c/o low back pain, constant at 8/10 and left knee pain, constant at 4/10. Pain radiates to (illegible) with numbness and tingling and pins and needles pain. Dx: 1) Internal derangement of knee, not otherwise specified. 2) Lumbosacral neuritis, not otherwise specified. 3) Sprain lumbar region. Tx plan: Patient has gained 100 lbs, from 217 lbs preinjury to 315 lbs now, since injury. Recommended weight loss program, gym membership with personal trainer, and home exercise program. Work Status: Off work. F/u on 01/30/13.

192. 12/27/12 Jalil Rashti, MD Industrial Testing and Reports. Back Conclusion: The Oswestry Index Questionnaire is a questionnaire used to assess back pain and how it has affected his ability to manage in everyday life. It is used to monitor him over time both to detect worsening of the condition and to assess response to therapeutic intervention. Disability Percentage: 0-20%: Minimal. 21-40%: Slight. 41-60%: Moderate. 61-80%: Severe. 81-100%: Crippled. Total Points Possible: 50. Points Scored: 28. He experiences a disability level of 56%. Pain remains the main problem with: Lifting, standing, social life, changing degree of pain, traveling and those activities of daily living are greatly affected. He experiences moderate difficulty with: Personal care, sitting,

pain intensity, walking, sleeping, are not grossly affected at this time. Comparatively his disability index score has risen by 0% since his last report.

193. 12/27/12 Jalil Rashti, MD Industrial Testing and Reports. Conclusion: The Oswestry Index Questionnaire is a questionnaire used to assess back pain and how it has affected his ability to manage in everyday life. It is used to monitor him over time both to detect worsening of the condition and to assess response to therapeutic intervention. Total points possible: 50. Points Scored: 28. He experiences a disability level of 56 %, which means moderate. Pain remains the main problem with lifting, standing, social life, changing degree of pain, traveling and those activities of daily living are greatly affected. He experiences moderate difficulty with personal care, and sitting. Pain intensity; walking, sleeping and are not grossly affected at this time. Comparatively his disability index score has risen by 0% since his last report.

194. 12/27/12 Jalil Rashti, MD Radiology/Diagnostics. Back Functional Data. Impression: The Oswestry Index Questionnaire is a questionnaire used to assess back pain and how it has affected patient's ability to manage in everyday life. It is used to monitor patient over time both to detect worsening of the condition and to assess response to therapeutic intervention. Total points possible: 50. Points scored: 30. Patient experiences a disability level of 60%. Pain intensity is not grossly affected at this time. Comparatively patient's disability index score has lowered by 0 % since his last report.

195. 01/03/13 Supplemental Certification. Patient still being treated for left knee internal derangement and lumbosacral spine radiculitis. Dx: 1) Chondromalacia patellae of unspecified knee. 2) Lumbosacral neuritis or radiculitis. 3) Sprain of ligaments of lumbar spine. Estimated RTW/regular duty on 04/03/13.

196. 01/17/13 David P. Reiner, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. Esophagram. Indication: Other dysphagia, unspecified chest pain. Impression: Normal esophagram revealing no evidence of stricture or mass.

197. 01/17/13 David P. Reiner, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. NM Bone Scan Whole Body. Indication: Odynophagia. Impression: No increased activity to suggest metastatic disease.

198. 01/30/13 Disability Certificate. Off work from 01/30/13 to 03/30/13. F/u on 03/20/13. (Illegible Handwritten Note)

199. 01/30/13 Jalil Rashti, MD PTP's Progress Report (PR-2). CC: Patient has increasing low back pain and left knee pain due to weight gain and inactivity. He has numbness and tingling of both legs. He is losing mobility of his lower extremities. Have requested authorization for treatment, including a gym membership and an adult weight loss

program: for this gentleman; however, this has been denied. Dx: 1) Status post left knee surgery by history with anterior cruciate ligament ALC tear. 2) Status post open reduction internal fixation of the right leg and left ankle by history. 3) Lumbar radiculitis as a compensable consequence. 4) Obesity as a compensable consequence. Tx plan: Requested authorization for him to attend an active treatment program and gym membership as well as an adult weight loss program would be appreciated. Advised to continue with home exercise program and taking medication on an as needed basis. Work Status: Temporarily totally disabled.

200. 01/30/13 Jalil Rashti, MD Radiology/Diagnostics. Electrodiagnostics Report. Indication: Rule in/out nerve pathology. Impression: The highest rated Class III impaired conduction is the primary pathology with 95% sensitivity. Rating of above 3+ suggests central disc etiologies while lower ratings are more suggestive of facet syndrome. In the absence of clear impairment contralateral discrepancy may suggest pathology. The normal variance in the cervical plexus is <20% and <30% in the lumbar plexus. Calculations may be made by comparing sides at the same level using data at bottom of this report. In the presence of muscle weakness large motor fiber studies are warranted. Normal findings do not rule out musculoskeletal or other non-neurogenic pain and paresthesia generators. Correlation with other clinical data is advised before initiating or changing treatment. The 95% sensitivity of Class III small-pain-fiber NCS compares to 29% sensitivity with 14.5% false positive findings of large fiber EDX (EMG/NCV). Over 25% of symptoms and 38% of physical exam findings incorrectly localize pain. MRI and CT-Scans reveal anatomy not abnormal function/pathology. Velocity is not diagnostic in Class III EDX. At no fee up to six additional controls are included to insure sensitivity.

201. 02/06/13 Jalil Rashti, MD Industrial Testing and Reports. Conclusion: The Oswestry Index Questionnaire is a questionnaire used to assess back pain and how it has affected his ability to manage in everyday life. It is used to monitor him over time both to detect worsening of the condition and to assess response to therapeutic intervention. Total points possible: 50. Points Scored: 30. He experiences a disability level of 60 %, which means moderate. Pain remains the main problem with standing, social life, changing degree of pain and those activities of daily living are greatly affected. He experiences moderate difficulty with personal care, lifting, walking, sitting, sleeping and traveling. Pain intensity are not grossly affected at this time. Comparatively his disability index score has risen by 4% since his last report.

202. 02/06/13 Jalil Rashti, MD Industrial Testing and Reports. Conclusions: The Owestry Index questionnaire is questionnaire used to assess back pain and how it has affected

his ability to manage in everyday life. It is used to monitor him over time both to detect worsening of the condition and to assess response to therapeutic intervention.

203. 04/10/13 Jalil Rashti, MD PTP's Progress Report (PR-2). CC: Patient presents for followup. He has knee pain and back pain. His condition is getting worse. He is overweight. He has difficulty with walking. He is unable to squat. He weighs 321 lbs. He can sit for a half an hour and stand up to 10 minutes. Dx: 1) Status post left knee surgery by history with anterior cruciate ligament (ACL) tear. 2) Status post open reduction, internal fixation of the right leg and left ankle by history. 3) Lumbar radiculitis as a compensable consequence. 4) Obesity as a compensable consequence. Tx plan: Ordered functional capacity evaluation. Recommended to continue with conservative care. Recommended to lose weight to take some pressure of his back. Work Status: Patient is totally incapacitated from 04/10/13 through 05/18/13. F/u on 05/15/13.

204. 04/17/13 EDD Claim for Disability Insurance Benefits/Employee's Claim for Disability Insurance Benefits. (Incomplete).

205. 05/09/13 Jalil Rashti, MD Industrial Testing and Reports. Conclusion: The Oswestry Index Questionnaire is a questionnaire used to assess back pain and how it has affected his ability to manage in everyday life. It is used to monitor him over time both to detect worsening of the condition and to assess response to therapeutic intervention. Total points possible: 50. Points Scored: 30. He experiences a disability level of 60 %, which means moderate. Pain remains the main problem with standing, social life, changing degree of pain, traveling and those activities of daily living are greatly affected. He experiences moderate difficulty with personal care, lifting, walking, sitting and sleeping. Pain intensity are not grossly affected at this time. Comparatively his disability index score has risen by 0% since his last report.

206. 05/15/13 Jalil Rashti, MD PTP's Progress Report (PR-2). CC: Patient presents for followup. His condition is getting worse every day. He can walk up to 20 minutes, stand up to 5 minutes and sit up to half an hour. Dx: 1) Status post left knee surgery by history with anterior cruciate ligament (ACL) tear. 2) Status post open reduction, internal fixation of the right leg and left ankle by history. 3) Lumbar radiculitis as a compensable consequence. 4) Obesity as a compensable consequence. Tx plan: Recommended to lose some weight. F/u as needed basis.

207. 05/29/13 Jalil Rashti, MD Industrial Testing and Reports. Back Functional Data. 1) Patients pain is bad, but they manage without taking pain killers. 2) He needs some help but manages most of his personal care. 3) He can lift only very light weights. 4) He can walk only if they use a can or crutches. 5) Pain prevents him from sitting for more the

1/2 hour. 6) Pain prevents him from standing for more the 10 minutes. 7) Even when he takes medication, he sleeps less than 4 hours. 8) He has no social life because of pain. 9) His pain restricts them to necessary Journeys under 1/2 hour. Back Conclusion: The Oswestry Index Questionnaire is a questionnaire used to assess back pain and how it has affected patient's ability to manage in everyday life. It is used to monitor him over time both to detect worsening of the condition and to assess response to therapeutic intervention. Patient experiences a disability level of 72%. Pain remains the pain problem with lifting, walking, standing, social life, changing degree of pain, traveling, activity of daily living are greatly affected. He experiences moderate difficulty with personal care, sitting, and sleeping. Pain intensity not grossly affected at this time. Comparatively his disability index sore has risen by 12% since his last report.

208. 06/26/13 Jalil Rashti, MD PTP's Progress Report (PR-2). CC: Patient c/o knee pain and weakness, back pain and numbness in both legs. Weight gain. Dx: 1) Internal derangement knee NOS. 2) Lumbosacral neuritis NOS. 3) Sprain lumbar region. Tx plan: Needs (illegible) for weight loss before left knee surgery. Patient is now at 320 lbs. Needs PT to left knee 2x6. Work Status: Off work until 08/09/13. F/u on 07/29/13. (Illegible Handwritten Note)

209. 07/10/13 Jalil Rashti, MD Industrial Testing and Reports. Conclusion: The Oswestry Index Questionnaire is a questionnaire used to assess back pain and how it has affected his ability to manage in everyday life. It is used to monitor him over time both to detect worsening of the condition and to assess response to therapeutic intervention. Total points possible: 50. Points Scored: 32. He experiences a disability level of 64 %, which means severe. Pain remains the main problem with lifting, standing, social life, changing degree of pain, traveling and those activities of daily living are greatly affected. He experiences moderate difficulty with personal care, walking, sitting and sleeping. Pain intensity are not grossly affected at this time. Comparatively his disability index score has risen by 8% since his last report.

210. 07/24/13 Jalil Rashti, MD PTP's Progress Report (PR-2). CC: Patient complains of knee pain and discomfort extreme lower back pain, extreme muscle weakness and weight gain. Dx: 1) Internal derangement knee, not otherwise specified. 2) Lumbosacral neuritis, not otherwise specified. 3) Sprain lumbar region. Tx plan: Patient is 100 lbs over weight and now has compensation. Patient will benefit from weight loss program. Before going forward with left knee surgery. Work Status: Off work until 09/06/13. F/u on 09/04/13.

211. 07/30/13 Thomas W. Fell, Jr., MD Orthopedic Panel Qualified Medical Reevaluation. (DOI: 01/26/08; CT: 04/28/11-11/04/12) Review and Interim Hx: Patient is last seen in

2009. At that time, he was seen for a specific injury of 01/26/08 when he sustained an anterior cruciate ligament tear and torn medial meniscus. He had an arthroscopic partial medial and lateral meniscectomies. He also had a history of previous fractures to his right leg and left ankle. Since that time, patient states that he went back to work limited duty as a property manager, but not doing any crawling, lifting or bending. He is collecting rents, and sometimes would change a light bulb or fix a leaky faucet. He would identify other problems and report them to management. This continued until 04/2012 when he was terminated. He feels the major reason for the termination is that he was not doing enough of the work and they wanted someone who could do more work. He in the interval has been going to the gym, walking 45-minutes and doing bike exercises. He has not returned to Dr. Mandelbaum. He states that on his own, he went to the Lindora program and lost weight from 295 lbs and he weighed 287 lbs on 06/30/09 to 238 lbs in 2012. He then gained 100 lbs since that time. He felt his knee pain increased in 2012. He was seen doctors under his Screen Actors Guild insurance at the Toluca Lake Clinic. He states he has seen different specialists including someone for his lower back. He has some MRIs and his nerves were checked. His attorney sent him to Dr. Komberg who did further MRIs of the knees and lower back. He also did sleep tests. He changed attorneys and he was sent to Dr. Rashti who has been requesting therapy, a gym membership, as well as the Lindora program. He on his own has been doing walking, swimming and has a personal trainer. He had no injections. CC: Patient complains of weight gain of 100 lbs in the past year. The left knee feels weak. He has difficulty going down stairs much more so than up stairs. He cannot alternate stairs. The pain is deep inside the knee when he tries to do any type of stairs, squatting or kneeling. If he walks for 30-minutes, he has the same dull pain inside his knee the next morning. There is no locking or buckling. There is very little swelling present with walking or biking. He describes low back pain, which he attributes to his weight gain of about a year. His doctor told him because he limped a little. The pain is left equal to right daily. He has difficulty getting out of bed. He cannot lift or bend. He has numbness and tingling in the left lateral thigh. There are no other neurological or radicular symptoms. There is no pain with coughing or sneezing. Dx: 1) Sprain/strain of the left knee with meniscal tears and anterior cruciate ligament tear, status post arthroscopic partial medial and lateral meniscectomy. Recurrent tearing of the posterior horn of the medial meniscus. 2) Previous fracture of the left ankle and right tibia. 3) Low back pain. 4) Meralgia paresthetica secondary to obesity. Discussion: Patient has a major complaint of weight gain. He was 289 lbs when he was last seen. He lost weight on his own on the Lindora program, down to 238 lbs and then over the past year and a half he has gained it all back. Significantly, he quit smoking a year and a

half ago with the concurrent weight gain. He is trying to attribute the weight gain to the lack of exercise. However, he had three years when he was not gaining weight. Patient was alleging a continuous trauma injury, but patient has been on very light duty. He has developed some low back pain that he attributes to his limp, but the limp is very minimal. He has been having the same problem for 4 years. He did have a repeat MR arthrogram of the left knee, which did show a complex tear of the posterior horn of the medial meniscus, suggesting some further tearing of the previously torn medial meniscus. Feel this is a consequence of the fact that he has instability of the anterior cruciate ligament causing pressure on the meniscus resulting in a tear of the meniscus. Do not have the records from Toluca Lake, which would be helpful. According to Dr. Laynes in internal medicine, patient cannot exercise, but patient is exercising. He is very determined to exercise and to try to get better. Impressed by his determination. He goes to the gym regularly and he understands aerobic exercise. He has a target rates that he gets to when he is exercising. It is not lack of exercise that is really hindering this patient. In fact praise him for his work ethic in working out and trying to keep the knee in as good as shape as possible. For some reason, he had an MRI of the cervical spine. He has no cervical spine complaints. The MRI of the lumbar spine does show some degeneration and stenosis; however, he has no stenotic symptoms. He does have some numbness in the left leg, but this is due to meralgia paresthetica, which is pressure on the anterolateral femoral cutaneous nerve at the level of the anterior superior iliac spine, secondary to obesity. Feels patient is still at Maximum Medical Improvement; however, under future medical care patient should continue treatment for his left knee. Causation & Apportionment: As noted, the weight gain is secondary to cessation of smoking. The low back pain is just normal low back pain due to age and possibly due to some of his weight gain. The limping is so minimal cannot contribute it to this. The left knee injury is secondary to the 01/26/08 work incident. There is no evidence of continuous trauma. Patient has very light duty. The symptoms that he is having are normal progression of symptoms due to the original injury and would not be present absent that injury. The torn meniscus is due to the motion of the knee due to the anterior cruciate ligament tear, tearing the meniscus with activities of daily living. This is also secondary to the 01/26/08 knee injury. With regard to apportionment of the left knee disability, would still apportion 5% to the pre-existing pathology and the remaining 95% to the aggravation and further injury in the 01/26/08 work incident. AMA Impairment: Using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition: Patient has some increased symptoms, however, using Chapter 17, his knee impairment is still the same since he had partial medial and lateral meniscectomies, as well as moderate cruciate instabilities, giving him a total of 13% Whole Person

Impairment. However, taking into consideration his pain, and its impact on his ADLs and work, using Chapter 18, Table 18-3, would provide him with 3% Whole Person Impairment, for a total Whole Person Impairment of 16%. Future Medical Care: A gym membership is a reasonable alternative treatment for this patient. Do not feel he needs a formal physical therapy program. He has had a personal trainer in the past and he has learned how to do his exercises. With a gym membership, he can continue to do his exercises, which will help keep his knee as strong as possible to prevent problems. Would also allow for injections of steroids and then Synvisc for his knee to reduce inflammation of the knee. If the knee pain becomes worse and he starts to swell more then he will need further arthroscopic surgery to remove the torn portion of the medial meniscus. Since there is a negative jerk test and does not have instability symptoms secondary to the anterior cruciate ligament, would not recommend anterior cruciate ligament reconstruction on him. He should also be allowed to use non-steroidal anti-inflammatory medications. In regard to the Lindora program, the weight gain is more likely due to stopping smoking more than lack of activities, given the amount of work he has been doing on his own with a personal trainer. Cessation of smoking is commonly associated with weight gain. Regarding his lumbar spine, patient should be doing core strengthening exercises. Patient should be using ice after he walks or does his exercises. He should also use non-steroidal anti-inflammatory medications. Work Status: Patient has permanent restrictions with the left knee for only occasional squatting and kneeling and he should not do climbing. He should not be on unprotected heights.

212. 07/31/13 Jalil Rashti, MD Industrial Testing and Reports. Conclusion: The Oswestry Index Questionnaire is a questionnaire used to assess back pain and how it has affected his ability to manage in everyday life. It is used to monitor him over time both to detect worsening of the condition and to assess response to therapeutic intervention. Total points possible: 50. Points Scored: 33. He experiences a disability level of 66%, which means severe. Pain remains the main problem with lifting, standing, social life, changing degree of pain, traveling and those activities of daily living are greatly affected. He experiences moderate difficulty with personal care, walking, sitting and sleeping. Pain intensity are not grossly affected at this time. Comparatively his disability index score has risen by 2% since his last report.

213. 10/09/13 Jalil Rashti, MD Permanent and Stationary Orthopedic Evaluation Report with AMA Impairment Ratings. HPI: Patient has constant pain of the left knee with instability. He has tow back pain that radiates to the legs with numbness and tingling. He has weight gain. He can walk up to a quarter of a mile. He is unable to squat or kneel. Past Medical Hx: Hit by a car. Past Surgical Hx: Multiple surgeries for the legs. Dx: 1) Status post left knee surgery with anterior cruciate ligament (ACL) tear. 2) Status

post open reductions internal fixation of the right leg and left ankle by history. 3) Lumbar radiculitis as a compensable consequence. 4) Obesity as a compensable consequence. Subjective Factors Of Disability: 1) Constant pain of the left knee, which is slight and becomes moderates. 2) Constant pain of the low back, which is slight. Objective Factors Of Disability: 1) MRI findings. 2) Surgical findings and scar. 3) Positive clinical findings. 4) Loss of range of motion. 5) Weakness of the left knee. 6) Tenderness at the lumbosacral region and left knee. Future Medical Care: Provisions should be made for future medical care for this as indicated by continuation of exacerbation of pain and consequent progression of disability. The care may include, but is not restricted to the following future reevaluation, consultations, and diagnostic studies. Physical therapy, aquatic therapy and acupuncture as needed. Medications such as anti inflammatory agents muscle relaxants, analgesics injectable corticosteroids, and injectable viscosupplementation. The use, maintenance, and replacement of such needed orthotic devices such as a lumbar spine brace and knee brace. Regular home use of an exercise program and availability of apparatus required. Pain management. Surgery, appropriate hospital and postoperative rehabilitative care in the event of deterioration of this patient's current clinical status relative to the left knee. Vocational Rehabilitation: Patient is unable to perform his usual and customary duties therefore he is considered a qualified Injured Worker for vocational rehabilitation purposes. Impairment Rating: WPI was 35%. Apportionment: Having reviewed his history, medical records, x-rays, diagnostic testing, have come to the following conclusion taking into consideration the possibility of any preexisting or non industrial or any post industrial injuries, it is concluded that one hundred percent of his current causation of the disability is the result of the 01/26/08 and continuous trauma from 04/28/11 to 04/11/12 work accident. Work Status: Patient is modified duty. Restrictions: Patient states with regard to the left knee, he should avoid squatting, kneeling, repetitive climbing stairs, and prolonged walking and standing. He should refrain from walking on uneven ground with regard to the lumbar spine he should avoid staying in one position such as prolonged sitting, standing, and walking and repeat bending and stooping. He should avoid lifting, pushing, and pulling heavy objects.

214. 10/15/13 Jalil Rashti, MD Industrial Testing and Reports. Conclusion: The Oswestry Index Questionnaire is a questionnaire used to assess back pain and how it has affected his ability to manage in everyday life. It is used to monitor him over time both to detect worsening of the condition and to assess response to therapeutic intervention. Total points possible: 50. Points Scored: 32. He experiences a disability level of 64 %, which means severe. Pain remains the main problem with standing, social life, changing degree of pain, traveling and those activities of daily living are greatly affected. He

experiences moderate difficulty with personal care, lifting, walking, sitting and sleeping. Pain intensity are not grossly affected at this time. Comparatively his disability index score has risen by 2% since his last report.

215. 11/23/13 Masoud Sadighpour, MD - California Sleep Disorder Centers Report with Polysomnogram and Sleep Disability Determination. Sleep History: Bed time is about 11PM. Sleep latency is long. Average of sleep is 5 hours. He complained of daytime sleepiness. Recommendations: He should refrain from driving when he feels sleepy. He was scored in mild range of sleepiness in Epworth Scale which is a subjective test scored by patient. Sleep hygiene. The above rating is only for his sleep related problem. PSG/MSLT. Epworth Sleepiness Scale Total: 14. Discussion and Opinion: This physician's impairment rating address only the identification and nature of sleep disorder and the assessment on the impingement on Global Assessment of Function (GAF) to Whole Person Impairment with an indication of a specific sleep disability percentage. Other components of patient's disability rated impairments are not addressed in this report or by this physician. Subjective Factors of Disability: Patient notes continuing sleep related issues, which appear to stem form both stress related concerns over, the work environment and the occupational injury, as well as objective sleep study results. The Epworth Sleepiness Scale note various somatic functioning concerns related to disrupted sleep activity, which can cause and or contribute to insomnia and sleep apnea. While overall apportionment is not an issue for this examining physician, in general, it is this physician's opinion that he appears to suffer from work-related sleep deprivation. Opinion is based, in part upon his noted complaints of being groggy after a night of attempted rest and daytime sleepiness, which impedes normal functioning in activities of daily living. Objective GAF to WPI Disability Determination GAF: Summary Outline From The DSM-IV, Page 32-91-100. Person has no problems OR has superior functioning in several areas OR is admired and sought after by other due to positive qualities 81-90. Person has few or no symptoms. Good functioning in several areas. No more than "everyday" problems or concerns. 71-80. Person has symptoms/problems, but they are temporary, expect able reactions to stressors. There is no more than slight impairment in any area of psychological functioning. Objective Factors of Disability: 61-70 mild symptoms in one area OR difficulty in one of the following: social, occupational or school functioning. But, the person is generally functioning pretty well and has some meaningful interpersonal relationships. 51-60 moderate symptoms or moderate difficulty in one of the following: Social, occupational, or school functioning. 41-50 serious symptoms OR serious impairment in one of the following: Social, occupational, or school functioning. 31-40 some impairment in reality testing or impairment in speech and communication or

serious impairment in several of the following: occupational or school functioning, interpersonal relationships, judgment, thinking or mood. 21-30 presence of hallucinations or delusions, which influence behavior or serious impairment in ability to communicate with others or serious impairment in judgment or inability to function in almost all areas. 11-20 there is some danger of harm to self or others or occasional failure to maintain personal hygiene or the person is virtually unable to communicate with others due to being incoherent or mute. 1-10 persistent danger of harming self or others or persistent inability to maintain personal hygiene or person has made a serious attempt at suicide. Disability Rating: Epworth Sleepiness Scale Results: 14. Apportionment: There is no indication of apportionment.

216. 11/27/13 Roger C. Lai, MD - Providence Saint Joseph Medical Center ED Note. HPI: Patient is a 51-year-old gentleman with a history of hypertension and asthma who came in complaining of chest pain that started currently around 3:30 PM after a walk. He stated 11/26/13 he developed a headache that is pressure, like, located in the peri-orbital region, and is constant, rated as 4/10. He checked his blood pressure and it was 150/90; therefore, he went to his primary doctor's office and checked the pressure there. It was 165/105. He was prescribed hydrochlorothiazide and sent home. He went for a walk and tried to lose the weight that he gained of about 100 lbs in the past 1-1/2 years and then developed this chest pain located in the left side of chest, radiating to the left shoulder. It is an intermittent, dull pain, rated 2/10. He admits to sweatiness and palpitation with this, but no shortness of breath, no dizziness, no nausea or vomiting. PMH: Hypertension and asthma. Past Surgical Hx: Appendectomy, cholecystectomy and Orthopedic surgery. Meds: Hydrochlorothiazide and albuterol. Vitals: BP: 161/93. HR: 107. RR: 20. Temp: 98.6 F. ED Course/MDM: Patient is a 51-year-old who came in with chest pain. His chest pain is possibly due to cardiac ischemia since this happened after exertion. His blood pressure also has been elevated, which could cause ischemic changes. Other etiology such as musculoskeletal and pulmonary embolism are also in the consideration. Labs will be sent off. Cardiac workup will be done. He was given aspirin 162 mg PO nitroglycerin paste 1 inch to chest. With that, he is in pain free. He is comfortable here. Pressure is down to 120/74 and heart rate came down to 81. Because of his risk factor, he never had a stress test. Felt he needs to be ruled out and would possibly benefit from cardiac risk stratification. On-call physician, Dr. Patel, was contacted and agreed to admit patient to the hospital for further inpatient evaluation and observation. Impression: 1) Chest pain, rule out myocardial infarction. 2) Hypertension. 3) Obesity. Tx plan: Patient will be admitted to telemetry observation under Dr. Sharad Patel for further inpatient evaluation, workup, and treatment.

217. 11/27/13 Sharad S. Patel, MD - Providence Saint Joseph Medical Center History and Physical. HPI: Patient started to have a headache involving the peri-orbital region. It was constant. He checked his blood pressure and it was elevated. Therefore, he went to his primary care physician's office. It was again noted to be elevated at 165/105. He was given a prescription for hydrochlorothiazide 25 mg. He was sent home. Since he has gained about 100 lbs of weight in the last 18 months, he went back to walking to lose the weight. He developed left-sided chest pain radiating to his left shoulder. It was intermittent. He also had some sweating and palpitations. He did not, however, seek medical attention until the later part of the day when he came to the emergency room here. He was evaluated by the emergency room physician. Since he has not had any significant cardiac workup and since he has a history of hypertension, which is uncontrolled, at the recommendation of the emergency room physician he is being hospitalized for further and care. Exam: BP: 130/80. HR: 80. RR: 18. Dx: 1) Chest pain, rule out acute coronary syndrome. 2) Hypertension, uncontrolled. 3) Obesity. Tx plan: He will have serial troponin levels. If they are negative, then he will have a cardiac stress test. In the meantime, he will be on nitroglycerin ointment.

218. 11/27/13 Providence Saint Joseph Medical Center Laboratory. **High** glucose of **115**, RBC of **6.64**, RDW of **15.8**, percent segmented neutrophils of **67.2**, absolute neutrophils of **8.6**, and absolute monocytes of **1.0**. **Low** hemoglobin of **13.7**, MCV of **65**, MCH of **20.7**, and MCHC of **15.8.** Abnormal RBC morphology. Urine culture report showed no methicillin resistant S Aureus recovered.

219. 11/27/13 David P. Reiner, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. X-ray of Chest. Indication: Pain. Impression: No evidence of acute cardiopulmonary process.

220. 11/28/13 Sharad S. Patel, MD - Providence Saint Joseph Medical Center History and Physical. CC: Patient started to have a headache involving the periorbital region. It was constant. He checked his blood pressure, and it was elevated. Therefore, he went to his primary care physician's office. It was again noted to be elevated at 165/105. He was given a prescription for hydrochlorothiazide 25 mg. He was sent home. Since he has gained about 100 lbs of weight in the last 18 months, he went back to walking to lose the weight. He developed left-sided chest pain radiating to his left shoulder. It was intermittent. He also had some sweating and palpitations. He did not, however, seek medical attention until the later part of the day when he came to the Emergency Room here. He was evaluated by the Emergency Room physician. Since he has not had any significant cardiac workup and since he has a history of hypertension, which is uncontrolled, at the recommendation of the emergency room physician he is being

hospitalized for further and care. Vitals: BP: 130/80. HR: 80. RR: 18. Temp: 97 F. Impression: 1) Chest pain, rule out acute coronary syndrome. 2) Hypertension, uncontrolled. 3) Obesity. Tx plan: Planned at this time is to hospitalize him. He will have serial troponin levels. If they are negative, then he will have a cardiac stress test. In the meantime, he will be on nitroglycerin ointment.

221. 11/28/13 Providence Saint Joseph Medical Center Laboratory. **High** RBC of **6.33**, RDW of **16.1**, glucose of **105**, and TSH of **4.47**. **Low** hemoglobin of **13.3**, MCV of **66**, MCH of **21.0**, and MCHC of **31.5.** Urinalysis showed negative.

222. 11/28/13 Donald S. Litvak, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. NM Myocardial Perfusion Multi SPECT. Impression: 1) No areas of stress-induced reversible left ventricular myocardial ischemia or fixed left ventricular myocardial scarring seen. 2) Left ventricular ejection fraction is calculated at 51% on stress images and 65% on resting images. The left ventricular wall motion appears within normal limits in all areas.

223. 11/28/13 Donald S. Litvak, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. X-ray of Chest. Indication: Other; follow up. Comparison: 11/27/13. Impression: Slightly prominent bibasal markings with no acute disease in the chest.

224. 11/28/13 Sharad S. Patel, MD - Providence Saint Joseph Medical Center Discharge Summary. (Admit Date: 11/27/13) Hospital Course: His serum troponin levels were within normal limits. He had a Cardiolite cardiac stress test. It did not show any evidence of stress-induced reversible left ventricular myocardial ischemia or fixed left ventricular myocardial scarring. He therefore was discharged home on a heart-healthy diet. He has been instructed not to do any activities until his blood pressure is under control. He is otherwise to see his primary care physician either on 11/29/13, or 12/02/13. His discharging medications will be as per medication reconciliation form. Discharge Dx: 1) Chest pain, non-cardiac. 2) Hypertension. 3) Obesity. Discharge Instructions: As per medication reconciliation form.

225. 01/09/14 Philip H. Conwisar, MD Orthopedic Treating Physician's Re-Evaluation Report. CC: Patient presents for followup. He has persistent pain, more severe. Dx: 1) Status post left knee arthroscopy, partial medial meniscectomy partial lateral meniscectomy and chondroplasty. 2) Early degenerative joint disease, left knee. 3) Lumbar spine myoligamentous sprain/strain. 4) Lumbar degenerative disc disease. Tx plan: Patient was recently taken to the emergency room on 10/05/14 due to severe left leg pain and low back pain. He was notified that no treatment was being authorized to the lumbar

seine. He was instructed on a home exercise program. He will take the medications prescribed in the emergency room. F/u as needed.

226. 02/03/14 Philip H. Conwisar, MD PTP's Initial Report. Hx of Injury: Patient reports he works as a Property Manager for Roberts Companies. He began employment with the Roberts Companies in 2001. He is not currently working. He last worked in 04/11/12, at which true be was placed off work by a treating physician, placed him on temporary total disability. He sustained a work injury on 01/26/08, to his left knee. It was raining and he was repairing a garage gait. He states that the rain was heavy and he slipped and felt striking his left knee against the cement flooring. He reported the injury to his employer. He went home following the injury. He was called in specifically to repair the garage gait. The following morning, because of left knee pain and swelling, he went to UCLA emergency. X-rays were taken of the left knee and he was provided with a knee brace. He was instructed to contact his employer and was subsequently discharged home. Following his emergency room visit, he came under the care of Dr. Mandelbaum of Santa Monica. He states that he said that his ligaments are broken. He states that he subsequently underwent left knee surgery approximately 3-4 weeks following his injury, performed by Dr. Mandelbaum. He was scheduled to begin postoperative physical therapy following his left knee surgery; however, he states that a week after the surgery he was bit by a car. His right side wt struck by the car and apparently the most extensive injury was to the right Leg, as well as fracture to the left ankle. He states that he has undergone 4-5 surgeries to the right leg, including open reduction internal fixation. He also states that he underwent open reduction internal fixation for the left ankle fracture. He states that as a result of being struck by the car, he was in a coma for approximately 1 week as a patient in the intensive care unit of Cedar-Sinai Medical Center. This was followed by a rehabilitation program to regain the ability to walk. The rehabilitation program was over a period of approximately 2-1/2 years and has been completed. He is currently limping on his left leg and occasional, uses a cane for ambulatory assistance. He was also given a home exercise program to perform following his period of rehabilitation. CC: Patient complains of low back pain. He states that pain is located all across the low back with radiation into his buttocks and into both lower extremities with the left leg getting numb. He states that the pain occurs continuously and is increased with attempts at bending, kneeling stooping, squatting and lifting activities. He does walk with a lump because of the left knee injury. He is awakened at night by low back pain. He c/o left knee pain described as dull. Pain is located over the medial aspect of the knee. He c/o weakness of the left knee. He states that he is afraid to use it. He states that the pain is continuous and is increased with attempts at walking, standing, bending, kneeling and lifting activities. He notes

increased pain with ascending and descending stairs, inclines and declines. PMH: Hypertension and asthma. Past Surgical Hx: He underwent multiple surgeries to the right lower extremity and his left ankle. He has undergone an appendectomy as a child. He has undergone a cholecystectomy. Meds: Antihypertensive medication and use of an inhaler, the names of which he does not recall. Exam: WT: 320 lbs. HT: 6'4". Dx: 1) Status post left knee arthroscopy, partial/medial meniscectomy, partial lateral meniscectomy, and chondroplasty. 2) Early degenerative joint disease, left knee. 3) Lumbar spine myoligamentous sprain/strain. 4) Lumbar degenerative disc disease. Causation: Based on the history, as stated by him, physical examination and a review of the records provided he patient sustained injury to the left knee as the result of an industrial injury that occurred on 01/26/08, arising out of employment with Roberts Companies. The mechanism of injury is consistent with the diagnoses. Tx plan: For the exacerbation of pain, recommended a course of physical therapy 2x/week for 4 weeks, for modalities and strengthening exercises to the left knee and the lumbar split. Requested additional pertinent medical records be made available for review, as well as authorization to review the records at the med-legal fee schedule. Work Status: Temporary total disability. F/u in 4 weeks.

227. 05/22/14 Philip H. Conwisar, MD PTP's Interim Report. CC: Patient returns to the office. He was last seen 3 months ago. He continues to have left knee pain. He had an industrial injury to the left knee on 01/26/08. He underwent left knee surgery approximately 3 to 4 weeks after the injury. He was then struck by a car one week after. He had severe injury involving the right leg and also had a left ankle fracture. He was hospitalized for a long period of time. He has gained approximately 100 lbs since the industrial injury. He had not received physical therapy or rehab after the surgical procedure on the left knee. Dx: 1) Status post left knee arthroscopy, partial medial meniscectomy, partial lateral, meniscectomy, and chondroplasty. 2) Early degenerative joint disease, left knee. 3) Lumbar spine myoligamentous sprain/strain. 4) Lumbar degenerative disc disease. Tx plan: In examiner opinion, the lumbar spine injury would be considered a compensable consequence of altered gait mechanics due to the left knee injury. He also had a severe right leg injury. Apportionment would be an issue but there is, in examiner opinion, evidence of relationship to the left injury and therefore a compensable consequence of this left knee injury. Would recommend a course of physical therapy, twice a week for 4 weeks, for modalities, stretching and strengthening exercises. He would also be taught a home exercise program so he could continue on his own after the session of physical therapy. Patient would benefit from a supervised physical therapy program which would then allow him to progress to an adequate home exercise program. Patient states that he has gained 100 lbs since the industrial injury. It

is noted that he had an injury involving the right leg. Obviously, with both lower extremities injured, he was very immobile which contributed to weight gain. Therefore the weight gain would be attributable to both injuries involving the lower extremities, both the left knee industrial injury and the right leg injury from the motor vehicle accident. Apportionment will be art issue once he has been determined Permanent and Stationary but there is evidence of industrial causation. Patient states that his primary care physician has stated that his weight gain has caused and contributed to high blood pressure and has contributed to respiratory problems. This is beyond the area of expense of an orthopedic surgeon. Recommended obtaining an internal medicine consultation, to determine whether the hypertension and respiratory problems are related to weight gain and secondarily related to the industrial injury. Early weight loss will help patient's left knee pain and lumbar spine pain. Recommended a medically supervised weight loss problem, as he has tried on his own to lose weight but is unable to do so. He has gained 100 lbs since the industrial injury. Presently, he weighs 320 lbs and is 6'4" tall. This does classify him as obese as per his BMI. He will be reevaluated in 4 weeks. Work/Disability Status: Due to the severity of his pain, he will remain at Temporary Total Disability.

228. 06/02/14 Thomas W. Fell, Jr, MD Orthopedic Supplemental Report - QME. After reviewing these additional medical records, there are no essential changes in previous reporting. In regards to the lumbar spine, he does not have multilevel disc problems. He has 1.0-2.0 mm bulges, of no clinical significance. Regarding causation, the limp that saw in this individual was so minimal, it would not cause a compensatory pain in the lumbar spine. It certainly would not cause multilevel disc pathology. Even if he did have significant multilevel disc problems, lifting would not cause the multilevel disc problems. Given the fact that he has a basically normal MRI of the lumbar spine, the limp has nothing to do with the findings of the lumbar spine.

229. 06/16/14 Philip H. Conwisar, MD PTP's Permanent and Stationary Report. CC: Patient returns to the office. He has persistent left knee pain. He has low back pain. He had an industrial injury to the left knee on 01/26/08. He underwent left knee arthroscopic surgery.. He developed low back pain after the industrial injury to the left kite; which he feels is related to altered gait mechanics. He also suffered a non-work related injury involving the right leg and .a left ankle fracture. He states that he has also gained approximately 100 lbs since the industrial injury of 01/26/08. For a complete review of the history and mechanism of injury please refer to 02/03/14 Initial Primary Treating Physician Report. He can now be considered Permanent and Stationary and has reached Maximal Medical Improvement. Exam: WT: 320 lbs. HT: 6'4". Dx: 1) Status post left knee arthroscopy partial medial meniscectomy, partial lateral meniscectomy,

and chondroplasty. 2) Early degenerative joint disease, left knee. 3) Lumbar spine myoligamentous sprain/strain. 4) Lumbar degenerative disc disease. Subjective Factors of Disability: Frequent slight to moderate pain in the left knee, increasing to moderate with more vigorous activities. Frequent slight to moderate pain in the lumbar: spine, increasing to moderate with more vigorous activities, Objective Factors of Disability: Left Knee: Arthroscopic incisions. Findings at the time of surgery. 1+ anterior drawer and Lachman test and x-ray findings. Lumbar spine: Paravertebral tenderness, restricted range of motion, and x-ray findings. Causation: In regards to the left knee, causation is industrial due to the injury of 01/26/08, arising out of employment with the Roberts Companies. The lumbar spine is a compensable consequence of the 01/26/05 industrial injury. Apportionment: In regards to the lumbar spine, the pattern has degenerative disc disease on x-ray findings. There was a separate non-industrial severe injury involving the right, lower extremity. This also caused altered gait mechanics, thereby contributing to lumbar spine impairment, would apportion one-third to the natural progression of degenerative disc disease; one-third as a compensable consequence of the industrial injury of 01/26/08; and one-third to the non-industrial injury involving the right lower extremity. Impairment Rating: Total whole person impairment for the left knee is 14%. In regards to lumbar spine, 8% whole person impairment is indicated. Future Medical Care: Future medical care should be provided. This would consist of evaluation and treatment by a physician. He should be provided with analgesic, anti-inflammatory and muscle relaxant medications, on an as-needed basis. Corticosteroid injection for the left knee should be provided, in addition to Hyaluronic viscosupplemental injections, as indicated. Additional surgery cannot be ruled out, in regards to the lumbar spine. He would benefit from short courses of physical or chiropractic therapy. Additional diagnostic testing as indicated, and additional treatment based on reexamination and diagnostic studies should also be provided. He would also benefit from a medically supervised weight-loss program, as indicated. Previously recommended an internal medicine consultation for non-orthopedic conditions which may be related to his weight gain and therefore to the orthopedic injury. This is beyond my area of expertise. Recommended internal medicine consultation. Work Restrictions: Restricted from repetitive bending, stooping pushing, pulling and lifting over 20 lbs, in addition to a restriction from squatting, kneeling, climbing, crawling and other similar activities. Vocational Rehabilitation: If recommended work restrictions cannot be accommodated, then he would be considered a Qualified Injured Worker.

230. 10/05/14 Carolina B. Baron, PA/Francois R. Martin, MD - Providence Saint Joseph Medical Center ED Summary. HPI: Patient presents to the ED for evaluation of acute

right lower extremity pain. States that on 10/05/14, he was exercising at the beach, he was riding his bike and then decided to go for a walk in the beach. He was going in the water he felt a pain on his right calf, since then has had a difficult time ambulating due to the pain. He presents to the emergency room for evaluation. PMH: Hypertension and asthma. Past Surgical Hx: Orthopedic surgery, cholecystectomy, appendectomy, and tonsillectomy. Meds: Albuterol, hydrochlorothiazide, and lisinopril. Exam: BP: 153/85. HR: 114. RR: 18. Temp: 98.1 degrees F. SpO2: 96%. Extremities: He has significant pain at the right leg/left gastrocnemius muscle. He had increased pain with plantar flexion. ED Course/Medical Decision Making: He presents for evaluation of new right lower extremity pain. On wish it was noted that he had pain at the leg at the site of the left gastrocnemius muscle. Due to the mechanism of the injury, the pain could be related to a small muscle tear, or a muscle cramp that it has not improved. Has normal sensation and motor function. No injury to the Achilles tendon. He was treated in the emergency room with a shot of Toradol with some improvement of the pain. He was discharged home with narcotic and Flexeril for the pain. He was advised to try to mildly stretch the leg. He was told that he must followup with his primary care provider within one to 2 days to evaluate the progression of his pain. He may need further workup at that time. He understood the plan and agrees to follow primary care provider. He was advised to return to the emergency room if the pain does not improved within 1 to 2 days, if he develops any increasing pain, or he develops any weakness or decreased sensation to the lower extremity. Dx: Muscle cramp. Disposition: Discharged in good condition.

231. 10/05/14 Nhan Tran, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. X-ray of Right Tibia and Fibula. Indication: Pain. Impression: No evidence of acute fracture. Old tibia and fibula fractures. Plantar calcaneal spur.

232. 10/09/14 Philip H. Conwisar, MD Orthopedic Treating Physician's Re-Evaluation Report - PR-2. CC: Patient presents for reevaluation. He has persistent pain, more severe. Dx: 1) Status post left knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy and chondroplasty. 2) Early degenerative joint disease, left knee. 3) Lumbar spine myoligamentous sprain/strain. 4) Lumbar degenerative disc disease. Tx plan: Patient was recently taken to the ER on 10/05/14, due to severe left leg pain and low back pain. He was notified that no treatment was being authorized to the lumbar spine. He was instructed on a home exercise program. He will take the medications prescribed in the ER. He will be reevaluated as needed.

233. 01/13/15 Philip S. Schwarzman, MD - Providence Saint Joseph Medical Center ED Summary. HPI: Patient presents to the ED for evaluation of chest pain. He states that a

day before he developed left upper chest and shoulder pain is intermittent it no shortness of breath nausea vomiting diaphoresis he still has the discomfort he rates it as dull 3/10 he has some numbness and tingling in his hands. He was evaluated for similar problem in November. He had a treadmill at that time. PMH: Hypertension, asthma. Past Surgical Hx: Orthopedic surgery, cholecystectomy, appendectomy, tonsillectomy. Meds: Albuterol nebulizer, hydrochlorothiazide, Norco, Prinivil. Exam: BP: 141/78. HR: 82. RR: 18. Temp: 37.2 degrees C. SpO2: 98%. ED Course: Patient presented to the Emergency Department for evaluation, and he was triaged to room ED28. Reviewed the nursing notes, and he was evaluated here. He presents with chest pain. Chest pain differential diagnosis considered includes but is not limited to angina pectoris, unstable angina, myocardial infarction, pleurisy, pulmonary embolism, pericarditis, pneumothorax, chest wall pain, abdominal pain presenting as chest pain, and chest pain of uncertain etiology. Other cardiac risk factors family history negative, cholesterol normal, no tobacco use. His chest pain is atypical. Hemovac had a negative treadmill several months ago. He has been reassured he is to followup with his doctor. Assessment: Atypical chest pain. Disposition: Discharged.

234. 01/13/15 Providence Saint Joseph Medical Center Laboratory. **High** RBC of **6.29**, RDW of **15.8**, absolute monocyte of **0.9**, and glucose of **109**. **Low** hemoglobin of **13.1**, MCV of **65**, MCH of **20.9**, MCHC of **31.9**, and sodium of **135**.

235. 01/13/15 Philip S. Schwarzman, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. ECG. Impression: 1) Normal sinus rhythm. 2) Possible left atrial enlargement. 3) Borderline ECG.

236. 01/13/15 Edward J. Jahnke III, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. X-ray of Chest. Indication: Chest pain. Comparison: 11/28/13 and 11/27/13. Impression: Stable chest with normal heart size. No evidence of acute process.

237. 01/13/15 Philip S. Schwarzman, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. ECG. Impression: No acute MI seen and reviewed by Dr. Schwarzman.

238. 01/23/15 Philip H. Conwisar, MD Orthopedic Treating Physician's Supplemental Report. Medical records were reviewed. Discussion: The records from Cedars-Sinai Medical Center document pertain to a non-industrial injury when he was struck by a car on 02/28/08, sustaining a fracture to the right tibia and the left ankle. There are additional medical records from Cedars-Sinai pertaining to non-orthopedic related treatment. Have also re-reviewed the QME reports from Dr. Fell. After review of the records from Cedars-Sinai, there are no changes to prior opinions other than in regards to

apportionment. Have re-reviewed the QME reports of Dr. Fell. Respectfully disagree with Dr. Fell in that weight gain was not related to the industrial injury. It is opined, the weight gain was related to both the industrial injury of 01/26/08, for which patient underwent left knee arthroscopic surgery, as well as to the non-industrial motor vehicle accident when he sustained a fracture to the right tibia and the left ankle and required prolonged rehabilitation. Believe that both of these injuries contributed to the subsequent weight gain for which he requires treatment. It is opined that this patient should have an evaluation by an internist to see if his other medical conditions are related to the weight gain and therefore secondarily related to the industrial injury. Certainly, being immobile will lead to weight gain. The left knee injury of 01/26/08, and the need for left knee surgery did contribute to immobility of patient and therefore, in opinion, contributed to weight gain. Additionally, changing opinion in regards to whole person impairment of the lumbar spine. The range of motion method is more appropriate, as there was no specific injury and there are multiple levels of involvement. After reviewing these records, the following are my amended opinions. Apportionment to Causation: In regards to the left knee, it remains opinion that apportionment is 100% to the industrial injury of 01/26/08, arising out of employment with Roberts Companies. There is no evidence of pre-existing disability or condition contributing to disability. In regards to the lumbar spine, there is degenerative disc disease, on x-rays. There is also the non-industrial injury when he was struck by an automobile, fracturing the right tibia and the left ankle. This also caused altered gait mechanics. Additionally, patient's work activities involving bending, stooping and lifting. This would also contribute to and aggravated the underlying degenerative disc disease. Would apportion 50% to the natural progression of degenerative disc disease; 20% as a compensable consequent of the industrial injury of 01/26/08; 20% to the non-industrial injury involving the right and left lower extremity fractures; and 10% to the cumulative trauma injury of 04/11/12. Permanent Impairment: In regards to the left knee, there are no changes to opinions in regards to whole person impairment. Total whole person impairment for the left knee remains 14%. In regards to the lumbar spine, the range of motion method is appropriate. In regards to the lumbar spine, using Table 15-8, there is 9% whole person impairment. Using Table 15-9, there is 4% whole person impairment. Total whole person impairment for range of motion is 13%. Currently, Table 15-7 is used. Patient is in Category IIc-f. This provides 10% lower extremity impairment, with 3 levels of involvement. 13% is combined with 10% for 22% whole person impairment. There is no additional impairment for neurologic deficit. Total whole person impairment for the lumbar spine is 22%. This does not include apportionment of the lumbar spine, which was discussed previously.

239. 09/29/15 Celina M. Barba-Simic, MD - Providence Saint Joseph Medical Center ED Summary. HPI: Patient presents to the ED for evaluation of flank pain. He states he has had 4 days of right upper quadrant abdominal pain that goes to his back. He states he was seen by his primary care physician and had outpatient CT scan does not have the results yet. He states he had his gallbladder removed many years ago. He states the pains of right upper quadrant (illegible) back intermittent about an 8/10. PMH: Hypertension, asthma. Past Surgical Hx: Orthopedic surgery, cholcystectomy, appendectomy, tonsillectomy. Meds: Albuterol, hydrochlorothiazide, Norco, and Prinivil. Exam: BP: 140/82. HR: 89. RR: 20. Temp: 37.3. SpO2: 99%. Constitutional: In mild distress. ED Course: Patient presents for evaluation of abdominal pain. Differential includes retained gallstone, kidney stone, gastritis, GERD versus other etiologies. Patient's exam, labs and ultrasound are unremarkable. Do not suspect an acute abdomen at this time. Patient will be discharged with Prilosec and is to follow up with his primary care physician in one day for CAT scan report and possible referral to GI. Patient's return to the ER for any worsening symptoms. The pulse oximetry was within normal limits. Dx: Gastritis. Disposition: Discharged.

240. 09/29/15 Providence Saint Joseph Medical Center Laboratory. Urinalysis showed abnormal 1+ ketones.

241. 09/30/15 Sumit Dua, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. Limited Abdominal Ultrasound. Indication: Abdominal pain. Impression: 1) Status post cholecystectomy. 2) Fatty liver.

242. 11/04/15 Gabriel V. Rubanenko, MD - Doctor's 1st Report of Occupational Injury or Illness. (DOI: 01/26/08) Hx of Injury: On 01/26/08, he was trying to close a garage door that was stuck by holding and pulling it down with both hands when he slipped and fell on the wet floor due to the rain. He states that fell landing on the ground on the left-side of his body hitting his knee against the floor and the garaged door closed down on him. He felt an immediate onset of pain in his back and left knee. He reported the incident to his employer who failed to offer medical care. He went to a hospital where he was evaluated, diagnostic studies were taken, medication was prescribed and he was told that he needed to have surgery to his left knee, which was performed several days later. He states that he also has since developed headaches. CC: Patient complains of headaches, back pain and left knee pain. Vitals: WT: 360 lbs. Dx: 1) History of headaches. 2) Lumbosacral musculoligamentous strain/sprain with radiculitis. 3) Lumbosacral spine multiple disc protrusions per QME, Dr. Fell. 4) History of left knee ligamentous tear per medical records. 5) Status post left knee partial meniscectomy in 2006 with residual impaired gait and atrophy. Causation: Patient's current disability

and diagnoses are due to his industrial injury and arose out of his industrial employment. Tx Rendered: Prescribed Ultram, Flurbi cream, and Theramine. Dispensed lumbosacral brace, left knee sleeve and TENS unit. Ordered labs. Requested authorization for left knee injection and then Synvisc per PQME Dr. Fell's recommendation and physical performance FCE requested to ensure him can safely meet the physical demands of their occupation. Referred to PT. Work Status: TTD until 12/16/15. F/u as scheduled.

243. 11/04/15 Gabrial V. Rubanenko, MD Doctor's 1st Report of Occupational Injury or Illness. (DOI: CT: 04/28/11–04/11/12) Hx of Injury: Patient reports he works as a property manager. He was responsible for conducting preventive maintenance of a building throughout the year, responding to guest calls demanding fixing/repairs instantly. As a result of his work activities, he gradually developed constant headaches and aggravated his back and left knee pain. He states that he gained approximately 150 lbs due to not being able to exercise because of his pain. He also has developed hypertension, diabetes mellitus and asthma. He laid off. He later sought care with Dr. Kaminsky who evaluated him, prescribed medications, and started a course of physical therapy. Presently, he remains off work and states that his symptoms persist and have not improved. He now presents to this facility seeking further medical care. CC: Patient complains of headaches, back pain, left knee pain, hypertension, diabetes mellitus and asthma. Exam: WT: 360 lbs. He ambulates with antalgic gait favoring the left lower extremity. Lumber spine tenderness to palpation bilateral paraspinal muscles/bilateral sacroiliac joints/bilateral sciatic notch/bilateral posterior iliac crests/bilateral gluteal muscles, spasms bilateral paraspinal muscles, decreased range of motion. Positive SLR. He is able to perform heel and toe walking joint line/medial joint line, decreased range of motion. Positive patellofemoral grinding/McMurry test; left thigh atrophy noted at 2-2.9 cm; decreased motor strength right hip and left knee at 4/5. Dx: History of headaches. 2) Lumbosacral musculoligamentous strain/sprain with radiculitis. 3) Lumbosacral spine multiple disc protrusions per QME, Dr. Fell. 4) History of left knee ligamentous tear per medical records. 5) Status post left knee partial meniscectomy in 2008 with residual impaired gait and atrophy. 6) Weight gain approximately 150 lbs secondary to pain and immobility. 7) Diabetes mellitus. 8) Hypertension. 9) Asthma. Causation: Based on consistency of injury biomechanics with history provided by him, subjective complaints, initial evaluation, review of available medical records, and given the absence of any other admitted, recorded or observed contributory causative factors, it is medical conclusion that his diagnoses are a direct result of the industrial injuries, he sustained on a cumulative trauma basis from 04/28/11 to 04/11/12 working for the Roberts Co. Tx Rendered: Prescribed TENS unit. Dispensed lumbosacral brace and left

knee sleeve. Requested authorization for MRI of the lumbar spine and left knee. Recommended physical performance-FCE to ensure he can safely meet the physical demands of his occupation. Ordered labs. Recommended consultation with internist. Work Status: Temporarily totally disability until 12/16/15.

244. 11/04/15 Pacific Toxicology Laboratories Laboratory. Urine drug screening is positive for naproxen, ethyl glucuronide and ethyl sulfate.

245. 11/12/15 Ina Hocutt, RPT Physical Therapy Initial Evaluation Report. CC: Patient presents with slight and moderate lumbar spine pain. He has pain in right and left lower extremity, tingling, numbness, weakness and stiffness. His pain level is at 9/10. He also complains of left knee pain. He has tingling, numbness, weakness and stiffness. Dx: 1) Lumbar spine strain/sprain. 2) Left knee S/P. Tx plan: Recommended PT 2x/week for 6 weeks. (Illegible Handwritten Note).

246. 11/25/15 Maciej Majzel, DC Physical Therapy Initial Evaluation. CC: Patient c/o pain in bilateral lower extremities, numbness and tingling, weakness and stiffness. He also c/o pain, numbness and tingling, weakness, and stiffness on left knee. He rates the pain as 8/10. Dx: 1) Lumbar spine sprain/strain. 2) Left knee status post. Tx plan: Recommended to continue physical therapy 2x/week for 6 weeks.

247. 11/25/15 William Feske, MD Radiology/Diagnostics. Multiposition MRI of Left Knee. Indication: History of fracture; clicking/popping sensation with joint motion; pain; numbness/tingling; decreased range of motion. Impression: 1) Fibrotic strands in the superior aspect of Hoffa's fat pad are seen extending to the intercondylar notch, indicative or prior arthroscopy. 2) Medial meniscus: hypoplastic fragmented appearance of the body segment, most likely due to meniscectomy, however severe tear and maceration should also be considered; extensive complex tear of the posterior horn; tear of the anterior horn. An MR arthrogram of the left knee is recommended for further evaluation of the medial meniscus. 3) Lateral meniscus: Hypoplastic fragmented appearance of the anterior horn, most likely due to meniscectomy, however severe tear and maceration should also be considered; complex tear of the body segment; myxoid change of the posterior horn. An MR arthrogram of the left knee is recommended for further evaluation of the lateral meniscus. 4) Anterior cruciate ligament, high grade partial versus full thickness tear. 5) Posterior cruciate ligament partial tear. 6) Lateral collateral ligament, low grade partial tear. 7) Grade 2/3 chondromalacia patella. 8) Semimembranosus tendinosis. 9) Moderate-severe medial femorotibial joint osteoarthritis; mild-moderate lateral femorotibial joint osteoarthritis. 10) Suprapatellar and semimembranosus bursitis. 11) Popliteal cyst (2.77 cm). 12)

Intramuscular varicosity, medial gastrocnemius. 13) Multiple posterior venous varicosities.

248. 12/21/15 John A. Donahue, MD Doctor's 1st Report of Occupational Injury or Illness. (DOI: CT: 04/28/11 - 04/11/12) Hx of Injury: CT 04/28/11-04/11/12. As a property manager, patient was responsible for conducting preventive maintenance of a building throughout the year, responding to guest calls demanding flexing/repairs instantly. His job related physical activities include lifting, carrying, pushing and pulling of up to 100 lbs, bending, at the neck, prolonged standing, constant walking, bending, kneeling, stooping, twisting, turning, grasping, hand manipulation and other activities. As a result of his works activities. He gradually developed constant headaches and aggravated his back and left knee pain. He reported his symptoms to his employer failed to offer medical care. He continued to work until 04/2012, at which time he was fired. He later sought care with Dr. Kaminsky evaluated him, prescribed medications, and started a course of physical therapy. In 11/2015, he sought further care with Dr. Rubanenko in Los Angeles evaluated him. Took diagnostic studies, prescribed medications, and referred him for physical therapy. He continued to attend followup visits until 12/2015. At which time he felt that treatment rendered was not improving his condition and decided to seek care elsewhere. Presently, he remains off work and states that his symptoms persist and have not improved. He also has since gained approximately 150 lbs due to not being able to exercise because of his pain. He also has developed asthma, borderline diabetes and hypertension all diagnosed with his private physician as due to weight gain. He now presents to this facility seeking further medical care. CC: patient presents with back pain, left knee pain, hypertension, asthma, borderline diabetes, weight gain. Exam: BP: 140/5. WT: 360 lbs. Lumbar spine tenderness to palpation bilateral paraspinal muscles/bilateral sacroiliac joints/bilateral sciatic notch/bilateral posterior iliac crests/bilateral gluteal muscles, spasms bilateral paraspinal muscles, decreased ROM, positive SLR (R 45), heel and toe-walking performed with pain in left knee; left knee well-healed arthroscopic surgical scar, tenderness to palpation laterally/medially/patella/lateral joint line/medial joint line, decreased ROM, positive patellofemoral grinding/McMurray tests: left thigh atrophy at 2-2.9 cm; decreased motor strength right hip and left knee at 4/5. Dx: 1) History of headaches. 2) Lumbosacral spine strain/sprain with radiculitis. 3) Lumbar spine multiple disc protrusions per PQME, Dr. Fell. 4) History of left knee ligamentous tear per medial records. 5) Status post left knee partial meniscotomy in 2008 with residual impaired gait and atrophy. 6) Weight gain (approximately 150 lbs). 7) Secondary to pain and immobility. 8) Diabetes mellitus. 9) Industrial causation deferred; hypertension. 10) Industrial causation deferred; asthma. Causation: Findings and diagnoses are

consistent with his account of injury or onset of illness. Tx Rendered: Given for lumbosacral brace, left knee sleeve, and TENS unit. Authorization is formally being requested for MRI of left knee, left knee steroid injection and then Synvisc per PQME, Dr. Fell's recommendation; consultations with internist to rule out industrial causation of diabetes mellitus, hypertension and asthma, consultation with weight loss specialist for a formal weight loss program and physical performance - FCE. A physical performance FCE is required to ensure him can safely meet the physical demands of occupation. PT evaluation and treatment for the lumbar spine and left knee 2x/week for 6 weeks. Work Status: TTD until 02/02/16.

249. 12/21/15 John A. Donahue, MD Doctor's 1st Report of Occupational Injury or Illness. (DOI: 01/26/08) Hx of Injury: On 01/26/08, patient was trying to close a garage door that was stuck by holding and pulling it down with both hands when he slipped and fell on the wet floor due to the rain. He states that he fell landing on the ground on the left side of his body hitting his knee against the floor and the garaged door closed down on him. He felt an immediate onset of pain in his back and left knee. He reported the incident to his employer who failed to offer medical care. He went to a hospital where he was evaluated, diagnostic studies were taken, medication was prescribed and he was told that he needed to have surgery to his left knee, which has performed several days later. He remained off work and eventually started on a course of postoperative therapy. He continued to attend followup visits and states that approximately one week after his surgery. He was ran over by a car, and sustained injuries to his right leg (thigh) and left ankle. Subsequently, all treatments to his left knee was stopped due to the new injuries sustained. He continued off work until 2010, at which time he returned to work with modified duties despite persistent and worsening pain. He states that he also has since developed headaches. CC: Patient complains of headaches, back pain and left knee pain. Exam: BP: 140/85. WT: 360 lbs. Lumbar spine tenderness to palpation bilateral paraspinal muscles, bilateral sacroiliac joints, bilateral sciatic notch, bilateral posterior iliac crests, bilateral gluteal muscles, spasms bilateral paraspinal muscles, decreased ROM, positive SLR (R 45), heel and toe-walking performed with pain in left knee, left knee well-healed arthroscopic surgical scar, tenderness to palpation laterally, medially, patella, lateral joint line, medial joint line, decreased ROM, positive patellofemoral grinding, McMurray tests; left thigh atrophy at 2-2.9 cm; decreased motor strength right hip and left knee at 4/5. Dx: 1) History of headaches. 2) Lumbosacral spine strain/strain with radiculitis. 3) Lumbar spine multiple disc protrusions per PQME, Dr. Fell. 4) History of left knee ligamentous tear per medical records. 5) Status post left knee partial meniscectomy in 2008 with residual impaired gait and atrophy. Causation: Based on consistency of injury biomechanics with the

history provided by him, subjective complaints, today's initial evaluation, review of available medical records, and given the absence of any other admitted, recorded or observed contributory causative factors, it is professionally medically concluded that his listed diagnoses are a direct result of the industrial injuries he sustained on 01/26/08 while working for The Roberts Company. Tx Rendered: Dispensed lumbosacral brace, left knee sleeve and TENS unit. Requested authorization for left knee steroid injection and then Synvisc per PQME, Dr. Fell's recommendation. Ordered MRI of left knee and physical performance FCE. A physical performance FCE is requested to ensure that he can safely meet the physical demands of their occupation. Recommended PT 2x/week for 6 weeks for lumbar spine and left knee. Work Status: TTD until 02/01/16.

250. 12/24/15 John S. Rankin, MD - Providence Saint Joseph Medical Center ED Summary. CC: Back pain. HPI: Patient presents to the ED for evaluation of low back pain that is 8 out of 10 severity dull sore sensation worse with movement that radiates down both legs over the back of the thighs to the knees but no further than that, slightly worse on the left. He describes as a sharp and tingling sensation but he denies any focal weakness or numbness, and I clarified this with him explicitly. He denies any bowel or bladder dysfunction, saddle anesthesia or urinary retention. He states he's had similar pain to this off and on for the past 2 years since he was in a car accident and he is gained significant amount of weight since that time this pain feels similar to his pervious back pain but has been worse over the last 2 days. Exacerbated by movement. He is able to walk but it is painful to do so. Past Medical Hx: Hypertension, asthma, depression and diabetes mellitus. Past Surgical Hx: Orthopedic surgery, cholecystectomy, appendectomy and tonsillectomy. Meds: Albuterol, amlodipine, hydrochlorothiazide and lisinopril. Vitals: BP: 120/56. HR: 96. RR: 18. Temp: 98.1 degree F. SpO2: 94%. Exam: Lower extremities are neurovascular intact with strong 2+ DP and TP pulses. Dx: Acute lumbar radiculopathy. ED Course, Procedures And Medical Decision Making: Patient presented to the Emergency Department for evaluation, and he was triaged to room EDO6. Reviewed the nursing notes, and he was evaluated by me. He has a history of 2 years of chronic low back pain but has had worsening pain in the last 2 days with radiation down the bilateral thighs but slightly worse on the left. Do feel is likely consistent with acute lumbar radiculopathy. He denies any trauma and x-ray reveals no evidence of acute fracture dislocation therefore doubt at this time. He would consider disc disease as contributing to his symptoms on differential diagnosis. He feels much better now. He is able to ambulate steadily. He has no sensory level, no bowel or bladder dysfunction, urinary retention or saddle anesthesia. He has no focal weakness or numbness and no neurologic deficits therefore I doubt acute spinal cord injury insult, cord compression, cauda equina syndrome or spinal abscess. He has no

abdominal pain or pulsatile abdominal mass and I doubt aortic aneurysm or dissection. No evidence of renal colic or pyelonephritis. He has no evidence of any neurovascular compromise to his extremities and no evidence of ischemic limb or DVT. He feels much better at this time. He will follow-up with his orthopedic surgeon has appointment coming up into several days also instructed to follow-up with primary doctor 1-2 days. He will be given prescription for Percocet as below as he states he does not have any pain medication at home and was told strictly not to take this or any other narcotic pain medication. He also be given meloxicam. Verbalized understanding very strict return precautions. Condition upon discharge is good. Disposition: Discharge.

251. 12/24/15 Joseph J. Roco, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. X-ray of Lumbar Spine. Indication: Low back pain. Impression: 1) Multilevel degenerative spondylosis of the lumbar spine most pronounced on the left at L1-L2. 2) Degenerative disc disease L1-L2, L3-L4 and L4-L5. 3) No evidence of acute lumbar spine abnormality.

252. 02/25/16 John A. Donahue, MD PTP's Progress Report (PR-2). CC: Patient complains of pain in the lower back and left knee. On a scale of 0-10, with 10 representing the worst, his pain in the lower back is rated as 8-9/10 per the VAS scale, which has increased from 5/10 on the last visit and 4-6/10 in the left knee, which has increased from 4/10 on the last visit. He is currently asymptomatic regarding his headaches, which have improved from 2/10 on the last visit. Dx: 1) History of headaches. 2) Lumbosacral spine strain/sprain with radiculitis. 3) Lumbar spine multiple disc protrusions per QME, Dr. Fell. 4) History of left knee ligamentous tear per medical records. 5) Statue post left knee partial meniscectomy in 2008 with residual impaired gait and atrophy. 6) Weight gain (approximately 150 lbs) secondary to immobility. 7) Diabetes mellitus, industrial causation deferred. 8) Hypertension, industrial causation deferred. 9) Asthma, industrial causation deferred. Tx plan: Patient is to continue PT for the lumbar spine and left knee, 2x/week for 6 weeks. He is referred for surgical consultation of his left knee for total knee replacement. He is pending authorization for consultation with a weight loss specialist for a weight loss program as well as with an internist for diabetes mellitus, asthma, and hypertension. Work Status: Patient is placed on temporary total disability from 02/25/16 until 03/24/16. He needs current and future medical care. He is scheduled for a followup examination on 03/24/16.

253. 03/04/16 Tina C. Wang, MD - Providence Saint Joseph Medical Center ED Summary. HPI: Patient presents to the ED with chief complaint of abdominal pain. He presents for evaluation of epigastric abdominal pain that is present for several months that radiates to his back. To have weeks ago, he was diagnosed with H. Pylori and was started on

triple antibiotic therapy. However, he states in the last 4 days since his medications were completed he feels much worse. His epigastric abdominal pain and last 3 days is constant radiates to his back associated with burping and bloating sensation and actually worsens when he is hungry and seems to improve when he eats. His pain is 7/10. He is in the process of being evaluated by GI. PMH: Hypertension, asthma, depression, diabetes mellitus, and gastritis. PSH: Orthopedic surgery, cholecystectomy, appendectomy, and tonsillectomy. Meds: Albuterol, Norvasc, hydrochlorothiazide, and lisinopril. Exam: BP: 145/85. ED Course/MDM: Patient presents to the ED for evaluation and he was triaged to room HALL05. Reviewed the nursing notes, and he was evaluated. Given the constancy of symptoms anginal equivalent is unlikely. He is currently not on proton pump inhibitor which may explain why his symptoms worsen. He has been taking over-the-counter Maalox for his symptoms. Given the fact that his pain seems to improve when he eats a suspected possible duodenal ulcer. Continue outpatient management with a GI specialist is appropriate. Based on location. It consider other etiologies including pancreatitis cholecystitis. However, patient LFTs and lipase are within normal limits he has no leukocytes and otherwise electrolytes are unremarkable. His urinalysis did not show evidence for infection. He had a abdominal ultrasound within the past year which showed a unremarkable aorta making abdominal aortic aneurysm unlikely for cause of symptoms. He was given a prescription for Protonix and Ultram. Dx: 1) Duodenal ulcer. 2) Abdominal pain, unspecified abdominal location. Disposition: Patient was discharged to home in stable condition.

254. 03/04/16 Providence Saint Joseph Medical Center Laboratory. **High** glucose of **109**.

255. 04/21/16 John A. Donahue, MD PTP's Progress Report (PR-2). CC: Patient complains of pain in the lower back and left knee. On a scale of 0-10, with 10 representing the worst, his pain in the lower back is rated as 8/10 per the VAS scale, which has decreased from 8-9/10 on the last visit and 6-7/10 in the left knee, which has increased from 4-5/10 on the last visit. He has been asymptomatic regarding his headaches since his last visit. Dx: 1) History of headaches. 2) Lumbosacral spine strain/sprain with radiculitis. 3) Lumbar spine multiple disc protrusions per QME, Dr. Fell. 4) History of left knee ligamentous tear per medical records. 5) Status post left knee partial meniscectomy in 2008 with residual impaired gait and atrophy. 6) Weight gain (approximately 150 lbs) secondary to immobility. 7) Diabetes mellitus, industrial causation deferred. 8) Hypertension, industrial causation deferred. 9) Asthma, industrial causation deferred. Tx plan: Prescribed flurbiprofen, 10% lidocaine, 5% amitriptyline, 5% hyaluronic 0.2% cream, 180 grams to apply a thin layer to the affected area 2 to 3 times a day. He is referred for consultation for medical weight loss program. Topical medications were prescribed in order to minimize possible neurovascular complications; and to avoid complications

associated with the use of narcotic medications, as well as upper GI bleeding from the use of NSAID medications. Work Status: TTD from 04/21/16 until 05/19/16. He needs current and future medical care. F/u on 05/19/16.

256. 04/21/16 John A. Donahue, MD PTP's Progress Report (PR-2). CC: Patient complains of pain in the lower back and left knee. On a scale of 0-10, with 10 representing the worst, his pain in the lower back is rated as 8/10 per the VAS scale, which has decreased from 8-9/10 on the last visit and 6-7/10 in the left knee, which has increased from 4-5/10 on the last visit. He has been asymptomatic regarding his headaches since his last visit. Dx: 1) History of headaches. 2) Lumbosacral spine strain/sprain with radiculitis. 3) Lumbar spine multiple disc protrusions per QME, Dr. Fell. 4) History of left knee ligamentous tear per medical records. 5) Status post left knee partial meniscectomy in 2008 with residual impaired gait and atrophy. Tx plan: Patient's physical therapy is on hold at this time. Work Status: TTD from 04/21/16 to 05/19/16. He needs current and future medical care. F/u on 05/19/16.

257. 05/19/16 Rene Nevarez, DC/John A. Donahue, MD PTP's Progress Report (PR-2). CC: Patient presents for f/u. He complains of pain in the lower back that radiates in the pattern of bilateral L4 and L5 dermatomes, as well as pain in the left knee. His pain in the lower back is rated as 7-8/10 per the VAS scale, which has decreased from 8/10 on the last visit and 7-8/10 in the left knee, which has increased from 7/10 on the last visit. He has been asymptomatic regarding his headaches since his last visit. Dx: 1) History of headaches. 2) Lumbar spine strain/sprain with radiculitis. 3) Lumbar spine multiple disc protrusions, per PQME, Dr. Fell. 4) History of left knee ligamentous tear, per medical records. 5) Status post left knee partial meniscectomy in 2008, with residual impaired gait and atrophy. Tx plan: Patient's PT is on hold at this time. Work Status: Patient remains Temporarily Totally Disabled from 05/19/16 until 06/02/10. He needs current and future medical care. F/u on 06/02/16.

258. 06/02/16 John A. Donahue, MD PTP's Basic Comprehensive Medical-Legal Permanent and Stationary Report with Review of Records. (DOI: CT 04/28/11-04/11/12; 01/26/08) Hx of Injury: Patient states that on 01/26/08, while performing his usual and customary duties as a property manager for The Roberts Co., he sustained injuries to his head, back, left knee and has since developed headaches. On 01/26/08, he states that he was trying to close a garage door that was stuck by holding and pulling it down with both his hands, when he slipped and fell due to wet surface from the rain. He fell to the ground landing on his left side of his body, hitting his knee and the floor, and the garage door dosed down on him. He reported his accident to his employer failed to offer any medical care. He felt an immediate sharp pain in his left knee and back. He went to the

hospital, there he was evaluated, diagnostic studies taken, prescribed medication, and was old that he needed to have surgery to his left knee. He states that he had surgery performed, to his left knee several days later. He states that he remained off work and eventually started on a course of post-operative surgery to his left knee. He continued to attend follow-up visits and states that 4 days after the left knee surgery, he was ran over by a car and sustained injuries and fractures to his right leg and left ankle. Subsequently, all treatments to his left knee were stopped, due to the new Injuries that ha had sustained. He underwent multiple surgeries to his bilateral legs and received 1 year of therapy. He further states that he continued to treat his left knee at home with prescribed pain medication and home remedies during that time. Meanwhile, he continued off work until 2010 at which he was returned to work with modified duties, despite the persistent and worsening pain. He states that he had since developed headaches, including his back and left knee pain. He states that from 04/28/11 to 04/11/12, while performing his usual and customary duties as a property manager for The Roberts Co., he gradually developed aggravating headaches, back and left knee pain. He has states that he gained approximately 150 lbs due to not being able to exercise because of his persistent pain and has since developed hypertension, asthma and borderline diabetes. He states that, during the course of his employment for The Roberts Co., from 2001 to 04/11/12 he was responsible for conducting preventive maintenance of the building throughout the year1 responding to guest calls demanding findings/repairing instantly and effectively. His job-related physical activities consisted of lifting, carrying, pushing and pulling items (weighing up to 100 lbs), bending at the neck, prolonged standing, constant walking, bending, kneeling, stooping, squatting, twisting, turning, climbing, hand manipulation, grasping, reaching and other physical activities required by his job duties. As a result of these activities, he gradually developed aggravating symptoms to the body parts mentioned. On numerous occasions, he reported his symptoms to the employer failed to offer any medical care. He continued performing his regular work activities, due to his financial necessity, until 04/2012, at which time he was fired. In 2011, he sought medical attention with an occupation doctor in downtown in Los Angeles. There he was evaluated, diagnostic studies taken, and continued off work. He continued to attend follow-up visits and treatment until 2012 at which time he was no longer satisfied with the treatment rendered and sought further medical attention elsewhere. In late 2012, he states that he sought further medical attention with Dr. Rashti in Enoino. There he was evaluated diagnostic studies were taken and continued to off work. He continued to attend follow-up visits and treatment until 2014 at which time he was not satisfied with the treatment rendered and decided to seek medical attention elsewhere. He sought out

medical care with Dr. Kaminsky through his private insurance, there he was evaluated, prescribed medication, and started on a course of therapy. He continued with all follow up appointments and treatment for approximately 4 months, until no further medical care was rendered. In 11/2015, he sought further medical attention with Dr. Rubanenko in Los Angeles. There he was evaluated, diagnostic studies were taken, prescribed medication, referred to physical therapy and continued to attend follow-up visits and treatment until 12/2015 at which time he felt that the treatment rendered was not improving his condition and decided to seek medical attention elsewhere. At the present time, he remains off work and states that his symptoms persist and have not improved. He states that he has since gained approximately 150 lbs, developed asthma, borderline diabetes and hypertension all diagnosed by his private physician, due to the weight gain. He now presents himself to this facility for a medical evaluation. CC: Patient presents with headaches. He did not suffer a direct head injury or loss of consciousness. He complains of generalized headaches. He describes his pain as intermittent in frequency. On a scale of 0-10, with 10 representing the worst, he rates the severity of pain at a level of 4/10 per the VAS. Pain is increased to a level of 5/10 with repetitive overhead looking, repetitive flexion of the head/neck, and repetitive extension of the head/neck, repetitive overhead work and loud sounds. It takes varying amounts of time for the pain to return to pre-activity level following these activities. Activities of daily living with respect to head pain in the area of self-care and personal hygiene, he reports that head pain interferes moderately with bathing, buttoning clothes, combing hair, eating, dressing, brushing teeth, and preparing meals. In the area of communication and sensory function, he reported that head pain interferes moderately with seeing, hearing, speaking, tasting, and smelling. In the area of physical activity he reports that head pain interferes moderately with overhead looking, flexion of the head/neck, extension of the head/neck, bending of the neck, overhead work, exposure to loud sounds, exposure to bright lights, reading, watching television, walking, standing, lifting, carrying, pushing, and pulling. In the area of sexual function, he reported that head pain interferes moderately with sexual activities. In the area of travel, he reported that head pain interferes moderately with driving. In the area of sports and exercise, he reported that head pain interferes moderately with these activities. In the area of sleep. He reports that head pain interferes moderately with restful nocturnal sleep. He also complains of low back pain. Pain occurs in the middle of the back at the waist, and the middle and bilateral sides of the sacroiliac region and lumbar region with radiation to the bilateral buttocks, bilateral thighs, bilateral knees, bilateral lower legs, bilateral calves, bilateral ankles, bilateral feet, and bilateral big toes. He describes his pain as constant in frequency. On a scale of 0-10/10, with 10

representing the worst, he rates the severity of his pain at a level of 8/10 per the VAS. Pain is characterized as dull, aching, sharp, shooting and pulling accompanied by sensation of pins and needles as well as pressure and tension. Pain is increased to a level of 9/10 with repetitive lifting of 10 lbs, walking for 30 minutes, standing for 30 minutes, repetitive walking on uneven ground, repetitive squatting/kneeling, repetitive climbing, repetitive crawling, repetitive crouching, repetitive stooping, repetitive carrying, sitting for 30 minutes, riding in a car for 0 minutes, repetitive pushing/pulling of 10 lbs, repetitive bending, repetitive twisting/turning, repetitive lifting of 10 lbs to shoulder level, repetitive lifting of 10 lbs to waist level, repetitive overhead work, and repetitive work above shoulder level. It takes varying amounts of time for pain to return to pre-activity level following these activities. Activities of daily living with respect to low back and lower extremity pain in the area of self-care and personal hygiene, he reported that low back and lower extremity pain Interferes severely with bathing, defecating, using the toilet, dressing, personal hygiene, getting on and off the toilet, and preparing meals. In the area of physical activity, he reported that low back and lower extremity pain interferes severely with walking, climbing stairs, standing, squatting/kneeling, sitting, reclining, arising from a chair, carrying grocery bag, lifting/pushing/pulling, household chores, and getting in and out of bed in the area of travel, he reported that low back and lower extremity pain interferes severely with getting in and out of a car, driving, and being a passenger in a vehicle, in the area of sexual function, he reported that low back and lower extremity pain interferes severely with sexual activities in the area of sleep, he reported that low back and lower extremity pain interferes severity with restful nocturnal sleep in the area of sports and exercise, he reports that low back and lower extremity pain interferes severely with these activities. 0%-20% = Minimal disability; 21%-40% = moderate disability; 41%-60% = severe disability; 61%-80% =crippled; 81%-100% = patient is bed-bound. With regard to pain intensity he states that the pain is moderate and does not vary much. With regard to personal care, he states that washing and dressing increases the pain and he finds it necessary to change the way he is doing it. With regard to lifting, he states that pain prevents him from lifting heavy weights off the floor, but he can manage if they are conveniently positioned (e.g. on a table). With regard to walking, he states that pain prevents him from walking more than 1/2 mile. With regard to sitting, he states that pain prevents him from sitting for more than 1/2 hours. With regard to standing, he states that he cannot stand for more than 1/2 hour without increasing pain. With regard to sleep, he states that because of pain, his normal night's sleep is reduced by less than one-half. With regard to social life, he states that pain restricted his social life and he does not go out very often. With regard to traveling, he states that he gets extra

pain while traveling, which compels him to seek alternative forms of travel. With regard to changing degrees of pain, he states that his pain is neither getting better nor worse. His score of 80% indicates he has severe disability. Rationale for using lower extremity functional Scale for the lumber spine. He has radicular involvement of the bilateral lower extremities. Therefore further functional assessment of the lower extremities is necessary. Lower extremity functional scale (LEFS) - bilateral: The following scale was used to determine his level of difficulty: Extreme difficulty 0; quite a bit of difficulty =1; Moderate difficulty 2; A little bit of difficulty 3; No difficulty =4. It is moderately difficult for him to perform his usual work, housework, or school activities. It is moderately difficult for him to engage in his usual hobbles, recreation, or sports activities. It is moderately difficult for him to get into or out of the bath. It is moderately difficult for him to walk between moms. It is moderately difficult for him to put on socks and shoes. It is moderately difficult for him to squat it is moderately difficult for him to lift an object like a bag of groceries from the floor. It is moderately difficult for him to perform light activities around his home. It is moderately difficult to perform heavy activities around his home. It is moderately difficult for him to get into or out of a car. It is moderately difficult for him to walk 2 blocks. It is moderately difficult for him to walk a miles, it is moderately difficult for him to go up or down one light of stairs (approximately 10 stairs). It is moderately difficult for him to stand for 1 hour. It is moderately difficult for him to sit for 1 hour. It is moderately difficult for him to run on even ground. It is moderately difficult for him to run on uneven ground. It is moderately difficult for him to make sharp turns while running fast it is moderately difficult for him to hop. It is moderately difficult for him to roll over in bed. The scores were added for a total score of 40/80. Based on this scale, where the score of 60 indicates no difficulty and the score of 0 indicates severe difficulty, his score of 40/80 suggests that he has moderate impairment of the bilateral lower extremities. Interpretation of Scores: The lower the score, the greater the disability. The minimal detectable change is 9 points. The minimal clinically important difference is 9 scale points. The percentage of maximal function equals the LEFS score/80. He also complains of left knee pain. Pain occurs in the left knee associated with limited range of motion. He describes his pain as constant in frequency. On a scale of 0-10/10, with 10 representing the worst, he rates the severity of pain at a level of 1/10 per the VAS. Pain is characterized as dull, aching and sharp. Pain is increased to a level of 8/10 with repetitive lifting of 10 lbs repetitive walking for 30 minutes, repetitive standing for 30 minutes, repetitive walking on uneven ground, repetitive squatting/kneeling, repetitive sitting, repetitive weightbearing, repetitive climbing and repetitive ascending/descending stairs and ladders. It takes varying amounts of time for the pain to return to pre-activity level following these

activities. Activities of daily living with respect to left knee pain in the area of self-cam arid personal hygiene, he reports that left knee pain Interferes moderate-to-severe with bathing, personal hygiene and dressing. In the area of physical activity, he reports that left knee pain interferes moderately to severely with walking, standing, squatting/kneeling, carrying grocery bag, climbing stairs, lifting, pushing/pulling, performing household chores and getting off and on the toilet in the area of travel, he reported that left knee pain interferes moderately-to-severely with riding as a passenger and driving in the area of sports and exercise, he reported that left knee pain interferes moderately-to-severely with these activities. In the area of sleep, he reported that left knee pain interferes moderately-to-severely with restful nocturnal sleep. He reports that during the week previous to this examination, he experienced swelling in his knee sometimes. He sometimes felt grinding heard clicking or other noise when he moved his knee. His knee sometimes catches or hangs up when moving. He can sometimes straighten his knee fully. He can sometimes bend his knee fully. He reports that during the week previous to this examination, he experienced moderate knee joint stiffness after first awakening in the morning; moderate knee stiffness after sitting, lying, or resting later in the day. He reports that his knee is painful on a weekly basis and that during the week previous to this examination, he experience pain during the following activities: Twisting or pivoting on his knee produced moderate pain. Straightening his knee fully produced moderate pain. Bending his knee fully produced moderate pain. Walking on a fiat surface produced moderate pain. Going up or down stairs produced moderate pain. At night while in bed, he experienced moderate pain. When sitting or lying down, he experienced moderate pain. When standing upright, he experienced moderate pain. He reports that he is aware of his knee problem on a weekly basis. He has modified his lifestyle moderately to avoid activities potentially damaging to his knee. He is troubled moderately with lack of confidence in his knee in general; he has moderate difficulty with his knee. Based on this scale, where 100 indicate no problems and 0 indicates extreme problems, his score of 50 suggests moderate impairment. He complains of weight gain, diabetes mellitus, hypertension and asthma. Exam: BP: 120/89. WT: 383 lbs. HT: 6'4". HR: 95. Dx: 1) Headaches, industrial causation deferred. 2) Lumbosacral strain/sprain with radiculitis. 3) Lumbar spine disc protrusion per medical records. 4) Left knee strain/sprain, chronic. 5) Status post left knee surgery on 02/18/08. 6) History of anterior cruciate ligament and meniscus tears. 7) Recurrent ligament and meniscus tears per MRI dated 11/25/15. 8) Diabetes mellitus, hypertension, asthma and weight gain, industrial causation deferred. Discussion: Having had the opportunity to examine patient, and having reviewed the mechanism of injury, subjective complaints, and objective findings including diagnostic testing

consisting of MRI, as well as, having had the opportunity to review available medical records by PQME, Dr. Thomas Fell, have arrived at the above-noted diagnoses. Causation: Based on the information provided by patient that there is no history of any unresolved prior injuries, or prior disability resulting In work limitations, it was opined that his current diagnoses listed under the diagnostic impression are the direct result of the injuries this patient sustained on a cumulative trauma period from 04/28/11 to 04/11/12 and on 01/26/08, while working for The Roberts Companies. Causation is deferred with regard to headaches weight gain, asthma, diabetes mellitus and hypertension. Current Disability Status: Treatment provided to him was structured to deliver maximal relief in pain and suffering and to restore occupational and functional capacity to the highest level possible. After treating him and being able to evaluate treatment effectiveness, concluded that his condition has reached Maximum Medical Improvement from a conservative perspective and therefore Permanent and Stationary status for rating purposes. Factors and Findings of Disability: Subjective Factors: Low back pain. Left knee pain. Objective Findings: Lumbar Spine: Decreased limited range of motion as demonstrated on physical examination. Spasm on palpation of the lumbar paravertebral muscles as demonstrated on physical examination. Left Knee: Surgical scars as demonstrated on physical examination. Decreased/limited range of motion as demonstrated on physical examination. Abnormal findings as demonstrated on MRI. Abnormal clinical tests as demonstrated on physical examination. Decreased motor strength as demonstrated on physical examination. Permanent Impairment Rating: Lumbosacral Spine Impairment: 6%. Left Knee Impairment: Patient's impairment as the result of a medial and lateral meniscus tear in the left knee is 9% for the whole person. Impairment was determined to be 10% for the whole person. Whole Parson Impairment percentage was determined to be 18% by combining 9% for the medial and lateral meniscus tear and 10% for status post ligament repair. When performing ADL's and/or any other activity requiring the use of left ankle he experiences moderate discomfort and qualifies for an impairment rating of 20% of the Whole Person. Muscle Weakness: Impairment due to muscles weakness about the knee was determined to be 10% WPI. Whole Person Impairment: 28%. Apportionment: Based on the history given to examiner by him and available medical records there is an indication of prior history of non-industrial factors that contributed to his current disability. In compliance with Labor Code § 4663 and § 4684, have analyzed causal factors of permanent disability for purposes of apportionment and have reviewed reports of consulting specialist. Apportioning 5% of the current level of impairment of the left knee to the prior non-industrial factors and 96% of the current level of impairment to the direct result of his industrial injury, which occurred on a cumulative trauma period from 04/28/11 to

04/11/12 and on 01/26/08 in the course of his employment with The Roberts Companies. With regard to remaining body parts, apportioning 0% of current level of impairment, to the presence of prior industrial or non industrial factors and 100% of current level of Impairment to the direct result of his industrial injury, which occurred on a cumulative trauma basis from 04/28/11 to 04/11/12 and on 01/26/08 in the course of his employment with The Roberts Companies. Benson Supra: Patient has flied 2 separate claims/dates of injury. Each has contributed to the overall residual disability. Therefore, hereby apportion the disability in the fashion required by Benson, supra, pertaining to the new statutory requirement that "apportionment must be based on causation, even in oases involving the same employer; disability must be apportioned between successive injuries wherever it is possible to do so. In accordance with Benson supra, the parties respective physicians must comply with Labor Code § 4863, including obtaining any necessary consultation to assist in the apportionment process." In the following manner in opinion, the disability caused by these 2 injuries became inextricably interwoven. It would not be possible within reasonable medical certainty to provide accurate assessment of apportionment between these injuries. If additional medical records become available for review, will be glad to re evaluate present conclusions. Future Work Restrictions: Since the Whole Person impairment rating discussed herein is not intended to account for the diversity and complexity of work activities, the following work restrictions are warranted as they apply to potential employment in an open labor market. If a formal job description should become available for him, will be happy to comment on restrictions of specific job requirements. The purpose of giving work restrictions is solely to prevent unnecessary exacerbation of pain and re-aggravation of injury, which may lead to repeated periods of temporary disability, and/or result in increased permanent disability. The following specific work restrictions may also prevent further requirements for medical care. These are recommended on a prophylactic basis. Lumbar Spine: Preclusion from the performance of heavy lifting, repetitive bending and stooping, which contemplates the individual has lost approximately one-half of pre-injury capacity for lifting, bending and stooping. Left Knee: Preclusion from the performance of prolonged climbing, walking over uneven ground, squatting, crouching, crawling, pivoting, or other activities involving weightbearing, which contemplates the individual cn do work approximately 75% of the time in a standing or walking position, and uneven ground, squatting, kneeling, crouching, crawling, pivoting or other activities involving comparable physical effort. Functional Capacity Assessment: Limited, but retains maximum capacities to lift including upward pulling and/or carry 25 lbs. Frequently (3-8 hours) lift and/or carry 20 lbs. Occasionally (less than 3 hours) lift and/or carry 25 lbs. Activities Allowed: Stand or

walk a total of less than 4 hours per 8 hours day. Sit a total of less than 8 hours per 8 hours a day. Push or pull including hand or foot controls. Limited to no pushing or pulling over 30 lbs range of motion in joints affected by the injuries. It also will increase muscle strength and improve endurance and level of occupational and social functioning, thus helping integration into a productive workforce. For minor pains, he was instructed to use moist heat applications and massage to the affected parts. He may experience acute exacerbations of pain which, if not treated timely and effectively, may lead to prolongation of temporary partial disability resulting in missed employment or in increase of permanent level of disability. Therefore, he should be awarded an opportunity to be evaluated by qualified medical orthopedic practitioners in case of such exacerbations. If treatment is determined to be warranted, a short course of chiropractic and/or physical therapy, access to over-the-counter, prescription medications and weight reduction, trigger point and/or epidural injections or other necessary modalities such as acupuncture should be made available on a timely basis. He is a surgical candidate for left knee arthroscopic surgery. Future Medical Care: Future medical care should be supportive In nature for periodic recurrent episodes of symptoms of exacerbation that may recur from time to time depending on level of physical activity of him. Behave that future medical care is required for him for the injured lumbosacral spine and left knee. Most importantly, he should maintain an active exercise program that he has been taught In our facility. This is designed to maintain and/or to increase. Vocational Rehabilitation: Have not had an opportunity to review a formal job analysis for him. Did, however, ascertain job duties from him. Based on information provided, it is reasonable to assume that his occupation as a property manager involves a variety of activities, which have been described in detail under the Job description heading of this report. It was opined, he can return to work with restrictions. Return Appointment: Patient will return to clinic on an as-needed basis.

259. 08/25/16 Maria R. Leynes, MD Secondary Treating Physician's Interim Internal Medicine Evaluation. CC: Patient presents for medications. Exam: BP: 125/75. WT: 285 lbs. HR: 90. Dx: 1) Obesity. 2) Weight gain. 3) History of increased WBC and CBC. 3) Anxiety and depression secondary to work injuries. 4) Sleep apnea with weight gain. 5) Hypertension, diabetes, gastritis/gastroesophageal reflux disease and asthma secondary to weight gain. Tx plan: Continue treatment plan. The sleep apnea, hypertension, diabetes, gastritis, gastroesophageal reflux disease, and asthma are compensable consequences of patient's work injuries. Disability Status: He is not Permanent and Stationary from an internal medicine perspective as he would need further treatment for the weight gain. He should have further evaluation on an industrial basis with regards to his complaints of sleep apnea, hypertension, diabetes, gastritis,

gastroesophageal reflux disease, and asthma. With regarding to obesity, he is not Permanent and Stationary. Recommended that obesity be further treated with gastric bypass surgery on an industrial basis and that he receive psych treatment and other workup for the other conditions.

260. 08/26/16 Maria R. Leynes, MD Progress Note. CC: Patient presents for followup. Assessment/Plan: 1) Obesity. 2) Sleep apnea. 3) Hypertension. 4) DM. Ordered labs. (Illegible Hand Written Note)

261. 09/16/16 Thomas W. Fell, Jr., MD Orthopedic QME Supplemental Report. (DOI: 01/26/08; CT 04/28/11 to 11/04/12) Comments: Review of records do confirm that the anterior cruciate ligament and meniscal tears did exist prior to the motor vehicle accident. At the time of the arthroscopy, the anterior cruciate ligament tear were confirmed, as well as the meniscal tears. The operative report also confirms that no repair or reconstruction of the anterior cruciate ligament was done. The medical records from Cedar Sinai do not indicate any additional injury to the left knee. It makes comment only to the fact that he had recent arthroscopic surgery. In regard to the lumbar spine, when examined him in 2009 he had a definite antalgic gait. When examiner saw him 4 years later, there was only a questionable limp on the left side. This indicates to examiner that the gait actually improved during that 4 year period, of time. During the time. his gait improved, his low back pain came on. In 07/2012 was the first time Dr. Komberg mentioned any back pain. This is 3 ½ years after the incident in question at a time when his gait actually improved. Therefore, would have difficulty attributing the low back pain as being secondary and compensatory to a limp. If it was going to be secondary to a limp, he would have developed the back pain at time when the limp was much more significant, that is 2008 and 2009. In fact the 2006 and 2009 period of time would have been when he was most unstable, as ha was recovering not only from the knee surgery and limping from the knee surgery, but limping from the ankle fractures, as well as the tibial fractures on the contralateral side. Would respectively disagree with Dr. Conwisar's apportionment in regard to the lumbar spine impairment. In regard to the left knee, the MRI scan of Dr. Feske suggested possible complex tears of the medial and lateral menisci; however, have the operative report and the findings are the alternative diagnosis given by Dr. Feske that is of previous meniscectomies, medial and lateral. Regarding Dr. Donahue's suggestion of a total knee replacement, Dr Conwisar in his reporting stated that there was a 2 mm joint space on the medial aspect of the knee. This is a moderate amount of arthritis, but not usually severe, enough for total knee replacement. After review of these additional records, it is still opined that his lumbar spine is unrelated to an antalgic gait, since the gait improved in the 4 years between examinations to a very minimal barely visible limp.

The back pain did not occur until 3 ½ years after the injury to the knee. His weight gain is not due to immobility as he is being seen riding his motorcycle and he is able to walk, but he told examiner the weight gain came on after he stopped smoking. This is not an uncommon occurrence. Cannot attribute the weight gain to the injury to the knee, tibia or ankle. With regard to future medical care, because of the instability of the knee and the fact that he has had medial and lateral partial meniscectomies, he is at significant risk for further degeneration of the knees. Allowance should be made in the future for total knee replacement, but based upon examiner's examination of 07/2013 as well as Dr. Conwisar's records just prior to Dr. Donahue seeing him, do not feel at this point that he is a candidate for total knee replacement. AMA Impairment: Using the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. Have not had the opportunity to review the actual weightbearing x-rays, however, based upon Dr. Conwisar's reporting, would then have to change examiner's rating. He would be rated according to Table 17-31. He has 20% lower extremity impairment for the arthritis. Using Table 17-33 he has a 10% lower extremity impairment for the partial medial and lateral meniscectomies and 17% impairment for the moderate instability of the ACL. Using Table 17-3, this converts to 19% Whole Person Impairment. Would not use Chapter 18 in this particular case as the pain is coming mainly from the degenerative arthritis, which has been rated according to Table 17-31.

262. 01/15/17 Melanie R. Cushing, PA-C/Christian Herrera, MD - Providence Saint Joseph Medical Center ED Summary. CC: Foot pain. HPI: Patient presents to the ED for evaluation of gradually worsening pain to the top of the right foot over the past 3 days. There is no specific injury or trauma. He has pain with movement of the foot. He has pain with bearing weight. He has a history of blood clots in the past after a trauma. He reports having rods in his bilateral lower extremities from the accident. He is diabetic but no history of peripheral neuropathy. PMH: Hypertension, asthma, depression, diabetes mellitus and gastritis. Past Surgical Hx: Orthopedic surgery, cholecystectomy, appendectomy and tonsillectomy. Meds: Albuterol, amlodipine, fluticasone-salmeterol, lisinopril-hydrochlorothiazide, metoprolol succinate and pantoprazole. Exam: BP: 126/64. HR: 97. RR: 16. Temp: 98.2 degree F. SpO2: 94%. Lower Extremities: Tenderness to the over the dorsal aspect of the right foot with slight swelling noted. Capillary refill brisk. Neurologic exam: Patient is ambulatory with an antalgic gait. ED Course/MDM: Patient presents for evaluation of right foot pain for the past 3 days, atraumatic. He had slight swelling and tenderness over the dorsal aspect of the right foot. X-ray was negative for any sign of an acute fracture and there is no overlying erythema and examiner did not suspect the latest. Due to his history of blood clots that time was ordered and was negative. Compartments were soft and he was

neurovascularly intact. He will be given a walker and Naprosyn for pain and inflammation. He was advised mandatory followup with his primary care doctor on 01/16/17 for further evaluation and treatment and possible referral to an orthopedic specialist. He may return if he develops new or worse symptoms such as worsening pain decreased sensation redness fever or any new or concerning symptoms. Dx: Right foot pain. Disposition: Patient was discharged. F/u in 24-48 hours with primary care doctor.

263. 01/15/17 Mauricio de La Lama, MD - Providence Saint Joseph Medical Center Radiology/Diagnostics. X-ray of Right Foot. Indication: Foot pain. Impression: 1) No radiographic evidence for fracture. 2) Soft tissues swelling. 3) Partially visualized ORIF hardware of the tibia.

264. 05/03/17 Michael G. Wetter, PsyD - Cedars Sinai Medical Center Progress Note. Patient was seen in clinic for psychological follow up the purpose of this appointment is to assess mood stability and healthy psychological functioning that is supportive to ongoing recovery from surgery, as well as to the continued lifestyle changes expected for long standing weight loss and maintenance. He made a comment months ago regarding suicidal ideation; that was the specific focus of today's assessment. He denies any current suicidal ideation, intent, or plan. He notes that his comment was made purely out of frustration of how long the process was taking to receive bariatric surgery. He feels "lost" due to his inability to be physically active and become healthy as a result of his weight. He realizes that making the comment of suicidal thoughts was not the correct thing to do, but attributes it to his strong frustration and desire to move forward. He while irritated and frustrated by the process, does not present with any immediate or imminent of self harm. His depression appears to be directly linked to his morbid obesity which prevents him to engage in his life in meaningful ways at this time, there is no need for any additional psychological follow up should any psychiatric emergency present itself, he should be immediately directed to an ER for crisis evaluation. He is cleared from psychological basis.

265. 05/03/17 Alexander Gershman, MD - Institute For Advanced Urology Progress Note. CC: Patient c/o urinary stream problems. He states the urinary stream is slow. He also has erectile dysfunction due to significant weight gain. He has this problem for more than 1 year. His symptoms occur with every urination, constant. Exam: BP: 120/70. WT: 409 lbs. HT: 6'4". HR: 70. Temp: 98 degrees F. BMI: 49.8, obese. Dx: 1) Frequency of micturition. 2) Enlarged prostate with lower urinary tract symptoms. 3) Urgency of urination. 4) Nocturia. 5) Feeling of incomplete bladder emptying. Tx plan: Recommended ultrasound of renal and pelvis. Ordered labs. F/u in 1 month.

266. 05/03/17 Richard J. Van Allan, MD - Cedars Sinai Medical Center Radiology/Diagnostics. X-ray of Chest. Indication: Asthma and sleep apnea. Comparison: 02/25/08. Impression: No radiographic evidence of cardiopulmonary disease. Stable exam.

267. 05/03/17 Xunzhang Wang, MD - Cedars Sinai Medical Center Radiology/Diagnostics. ECG. Impression: 1) Normal sinus rhythm. 2) Normal EKG.

268. 05/11/17 Wayne Shin-Way Lee, MD - Cedars Sinai Medical Center Operative Report. Preop/Postop Dx: Morbid obesity. Operation Performed: Flexible esophagogastroduodenoscopy with biopsy.

269. 05/11/17 Stacey A. Kim, MD - Cedars Sinai Medical Center Laboratory. Surgical Pathology. Specimen A: Stomach antrum biopsy. Impression: 1) Oxyntic mucosa with mild chronic gastritis. 2) No significant active inflammation identified. 3) No Helicobacter pylori identified. 4) No intestinal metaplasia or dysplasia identified. Specimen B: Stomach antrum additional biopsy. Impression: 1) Antral and oxyntic mucosa with mild chronic gastritis. 2) No significant active inflammation identified. 3) No Helicobacter pylori identified. 4) No intestinal metaplasia or dysplasia identified. Specimen C: GE junction biopsy. Impression: 1) Squamous mucosa with no significant histopathologic changes. 2) No columnar mucosa identified.

270. 05/18/17 Marie K. Acorda Reece, NP - Cedars Sinai Medical Center Bariatric Surgery Multi-Disciplinary Conference Note. Operation being considered: sleeve gastrectomy. Comorbidities: Diabetes mellitus HgA1 c unknown, obstructive sleep apnea, hypertension; well controlled and morbid obesity. Psychology comments/concerns: Not cleared for surgery. Dietitian comments/concerns: Cleared for surgery. Group concerns: Patient scheduled for bariatric surgery with another physician. Multidisciplinary group impression and comments: Decline patient since scheduled with other physician.

271. 08/09/17 Sergey Lyass, MD Consultation. CC: Patient presents for consultation of morbid obesity. He achieved a maximum weight loss of 10-30 lbs. PMH: Cholecystectomy. PSH: Numerous leg surgeries. Meds: Valium, metformin, Invokana, atorvastatin, Toprol XL, Diovan HCT, Benicar HCT, and lisinopril. Exam: BP: 120/70. WT: 407 lbs. HT: 6'4". BMI: 49.5, obese. Dx: 1) Morbid (severe) obesity due to excess calories. 2) BMI of 45.0-49.9 adult. 3) Adjustment disorder with depressed mood. 4) Essential (primary) hypertension. 5) Gastroesophageal reflux disease without esophagitis. 6) Mild intermittent asthma, uncomplicated. 7) Obstructive sleep apnea (adult) (pediatric). 8) Diabetes mellitus type 2 without complications. 9) Polyosteoarthritis, unspecified. Tx plan: Recommended bariatric surgery for weight loss.

272. 08/10/17 Jane Y. Kaufman, MD - Cedars Sinai Medical Center Cardiology Consultation. HPI: Patient presents with chief complaint of new onset of Afib. Received a call this morning from the surgeon anesthesia saying that this patient is in atrial fibrillation, which is new, and he was totally asymptomatic. I saw him in the office for cardiac clearance recently, and at that time, he was in sinus rhythm. He has morbid obesity, and he just underwent the gastric sleeve surgery. He weighed 417 lbs. PMH: Diabetes, hypertension, morbid obesity, and sleep apnea. PSH: Knee replacement, cholecystectomy, appendectomy and hip fracture. Assessment/plan: Patient had episode of paroxysmal atrial fibrillation in the morning, asymptomatic. It is of concern that he might have paroxysmal atrial fibrillation being asymptomatic. At present time, he is in sinus rhythm. He is not a candidate for anticoagulation at present time anyhow, even if he is in AFib, because he just underwent surgery. However, I am planning to follow him and probably apply a ZIO Patch or some other kind of monitor to ensure that he does not have paroxysmal AFib frequently and he does not have indications for anticoagulation. Otherwise, I agree with your current management.

273. 08/10/17 Sergey Lyass, MD - Cedars Sinai Medical Center Operative Report. Pre-Op Dx/Post-Op Dx: Morbid obesity. Procedures Performed: 1) Robotic-assisted laparoscopic sleeve gastrectomy. 2) Bilateral TAP block.

274. 08/10/17 Cedars Sinai Medical Center Laboratory. **High** glucose **117**, RBC **6.18**, RDW **17.9**. **Low** creatinine **0.7**, calcium **8.4**, hemoglobin **12.8**, MCV **67.3**, MCH **20.7**, MCHC **30.8**.

275. 08/10/17 Mohammad Khan, DO - Cedars Sinai Medical Center Laboratory. Surgical Pathology. Specimen: Stomach, sleeve gastrectomy. Impression: 1) Segment of stomach with oxyntic mucosa with changes consistent with proton pump inhibitor (PPI) effect. 2) No Helicobacter pylori identified. 3) No intestinal metaplasia or dysplasia identified.

276. 08/10/17 Xunzhang Wang, MD - Cedars Sinai Medical Center Radiology/Diagnostics. ECG. Impression: 1) Atrial fibrillation. 2) Abnormal ECG.

277. 08/11/17 Cedars Sinai Medical Center Laboratory. **High** glucose **150**, RBC **5.9**, RDW **16.4**. **Low** creatinine **0.7**, calcium **8.7**, hemoglobin **12.4**, hematocrit **39.3**, MCV **66.6**, MCHC **31.6**.

278. 08/12/17 Michael Shehata, MD - Cedars Sinai Medical Center Radiology/Diagnostics. ECG. Impression: 1) Normal sinus rhythm. 2) Normal EKG.

279. 08/12/17 Melissa Chen, MD - Cedars Sinai Medical Center Discharge Summary. (Admit Date: 08/10/17) Hospital Course: Patient is a 55 year old male who was evaluated in

clinic for morbid obesity. He underwent a robotic-assisted laparoscopic sleeve gastrectomy on 08/10/17. There was a question of a fib preoperatively, but he did not experience any hemodynamic instability intraoperatively. He tolerated the procedure well and was transferred from the PACU to the floor with no complications. The post-operative course was uneventful and without complication. Abdomen remained soft with incisions clean, dry, and intact. Diet was advanced in a stepwise fashion to full liquids and tolerated without nausea or vomiting. Pain was well controlled and transitioned to oral pain medications, and was able to ambulate without difficulty. He did not have any further a fib witnessed during his hospitalization. He was deemed safe and stable for discharge home on 08/12/17. Discharge Meds: Amlodipine, fluticasone-salmeterol, Norco, Invokana, lisinopril-HCTZ, metformin, metoprolol and pantoprazole. Discharge Instructions: Patient was told to call a physician or go to the ER with persistent elevated temperatures, intractable pain, severe nausea, vomiting, or signs of infection, swelling, or bleeding at the incision site, or for any other concerning symptoms. Activity: Patient was encouraged to continue to get out of bed and ambulate. Avoid heavy lifting, strenuous exercise, straining during bowel movements for 6 weeks. Diet: Full liquids. Wound/Line/Drain Care: Advised to keep incisions clean and dry. Ok to shower, no baths. Disposition: Patient was discharged to home in stable condition. F/u with Dr. Lyass, Bariatric surgery and with Dr. Kauffman, Cardiology.

280. 08/23/17 Sergey Lyass, MD Progress Note. CC: Patient presents for f/u on his bariatric. Dx: 1) Bariatric surgery status. 2) Morbid (severe) obesity due to excess calories. 3) Encounter for surgical after following surgery on the digestive system. Tx plan: Patient is status post laparoscopic gastric sleeve. Continue PPIs and protein shakes and multivitamins. F/u in 3 months.

281. 11/20/17 Laboratory. **High** RBC of **6.32**, MCH of **6.0**, MCHC of **2.0**, MCV of **0.6** and glucose of **132**. **Low** HGB of **13.1**, MCV of **66**, MCH of **20.8** and MCHC of **31.6**.

282. 11/20/17 CSJ Providence St. Joseph Medical Center Laboratory. **High** RBC of **6.32**, eosinophils percent of **6.0**, basophils percent of **2.0**, absolute eosinophils of **0.6**, absolute basophils of **0.2**, NT-proBNP of **187** and glucose of **108**. **Low** hemoglobin of **13.1**, MCV of **66**, MCH of **20.8** and MCHC of **31.6**.

283. 11/22/17 Sergey Lyass, MD Progress Note. CC: Patient presents for followup of bariatric surgery. He has laparoscopic gastric sleeve surgery. Exam: BP: 120/89. WT: 326 lbs. HT: 6'4. HR: 68. RR: 15. Temp: 98.5 degrees F. BMI: 39.7. Dx: 1) Bariatric surgery status. 2) Morbid (severe) obesity due to excess calories. 3) Encounter for followup exam after treatment for condition other than malignant neoplasm. Tx plan: Performed laparoscopic gastric sleeve. Continue PPI's, protein shakes and

multivitamins. Required vitamin and mineral supplements after weight loss surgery. F/u in 3 months with Lyass Sergey.

284. 11/22/17 Alexander Gershman, MD - Institute For Advanced Urology Progress Note. CC: Patient c/o right flank pain, microhematuria for 1 week. He has continuous pain unrelated to his position, nocturia, hesitancy and post void dribbling. He has mild nausea. Exam: BP: 115/78. WT: 236 lbs. HT: 6'4". HR: 65. RR: 15. Temp: 98.5 degrees F. BMI: 28.7, overweight. Dx: 1) Frequency of micturition. 2) Nocturia. 3) Other specified disorders of kidney and ureter. 4) Calculus of kidney. 5) Right upper quadrant pain. Tx plan: Ordered labs. Recommended renal and pelvic ultrasound and uroflow study. Recommended cystoscopy to rule out microhematuria, CT is optional. Ordered abdominal CT scan. NSAIDs recommended to provide pain relief and reduce ureteral spasm. Encouraged to increase fluid intake. Also recommended limiting dietary oxalate, animal protein and salt, increasing fruits and vegetables. F/u in 1 month.

285. 11/22/17 Medical Measurement Systems Radiology/Diagnostics. Uroflow Study. Impression: Normal exam.

286. 12/07/17 Dianna Chooljian, MD - Providence St. Joseph Medical Center Radiology/Diagnostics. MRI of Lumbar Spine without Contrast. Indication: Low back pain for 2 days. Comparison: 11/30/17. Impression: 1) Straightening of the normal lumbar lordosis is present with 2 mm degenerative retrolisthesis of L5 on S1. 2) Multilevel broad-based disc osteophyte complexes as noted above contributing to congenital spinal canal stenosis with moderate central canal stenosis at L2-L3 through L4-L5 levels. 3) Multilevel neural foraminal stenosis at the L3-L4 and L4-L5 levels. 4) A 1 mm left subauricular recess disc protrusion at T12-L1. 5) A 2 mm central disc protrusion at L2-L3. 6) A 3 mm central disc protrusion and annular tear at L4-L5. 7) Multilevel facet and ligamentum flavum osteoarthropathy as noted above.

287. 12/11/17 George Mednik, MD - Olympic Imaging Services Radiology/Diagnostics. Thyroid Ultrasound. Impression: 1) Thyroid gland is mildly enlarged. 2) Hypoechoic lesion in the upper pole of the right lobe of the thyroid.

288. 03/05/18 Michael D. Smith, MD Panel Qualified Medical Evaluation. (DOI: 01/26/08; CT 04/28/11 to 04/11/12) HPI: For back pain, there is pain in the lumbar and lumbosacral regions. The pain frequently radiates down the right and left leg with numbness and tingling. The symptoms are increased by pushing, pulling, lifting, carrying, reaching above shoulder level, twisting, stooping, bending, squatting, climbing stairs, prolonged positions, sudden movement and by a cold environment. The back symptoms are also increased by prolonged standing, walking or sitting. For left knee, there is pain in the

left knee. The knees no longer bend as easily as before the accident. The symptoms are increased by prolonged standing or walking. They are also increased by twisting, climbing stairs, and by a cold environment. For left ankle and foot, there is pain in the left ankle and foot. The symptoms are increased with any prolonged standing or walking, walking on uneven surfaces or up and down stairs, and wearing certain shoes. CC: On 01/26/08, patient fell down. He sustained cumulative work trauma due to repetitive work activities. He sustained injuries to the back, left knee, and left ankle and foot. His employer was notified. He was seen at UCLA ER where x-rays were taken and medications were prescribed. He has since received treatment with physical therapy. He had no other accidents or injuries to the areas of current concern. PMH: High blood pressure, diabetes, asthma, arthritis and heart disease. Dx: 1) Lumbar spine injury. 2) Left knee injury. 3) Left ankle and foot injury. Causation: The back, left knee, and left ankle and foot symptoms, impairment and associated disability are the result of the 01/26/08 work accident. There is no evidence of any cumulative work trauma both in the medical records nor in his history. The findings are consistent with the injuries claimed by him. Apportionment: Having taken into account the new legislation SB899 with regard to the changes in Labor Code § 4663 and 4664, and having reviewed his history, medical records, x-rays, diagnostic testing, have come to the following conclusions. He is taking into consideration the cumulative work trauma, and the possibility of any preexisting or non-industrial injuries or any post-industrial injuries, it is concluded that 100% of his current causation of the back, left knee, and left ankle and foot disability is the result of the 01/26/08 work accident. There is no history of injuries or disability prior to the 01/26/08 work accident and no evidence of cumulative work trauma that caused any injuries in this patient's symptoms or disability. Objective Factors of Disability: For thoracic region, normal examination. For lumbar region, restricted torso motion. Abnormal straight leg tests suggesting sciatic nerve irritation. Restricted squatting. For left knee, multiple parapatellar scars. Anterior and lateral joint tenderness. Impaired knee motion. Restricted squatting and kneeling. For left ankle and foot, 3-inch medial ankle scar. Ankle tenderness. Impairment Rating: Whole person impairment rating is 27%. Vocational Rehabilitation: Because of his injuries, he cannot work the regular, unmodified job. However, a return to the pre-injury place of employment is appropriate if reasonable accommodations can be made to coincide with the work restrictions. Future Medical Care: Medications per MTUS. Lumbar disc surgery and/or left knee replacement surgery may be needed in the future. Recommended urology Qualified Medical Evaluation for evaluation of impotence and internal medicine Qualified Medical Evaluation due to weight gain. Work Status: Because of the back condition, the work capacity is limited to no heavy work with no

lifting greater than 20 lbs and no repeated bending or stooping. Because of the left knee and left ankle-foot conditions, the work capacity is limited to preclude heavy lifting and carrying, all but occasional squatting, kneeling, stair and ladder climbing, working on ladders or scaffolds, all work on unsteady surfaces and rough or uneven ground. Work should be at ground level.

289. 04/05/18 Illegible Signature Adult Progress Note. CC: Patient was seen by on (illegible). He complains of mild (illegible). Exam: BP: 118/81. WT: 329 lbs. HT: 6'4". HR: 68. RR: 12. Temp: 97.5 degrees F. Dx: 1) Morbid obesity. 2) History of atrial fibrillation. Tx plan: (Illegible). Ordered labs. (Illegible Handwritten Note).

290. 04/09/18 Jan H. Merman, MD Panel QME Consultation. (DOI: 01/26/08; CT 04/28/11 and 04/11/12) Hx of Injury: Patient has had no headaches before 02/22/08. He had an injury from 1997-1998 where he fractured his left middle finger. It was a Workers' Compensation injury and he does not remember the details. He on 01/26/08 was attempting to fix a gate. It was apparently raining. He fell hitting his left knee against the ground. He had left knee pain and swelling. The next day, he went to UCLA Hospital. He had x-rays which revealed "torn ligaments." However, no surgery was done at that time. On 02/28/08, he was hit by a car while crossing street. He was unconscious for about 2 days. He does not remember the details of the accident. He had a fracture of his right lower leg and left ankle. He was admitted to the hospital for 8 days and had surgery on both legs with nails and rods. He had laceration of his head and his memory was "erased." He had some headaches after this injury lasting about 3-4 weeks. He did not see a neurologist outside the hospital. After this injury, he noted numbness in his arms and legs. He reported this injury, but Workers' Compensation refused any treatment. He did go and have rehabilitation for his right leg, but no immediate treatment for his left knee. He stopped working after the 02/22/08 injury. He stopped working after the 02/22/08 injury and went back on modified duty in 2011. He worked as an actor. He over time did gain a lot of weight and he saw multiple doctors whose names he has trouble remembering. He was sent for weight reduction. He notes that his weight gain started significantly in 2011 through 2012 and 2013. He got up to 417 lbs in 08/2017. It is now down to between 329 lbs after a sleeve was placed in 08/2017. He also developed hypertension and asthma and he had weight gain and he got treated for it. He was given blood pressure pills, but he cannot remember the names of the blood pressure medicine. Beginning in 2015, he began to get headaches lasting about 30 minutes. Headaches were not specifically treated. He told that he started to have sleep apnea when he weighed 315 lbs and started on CPAP in 2017. CC: Patient complains of headaches 2-3 days a week in the middle of frontal areas. They last 45 minutes. He takes Tylenol and it goes away. The headache starts

gradually and builds up. It "like a bruise." It is between 3-5/10 in severity. There is no nausea or vomiting. It is aggravated by stress and bending over, but not by light, noise or Valsalva maneuver. He complains of depression and anxiety, which started when he was fired in 2011, although he had some depression before being fired. He has hearing loss in his left ear because of "swimmer ears." There is no tenderness, dysarthria or dysphagia. He complains of gait disorder because of his increasing weight, but there are no recent falls. He used to be very athletic due to the fact he was on the Junior Ukrainian Olympic Team for downhill skiing before the age of 18 years. He also did in his acting career a lot of physical activity before his injuries. He used to play beach volleyball three times a week and then stopped. He "did not eat much." He started smoking at the age of 25, 8-10 cigarettes a day and stopped in 2008. He took a weight loss program in 2011. In 2012, he went from 270-245 lbs. It was "costly." He was on a physical program from 2008-2009. He rarely gained about 5-10 lbs. He complained of shortness of breath with his weight gain and was diagnosed with "asthma." He also had discomfort and arrhythmia in 08/2017. He saw a cardiologist. She placed him on metoprolol and possibly "blood thinners" although he does not know the names of his medicines. He complains of some chest pain for two to three times a month, comes off and on without exertion and may last as long as 7 hours. He had an EKG which is "normal." He probably never had coronary angiogram. His uncle had Parkinson disease. His mother had heart disease, hypertension and type 2 diabetes. Vitals: BP: 126/90. HR: 82. RR: 16. Dx: 1) Cerebral concussion with 10-cm laceration slightly superior to the left ear, non-industrial. 2) Tibia-fibula fracture of the right lower extremity, non-industrial. 3) Left foot fracture of the ankle, non-industrial, status post open reduction and internal fixation with multiple surgeries. 4) Pulmonary embolus, non-industrial. 5) Hypertension, non-industrial. 6) Tension headaches, non-industrial. 7) Obesity, non-industrial. 8) COPD, non-industrial. 9) Sprain/strain of the left knee with meniscal tear and ACL tear, status post arthroscopic partial medial and lateral meniscectomies. 10) AODM type II, he is on medications, does not know the names, discovered in 2011. 11) Kidney disease type unknown, possibly a cyst. 12) Sleep apnea, diagnosed in 2017. 13) Peptic ulcer disease, date unknown. Discussion: Saw patient in panel QME consultation on 04/09/18. He was a property manager for the Roberts Companies and also did acting. He had a previous fracture of his left middle finger in 1997 and 1998. This was a Workers' Compensation injury. He does not remember the details. On 01/26/08, he was attempting to fix a gate. It was raining. He fell hitting his left knee against the ground. He had left knee pain and swelling. He went to UCLA Hospital on 01/27/08 and was treated. He was in discomfort at that time. On 01/28/08, he had an MRI scan of his left knee which revealed a tear of the anterior cruciate ligament with moderate joint

effusion, mild partial thickness, chondromalacia of the lateral facet at the patella. He was referred to Dr. Mandelbaum, an Orthopedic surgeon. He saw him several times and he had surgery on his left knee on 02/18/08. Four days later, he was hit by a car, was knocked unconscious for a few minutes. He was taken to Cedars-Sinai Medical Center. He had a fracture of his right tibia and fibula and had a right tibia intra-medullary nailing and the left ankle open reduction and internal fixation. He developed pulmonary embolus and had an IVC filter was placement on 02/25/08. He was noted to have a deep vein thrombosis causing this pulmonary emboli. He was weightbearing before this accident and he was non-weightbearing on discharge from UCLA on 03/04/08. He had a laceration repaired in the hospital and on 02/22/08, he had a non-contrast CT scan of the brain which revealed a facial fracture. Otherwise, the brain was pretty much normal. He did have some fluid in the left maxillary sinus and extensive right scalp laceration. He had a CT scan of the cervical spine on 02/22/08, which revealed no acute disease. His left tibia and fibula x-rays revealed a slightly displaced fracture of the medial malleolus and had a nondisplaced fracture seen on the lateral malleoli. The x-ray of the left ankle revealed a soft tissue swelling and nondisplaced bimalleolar fracture on 02/22/08. Dr. Nathan McNeil saw him on 02/22/08. He denied a smoking history, alcohol or drug use. There was no previous history of hypertension or asthma or heart disease. His EKG in 02/23/08 revealed sinus tachycardia, otherwise it was normal. He on 03/24/08 had a history and physical evaluation for a surgery to be done on 03/28/08. It was noted that he had a history of leukocytosis and he had "borderline blood pressures," but was never treated with medications. He also had prostadynia without any clear-cut etiology. He had a previous history of cholecystectomy. Blood pressure at that time was 122/82. He was 64 inches tall and 255 lbs and BMI of 31 kg/m2. He on 04/28/08 weighed 277 lbs and his BMI at that time was 33.87 kg/m2. He noted himself that he had gained "significant amount of weight over the last several weeks and was asking for activities which seemed to help him lose weight." His left ankle was doing well at that time. He was referred to Dr. Gart. Have a progress note from 05/15/08 and 06/23/08. He was to be treated for his back pain which he developed after the accident. He was started on a course of physical therapy with a weight loss program. He was experiencing some pain, although he was getting better. He had some tenderness of left knee and tenderness of the paraspinous muscles on 06/23/08. He continued to be treated. His right tibia and fibula fracture on 11/06/08 on x-ray showed some healing. He then had removal of the screw and was seen by Dr. Saliman on 02/11/09. He was doing "quite well" at that time and had minimal complaints. He saw Dr. Fell, Jr., a panel QME, on 07/27/09. He had pain above his legs and left knee after a brief walking. His left ankle gave him some pain. He had some difficulty with stairs and problems

squatting. His right leg was "a mess." He had plantar fascial pain early in the morning. He could not squat fully on his left because of his left ankle. He had pain after 5-7 minutes of walking in the left ankle but no swelling. He stated his weight was 287 lbs with a BMI of 49.9 kg/m2. He had a slightly wobbly gait and it was antalgic. He had difficulty arising from a chair. He had some mild tenderness of the medial facet at the patella and some crepitus in the left knee. Diagnoses at that time were: 1) Sprain/strain of the left knee with meniscal tear and ACL tear, status post arthroscopic partial medial and lateral meniscectomies. 2) Fracture of the left ankle, non-industrial, status post open reduction and internal fixation with multiple surgeries. 3) Mild shaft tibial fracture, right, non-industrial, status post open reduction and internal fixation with multiple surgeries. Dr. Fell did not feel that his subsequent accident increased his left knee disability. He gave him a 5% preexisting pathology apportionment for his left knee, 95% aggravation of further injury for his left knee was as a result of work incident on 01/26/08. His Whole Person Impairment was 13%. He saw Dr. Rashti, an Orthopedic surgeon, on 10/31/12. The diagnoses were: 1) Status post left knee surgery by history and anterior cruciate ligament ACL tear. 2) Status post open reduction and internal fixation of the right and ankle by history. 3) Lumbar radiculitis, compensable consequence. 4) Obesity compensable consequence. He when he saw Dr. Rashti was complaining of constant low back pain radiating into the legs with numbness of the thigh. The constant left knee pain was aggravated by 20 minutes of walking. He was Temporary Totally Disabled. He also had continuous trauma of his back due to repetitive work activity also a compensable consequences of industrial injury. His causation was industrial. He was also referred to Dr. Komberg who he saw mostly in 2012, a chiropractor) you can review his reports. He saw Dr. Fell again on 07/30/13 for QME evaluation. Since his last examination, he was "always going to the gym, walking 45 minutes, and doing bike exercises." He went to the Lindora program and lost weight from 294 lbs and he lost weight all the way down to 235 lbs in 2012 and gained 100 lbs since that time. He felt his left knee pain increased in 2012 and went to the Toluca Lake Clinic. He has been doing walking and swimming and has a personal trainer. His left knee was feeling "weak" and he had difficulty going up and downstairs. He was also complaining of lower back pain which he attributed to the weight gain and difficulty getting out of weight. He could not lift or bend. He had numbness and tingling in the left thigh. There were some "neurologic or radicular symptoms." He had normal motion of the left knee, but +2 anterior cruciate ligament instability. He had decreased sensation of the left lateral thigh. In his discussion, Dr. Fell noted that he was a smoker and did lose weight on his own after Lindora program. He was down to 230 lbs; however, over the past year and a half he gained it back. He felt it was significant that

he quit smoking year and a half ago with concurrent weight gain. He did have three years when he was not gaining weight; however, he felt that he was not getting enough exercising which caused his weight gain. He developed some low back pain which was due to a limp which Dr. Fell thought was minimal. He has had the same problem for 4 years. Dr. Fell noted that he went to the gym regularly and did aerobic exercise and it was not the lack of exercise that was hindering him. The weight gain was secondary to cessation of smoking. His apportionment was unchanged. He saw Dr. Julian Girod, an Orthopedic surgeon, on 08/31/12. He was complaining of constant severe pain and restricted mobility. He was seen by Dr. Maria Leynes on 09/05/12 and she tried to get him into a weight loss program which was pending. His blood pressure at that time was 137/94 with a pulse of 99 and his weight was "380 lbs." He lost 2 lbs from 08/08/12. He was to resume his weight loss program at Lindora with a decreased diet, decreased fat and exercise regularly, bypass was still an option. He had further studies of the left knee. He had an MRI arthrogram of the left knee on 06/14/12 which revealed complex tear of the posterior horn of the medial meniscus extending both superior and inferior articular surfaces. There was a previously described Baker's cyst. He continued to see Dr. Rashti. Dr. Rashti did obtain on 07/31/13 a back functional data. He noted at that time his pain was "bad," but he managed to not take painkillers. He had further back functional data. He saw Dr. Rashti again on 06/26/13 and 07/10/13. He was sleeping for less than 6 hours. His pain was "bad" and he could only lift fairly light weights. The pain prevented patient from walking "more than a quarter of a mile." The back functional data scores, see his notes for his disability scores and back functional data scores. He had a nerve study on 01/30/13 which is somewhat uninterpretable. It is noted on 01/30/13 by Dr. Rashti that his weight was 325 lbs; however, by the time he saw Dr. Rubanenko, his weight on 11/04/15, an Orthopedic surgeon, his weight got up to 360 lbs however, his blood pressure was 110/70. On 11/30/15, he had another MRI of the left knee. He also saw Dr. Donahue several times. On 02/24/16 and he complained of headaches or at least had a history of headaches. He also was having problems with hypertension and diabetes mellitus and asthma. His weight increased up to 417 lbs in 08/2017. In 08/2017, he had a gastric sleeve and he also noted he developed hypertension and asthma. He was given blood pressure pills but he could not remember the names of the blood pressure medicine. He told me his headaches began in 2015 and lasted 30 minutes and were not specifically treated. He also was diagnosed with sleep apnea when he weighed 315 lbs and was on CPAP in 2017. He complains of headaches 2-3 days a week in the mid frontal area, they last 45 minutes. He takes Tylenol and they disappear. They start gradually and build up and it is "like a bruise" between 3-5/10 in severity. There is no nausea or vomiting. It is aggravated by stress

and bending over. He complains of depression and anxiety which started when he was fired in 2011, although he had some depression before being fired. He denies any loss of smell or taste or diplopia, but has blurred vision for distance. He has hearing loss in the left ear because of "swimmer1s ears." He complained of a gait disorder or trouble walking because of his recent weight gain. He complained about shortness of breath and weight gain and was diagnosed with "asthma." He also had discomfort and arrhythmia in 08/2017. He saw a cardiologist at that time. She placed him on metoprolol, blood thinners and he does not know the name of the other medications. He has had complaint of chest pain two to three times a month which comes off and on without exertion and may last as long as 7 hours. There are no other general symptoms. His physical examination revealed that he was very obese and in no acute distress. His blood pressure was only 126/90 with a pulse of 82 and regular. His general exam revealed he had a significant amount of ear wax bilaterally both ears and poor dentition. His lungs were clear. Could not hear any wheezing. Cardiovascular system was normal. The abdomen was very obese. Bowel sounds were intact. He had multiple small scars on his abdomen. There was no tenderness or organomegaly. His extremities revealed a 3.3-cm scar slightly below the right knee with some bulging in the bone on the right shin. He had small surgical scars in the anterior shin area. He had bulging mass in the anterior part of his right lower extremity. In the upper extremities, he had a small cyst on the left thumb with some scarring. Could not feel his peripheral pulses in the lower extremities. He has significant tenderness around the left large toe to palpation. After review of his information, he probably has tension headache disorder and the probable cause is the combination of stress related to his 2 injuries. His medical illnesses are basically dependent on several causations. 1) Increasing age. 2) History of smoking. 3) Possibly the most significant one would be obesity. There are several questions about his obesity. He could not do anything about his age and his genetics and male sex and his smoking history. The question is whether or not his obesity was industrially caused. Thought the predominant evidence points to overeating as the cause of his weight gain. Therefore, at this point in time, it would have to be non-industrial. Unless someone can provide any evidence to show that his overeating is industrial in nature, the cause of this would be non-industrial. Will also let the parties know that he was actually obese. Either shortly before or shortly after his second injury, his BMI in March was 31 kg/m2. This is defined as obese since obesity is defined as over 30 kg/m2. However, his BMI increased with time, but it also decreased to the point where it was less than 30. It decreased primarily due to his dieting at Lindora and not due to any exercise which is he may not have participated in. He apparently went to the gym and was doing stationary bike. Therefore, he is getting some exercise. Noted that on 07/22/05, he weighed 250

lbs. He was 6 feet 4 inches. Therefore, he was not obese at that time. Next question is how effective actually is exercise in weight loss or preventing obesity. Apparently, review of the literature reveals that exercise had some effect, but not much. People in general tend to gain weight as they age; however, he, as noted through the Lindora program, could control his weight. The actual role of physical activity and exercise in controlling obesity in adults is somewhat important, but without diet it is not as effective. The exercise only results not as reduction in weight compared with no treatment. The weighted difference is only minus 1.6 kg which is about 3.52 lbs. It does, however, have a beneficial effect in reducing body fat and insulin resistance. However, exercise programs added to diets with monitored caloric restriction have a little additional effect upon weight loss. According to the authors Leigh Perreualut, et al. and up-to-date obesity in adults and role of' physical activity and exercise in 03/2018. Exercise programs added to diets with monitored severe caloric restriction have little additional effect upon weight loss. Seventeen randomized trials in overweight and obese patients showed that compared with weight loss by diet alone, adding exercise to diet produced slightly greater weight loss than diet alone. Mean increase in weight loss was approximately 1.5 kg which is again around 3.5 lbs; however, the results were only statistically significant in 2 trials. The exercise interventions ranged from 60 to 240 minutes a week. Similar findings were found in obese older adults, mean age 70 years, who were randomly assigned diet or exercise alone or diet plus exercise. Body weight decreased similarly in the diet alone than diet plus exercise groups, 10 and 9% respectively, but did not decrease on the exercise alone or control groups; however, physical functioning improved significantly in all treatment groups. Weight loss is important. According to obesity in adults and overweight management, author Leigh Perreault, MD. et. al. 03/2018, the higher the BMI index the greater risk of morbidity and mortality. BMI of 20-25 kg/m2 is associated with a little or no increased risk unless waist circumference is high which is a marker of increased cardiometabolic risk when the has gained more than 10 kg since the age of 18 years. Low risk is in 25-29.9 kg/m2 with one or more risk factors for CVD including diabetes, hypertension and dyslipidemia; however, the MI alone of 30-34.9 kg/m2, they are at moderate risk. High risk is anywhere from 35-40 kg/m2. Above 40 kg/m2 are at very high risk from the obesity. It is interesting to note that even when he was heavy, his blood pressure was normal at several points. When saw him, his blood pressure was only 126/90 which is basically normal, except for slightly elevated diastolic blood pressure. His BMI was less than 30 kg/m2. He only weighed 329 lbs at this time. As far as his asthma is concerned, he was a smoker. He may have COPD which may be partially related to tobacco use which can cause shortness of breath, although shortness of breath could also be due to weight

gain causing restrictive disease of his pulmonary function. Asthma is an obstructive decrease in pulmonary function as well as emphysema and bronchitis which he does not have. It may be difficult to separate out the effects of tobacco from actual asthma. Frequently older adults who have asthma, it starts in the childhood which may disappear and then come back again as they get older. According to Up-To-Date Diagnosis Management of Asthma in Older Adults, author Carlos A. Fragoso, MD, et. al. 03/2018, the prevalence of asthma in adults age 65 and older is estimated to be 40% and up to half older people with a diagnosis of asthma are current or former smokers. Cigarette smoking is a major cause of COPD and emphysema. It also increases production of IgE antibodies and bronchial response and production of inflammatory markers in the sputum in older asthmatics. Tobacco smoking is not a major risk factor for development of asthma in older adults, but can contribute to worsening control. He has not had any pulmonary function tests. Therefore, do not know if he has asthma or not. Obesity and deconditioning can also add to shortness of breath. Smoking is also a risk factor for coronary artery disease as well as hypertension. However, the evidence shows in him that he actually did exercise even with his injuries. It is obvious that the 2nd injury is much worse than the first. It is also obvious that his diet got out of control which caused him to gain weight and it is also obvious that overeating caused his obesity to get out of control and that his diet caused him to lose weight down to a BMI of less than 30 kg/m2. Therefore, would have to agree with Dr. Fell that his obesity aggravated his diagnosis of asthma, organic heart disease, hypertension and diabetes and is not industrial. Although there are some benefits from exercise, exercise alone cannot cause any substantial weight loss which is actually proved in this patient. If look at the anesthesiology note from 07/22/05, there is a mention that he had hypertension for 5 years which was obviously before his two injuries. As far as his headaches are concerned, he probably has a tension headache disorder the causation of which may be due to both of his injuries. Interestingly enough, there is very little mention of headaches from 2011 on to this time. He never saw a neurologist and never got treated, specifically for his headaches. He has sleep apnea which by the way is usually seen in obese males over the age of 50 who have short necks. The sleep apnea can also cause elevated blood pressure which can contribute to hypertension as well as headaches although at this time, do not think it is causing his headache disorder. Therefore, since a neurologist, will speak of his headaches. Thought the causation is probably a combination of his 2 injuries which caused him to have increased stress. Trying to separate out the 2 is difficult. It may seem obvious that the 2nd injury was much worse than the first and would cause him the more stress, although I do not have an evaluation by his psychiatrist. He is not quite Permanent and Stationary for his

headache disorder and should be treated. Assuming he does not have kidney stones, would use Topamax or Zonegran since they can cause weight loss. Before finish this evaluation, would defer his disability, apportionment, vocational rehabilitation and work restrictions until he gets three to 6 months of headache treatment. He can then be sent back for further evaluation. He should be treated by a neurologist who can use either Topamax, Zonegran, beta-blockers, calcium channel blockers. Increase his beta-blockers assuming his cardiologist agrees. Tricyclic antidepressants may be useful, but unfortunately they can cause arrhythmias and weight gain. Exercise is also a good treatment for headaches. He can increase his exercise level by using swimming or stationary bike. Obviously, he has to diet which will help him overall. Can then send him back for further evaluation after some treatment for his headaches.

291. 04/11/18 Sergey Lyass, MD Progress Note. CC: Patient presents with chief complaint of bariatric surgery. Exam: BP: 110/70. WT: 333 lbs. HT: 6'4". BMI: 40.5 kg/m2. Dx: 1) Bariatric surgery status. 2) Morbid obesity due to excess calories. 3) Encounter for followup exam after treatment continued other than malignancy neoplasm. Tx plan: Recommended to continue PPI's, protein shakes and multivitamins. F/u as needed basis.

292. 04/11/18 George Mednik, MD - West Coast Medical Diagnostic Service, Inc. Radiology/Diagnostics. Carotid Duplex Scan Examination. Impression: 1) Soft plaque measuring 0.3 cm with 20% narrowing of the lumen in the left bifurcation. 2) Spectral broadening of the left internal carotid artery consistent with 15-49% stenosis.

293. 06/06/18 Physicians Diagnostic Reference Laboratory Laboratory. **High** RBC of **6.31** and basophils percentage of **2.53**. **Low** MCV of **72.3**, MCH of **21.9**, MCHC of **30.3** and neutrophils percentage of **35.00**.

294. 08/10/18 Michael D. Smith, MD Supplemental Orthopedic Report By Qualified Medical Evaluator. Based upon review of records I am in receipt of your 08/07/18 correspondence and have reviewed prior report with regard to the non industrial car accident, I apportion 100% of his left ankle and foot disability is the result of the 02/22/08 car accident with regard to the left knee disability, I apportion 25% to the non industrial car accident of 02/22/08 and 50% to the 01/26/08 work accident and 25% to obesity.

295. 09/07/18 Alexander Gershman, MD - Institute For Advanced Urology Progress Note. CC: Patient presents with chief complaint of prostatitis. Quality is dull and aches. Associated signs and symptoms include urinary frequency. Dx: 1) Prostatodynia syndrome. 2) Other specified disorders of prostate. 3) Chronic prostatitis. 4) Prostatocystitis. 5) Frequency of micturition. 6) Nocturia. 7) Urge incontinence. 8)

Male erectile disorder. Tx plan: Prescribed Cipro. Labs were ordered. Ordered ultrasound. F/u in 3 months.

296. 09/27/18 Jan H. Merman, MD Supplemental Panel QME Record Review. Medical records of Dr. Michael D. Smith and also reviewed panel QME consultation from 04/09/18 versus Dr. Michael D. Smith on 05/05/18 were reviewed. His current symptoms are back pain that frequently radiates down the right and left leg with numbness and tingling. This is in the lumbosacral regions increased by pushing, pulling, lifting, carrying, reaching above left shoulder level, twisting, stooping, bending, squatting, climbing stairs, prolonged positions, sudden movement, and cold environment. These also had increased by prolonged standing, walking, or sitting. He also complains of left knee pain which does not bend as easily as before. It increases with prolonged standing, walking, twisting, climbing stairs, and cold environment. He also complains of left ankle and foot pain aggravated by prolonged standing or walking on uneven surfaces or up and down stairs and wearing certain shoes. The activities of daily living are described. He has difficulties with personal hygiene including defecating, urinating, brushing his teeth, combing his hair and bathing, and sexual dysfunction with orgasm, lubrication and erection. He also has difficulty with hearing, tinnitus, tasting problems, and feeling problems. The physical activities impaired including standing, sitting, climbing, walking, and climbing stairs. He also has difficulty with non-specialized hand activities. He has trouble driving and writing. He has poor restless leg. In his history of current complaint, patient on 01/26/18 fell down. He sustained cumulative work trauma due to repetitive work activities. He sustained injuries to the back, left knee, and left ankle and foot. His employer was notified. He went to the UCLA Emergency Room and had x-rays. He had no other accidents or injuries in the areas of current concerns. Other medical history, he is currently taking no medications. He did perform "leg maintenance" very tightly and showing properties, checking and scheduling maintenance, and working with vendors. Medical record is reviewed. On physical examination, his neck appeared to be mostly normal. He had moderate tenderness of the lumbar spine on both sides and in the center. He had limitation of motion of his lumbar spine. His gait was normal. There was no limping or tandem gait or heel gait. The squatting appeared to be symmetrical. There was no increased pain with changing positions. Sitting did not cause pain. Strength was normal in the lower extremities. His Achilles reflexes were absent. Patellar reflexes are +1. Sensation was normal from the waist to the toes. Circumferences of the lower extremities were normal. Knee motion appeared to be symmetrical. There is some moderate tenderness to palpation of the left knee. He had tenderness of the left anterior deltoid and talofibular, talocalcaneal ligaments and joint line on the left. There was brief

bibliography presented. Dx: 1) Lumbar spine and left knee injury. 2) Left ankle and foot injury. Causation: The back, left knee, left ankle, and foot symptoms and impairments and associated disability are the result of 01/26/08 work accident. There is no evidence of any cumulative work trauma in patient's history. Findings are consistent with an injuries claimed by patient. He is currently permanent and stationary for rating purposes. Thoracic region was normal. His lumbar region was restricted in torso motion and abnormal straight leg test suggesting sciatic nerve irritation. Also, reviewed the MRI scan of 04/29/08 and 10/03/12. He also noted objective factors of disability of the left knee and left ankle and foot. They have previously described Baker's cyst. Work status and restrictions, they gave work restrictions to his back, lifting no greater than 20 lbs, no repeated bending and stooping. He was precluded from heavy lifting and carrying all but occasional squatting, kneeling, stair and ladder climbing, working of ladders and scaffolds, walking on unsteady surfaces, and impairment rating was given. His left lower extremity was 10% whole person impairment. He got 13% whole person impairment for his lumbar spine through DRE lumbar categories relating. He had 6% impairment for his left ankle and foot. He is a qualified injured worker. Discussion, he could not work modified duties as he is a qualified injured worker. Apportionment; back, left knee, left ankle, and foot disability as a result of 01/26/08 work accident. He has no history of injuries or disability prior to 01/26/08 accident. He had no evidence of cumulative trauma that caused any injuries and patient's symptoms or disability. He might need lumbar disc surgery and left knee replacement surgery. Next one is a urology QME an internal medicine evaluation due to his weight gain. Other available medical records were reviewed. Discussion: After deposition a day before and review of the further medical records from Dr. Smith, would like to discuss three points: 1) Brought up the fact and thought deposition is too much money, $1050. However, scheduled deposition for two hours, from 3 to 5, which is what always generally do for worker's compensation depositions. Also, the night before, around 8:30 or 9 p.m., started to review report which took about an hour. Therefore, actually got three hours of time which tends out to be $350 an hour. Did not provide me with any guidelines on how to charge for deposition. However, other circumstance such as personal injury depositions, the deposition fees are much higher, which are over $500 an hour. Will send a copy of schedule from yesterday to prove that gave two hours of deposition time from 3 to 5 p.m. 2) One of the parties was overly aggressive in the questioning. They would not let me and frequently interrupted when had to say. Thought that this was unfair and the party was obviously angry about opinions, which show problems with his temperament. Therefore, it would be helpful that the parties in question would be a little bit more judicious and allow persons to try to answer the questions. This kind of

questioning and activity does interfere with one's thinking and ability to use of the question slowly. 3) If you look at Dr. Smith's report from 03/05/18, one notes that he was "currently taking no medications" for his pain. Therefore, one of the questions is how severe was his pain in his lower extremities. In addition, he does not make signs that can tell, he does not make any connection in the evaluation of patient's injuries to his obesity. He notes that patient was "normally developed and nourished male" on his physical examination. Patient was significantly obese. 4) He does not make any connection between the second injury and his first knee injury. Think this is a problem for instance how did the second injury affects the first injury since without the second injury patient's prognosis and healing might have been significantly different. If he does not think so he could have obviously stated and/or give his reasons for it. During the deposition, did not go over Dr. Gart's 05/2007 progress note for patient's epidural of his lumbar spine. The date of service was 05/03/07. In his post-procedure diagnosis, he noted that he had a "lumbar disc herniation" and lumbar facet syndrome and lumbar radiculitis. He gave facet injections at L4-L5 and L5-S1 and again L4-L5 lumbar epidural steroid injection. In other words he had significant preexisting disease prior to his knee injury and it was necessary for him to get significant treatment outside of "conservative care." Probably in order to make the diagnosis, he must have reviewed the previous MRI scan of his lumbar spine. However, in the medical records that reviewed from Cedars Sinai Medical Center could not find them preexisting MRI scan. Therefore, patient must have had it at a different institution or as an outpatient prior to his epidural facet treatment. Even Dr. Smith in his second report of 04/10/18 added that he apportioned 25% in the nonindustrial car accident. He apportioned the left knee disability 25% of the nonindustrial car accident and 25% to obesity and 50% to 01/26/08 industrial injury. As far as in his first report of 03/05/08, he concluded that 100% of patient's current causation of his back, left knee, and left ankle and foot disability result of 01/26/08 work accident. This is obviously different from his second report. 5) As far as the discussion of patient's obesity is concerned, in opinion his obesity was mostly due to his overeating. During the deposition, it was brought up that there was "no evidence" and overeating was the cause of his weight gain. This is partly my fault since that was obvious that most people currently that taking in too many calories will be major cause of obesity that is why we have diet. If diets fail, use drugs and if that fails, used surgery like putting in a gastric sleeve which patient had. If look at Ms. Carolina Castillo's report on 07/19/16, dietitian report, a copy of which will send you. She lists that she had been got hit by a car and was not physically active for nine months and has not been able to exercise since the accident. However, this is not exactly true. If look at his physical activity he actually does aqua aerobics four to six times per week.

Therefore, patient was actually exercising at that time. She even state that under the nutrition diagnosis is morbid obesity was due to extensive oral fluid/beverage intake related to consuming large portions. In other words, there is overeating that was evidenced by his actual morbid obesity. If look at his actual dietary information and eating patterns or what he states he actually ate during the day, he did drink sweetened beverages, hibiscus tea. However his other food intake seems reasonable which kind of conflicts with her opinion. In experience, obese patients frequently say that they "do not need that much." In other words may tend to underestimate how much food intake they actually consume. This also applies to alcohol where he routinely underestimate how much alcohol they drink. Whether or not it is true in this case is hard to say. However, he tries to avoid but he did drink one to two glasses of wine when he saw Ms. Castillo. If look at his smoking history, he also said he was a "nonsmoker." This obviously is not true since he did have a history of tobacco use. Also he had a history of alcohol use which can add useless calories. Therefore, would state that this time after the deposition, exercise does help to lose weight. However, with overeating this would blunt the affect of exercise and make it much less effective if effective at all in helping to lose weight. However as noted, patient was exercising, the question is how much exercise. By the way, exercise does not always lead to weight loss. Do not know if the attorneys have every lifted weights, however, when I used to lift weight for sports, however, he has tended to overeat and gain weight, but this was lifting heavy weights over 450 lbs plus leg presses. The second minor point is patient told he is 6 feet 4 inches tall, however, on medical records from Cedars Sinai they list his height as 6 feet 3 inches tall, but it will actually make his BMI greater than was calculated. Patient states to Ms. Castillo that his maximum adult was 175 lbs. Thought at that time patient was competitive athlete and did excessive exercise which would obviously help him maintain the weight but however at this point in his life although after he became older obviously he was not a competitive athlete especially at this point in his life. Also the other risk factors for obesity in older males for instance: 1) In general physical activity does decline with age. 2) There may be decreased in testosterone in males which would lead to obesity.

297. 01/04/19 Progress Note. CC: Patient complains of low back pain and left knee pain. He lost 20 lbs after bariatric surgery. Dx: 1) Chronic lumbar radiculopathy. 2) Morbid obesity. 3) Plantar fasciitis. Tx plan: Recommended to continue physical therapy. F/u as needed basis. (Illegible handwritten scan)

298. 02/27/19 Sergey Lyass, MD Progress Note. CC: Patient presents for followup of bariatric surgery. He has laparoscopic gastric sleeve surgery. Exam: BP: 131/82. WT: 355 lbs. HT: 6'4". BMI: 43.2. Dx: 1) Bariatric surgery status. 2) Morbid (severe)

obesity due to excess calories. 3) Encounter for followup exam after treatment for condition other than malignant neoplasm. 4) Abnormal weight gain. Tx plan: Performed laparoscopic gastric sleeve. Advised to continue multivitamins, calorie, counting and exercising. Required vitamin and mineral supplements after weight loss surgery. F/u in 3 months with Lyass, Sergey.

299. 02/27/19 DIS Laboratory. **High** glucose of **106**, RBC of **6.22**, RDW of **18.4**. **Low** HDL of **40**, MCV of **67.7**, MCH of **20.6**, testosterone of **194**, 25-hydroxy vitamin D of **21.0**, vitamin C of less than **0.1**.

300. 03/06/19 Illegible Signature **Adult** Progress Note. CC: Patient reports gained weight gained >30 lbs, but on lesser (illegible) feet (illegible) fascitis feels better now, has less exercise (illegible) cardiologist knees push (illegible) low back pain. Exam: BP: 132/72. WT: 355 lbs. HT: 6'4". HR: 75. RR: 18. Temp: 97.7 degrees F. SpO2: 98. Dx: 1) Obesity. 2) Low back pain. Tx plan: Recommended diet and exercises. (Illegible Handwritten Note).

301. 05/17/19 Telly D. Arispe, PA-C - CSJ Providence St. Joseph Medical Center ED Note. HPI: Patient presents to the ED for evaluation of right upper quadrant abdominal pain. He has had pain for the past week which worsened now. Pain is constant and worsened with sitting forward and improved with tying supine. Has had similar pain previously and was found to have gallbladder disease. Had a cholecystectomy in 2006. High level scopic gastrectomy one year prior at outside facility and is had significant weight loss since. He states the pain does not radiate. Describes pain as dull and achy. PMH: Asthma, depression, diabetes mellitus (HCC), gastritis and hypertension. Past Surgical Hx: Appendectomy, cholecystectomy, orthopedic surgery and tonsillectomy. Meds: Lipitor, fluticasone-salmeterol, Norco, ibuprofen, metoprolol tartrate, Xarelto and valsartan. Exam: BP: 138/75. HR: 66. RR: 20. Temp: 98.7 degree F. SpO2: 97%. GI/Abdomen: Guarding or pulsatile masses. ED Course/MDM: Patient presented to the emergency department for evaluation, and he was triaged to room HALL07. Reviewed the nursing notes, and he was evaluated by examiner. He presents for evaluation of RUQ abdominal pain. The differential for abdominal pain includes appendicitis, colitis, obstruction, diverticulitis, pancreatitis, enteritis, gallbladder pathology, vascular pathology such as AAA or dissection, kidney stones, infection such as urinary tract infection or pyelonephritis. It also includes possible cardiac etiologies as well as torsion. He received a comprehensive workup which included blood work, blood counts, electrolyte measurements, renal function testing and blood glucose measurement. Labs are reassuring. X-ray and ultrasound both unremarkable with exception of liver steatosis which is likely causality pain. Abdomen soft and nontender. Liver enzymes

unremarkable and CBC unremarkable on ultrasound. Do not suspect choledocholithiasis or cholangitis. He is afebrile and well-appearing and will be discharged home without any new medications. Recommended to follow up with surgeon at Cedar Sinai for further evaluation. He is hemodynamically stable; vitals are within normal limits, he in non toxic appearing so feel that he is stable for discharge at this time. Have discussed the results, examination findings, and treatment plan prior to discharge. Indications for emergent reevaluation were discussed and questions were answered. Verbalized understanding and agreement with the treatment plan. He left the emergency room in stable condition with no clinical evidence of emergent medical condition upon discharge. Dx: 1) RUQ pain, acute. 2) History of cholecystectomy, acute. 3) Steatosis of liver, acute. Disposition: Patient will be discharged to home.

302. 05/17/19 Laboratory. **High** RBC of **6.19**, absolute lymphocytes of **3.40**, sodium of **146**. **Low** hemoglobin of **12.9**, MCV of **65.9**, MCH of **20.9**, MCHC of **31.7**.

303. 05/21/19 Val Shulman, MD Progress Note. CC: Patient presents with right-sided low back pain which is dull and constant. He was seen in ER. Pain is same with any activity. He also c/o right upper quadrant pain. He is taking Norco. Exam: BP: 132/72. WT: 349 lbs. HT: 6'4". HR: 68. RR: 17. Temp: 97.9 degree F. SpO2: 98%. Dx: 1) Low back pain. 2) Abdominal pain. Tx plan: Referred to physical therapy and encouraged to do home exercise program. Advised weight loss. (Illegible Handwritten Note)

304. 07/20/19 Anthony G. Rodas, MD Panel Qualified Medical Evaluation. (DOI: 01/26/08) History of Injury: Patient has alleged two injuries. The first is a specific injury dated 01/26/08. He has alleged injuries to his back, knee, body systems, and head. CC: Patient's chief complaints are concerning his orthopedic issues, including constant pain in the left knee, low back radiating down to the left leg and bilateral hips. He says he is in constant pain most of the time that does not change with coughing or sneezing. It does awaken him from sleep. In addition, he has sleep apnea, which he uses a CPAP mask for. He has numbness down the left leg, tingling in the right leg and both hands, and also down the left knee. Grinding of the joints in the left knee. Locking of the joints in the left knee. He states that he can sit comfortably for 30 minutes, stand for 5 minutes, and walk for 5-10 minutes. Currently, he is using several assistive devices including a cane. He also uses a soft brace on the left knee in addition to a CAM walker for the left ankle. He complains of depression and suicidal thoughts. He states he is unable to do anything that he was before. He states that he is unable to work at the present time. He was asked why he is unable to work. He states that he cannot perform any physical activities that he was doing. He was asked how much he could lift, and he states between 5 and 20 lbs. Prior, he could lift up to 140 lbs. PMH:

Cholelithiasis. History of lumbar facet syndrome, lumbar disc herniation, and lumbar radiculitis. Status post MVA 02/22/08 with head laceration, closed head injury, right tibia/fibula closed fracture status post intramedullary rod pinning, status post left ankle bimalleolar fracture status post ORIF, status post hardware removal, industrial injury 01/26/08, torn ACL, meniscal tears medially and laterally, status post arthroscopy 02/18/08, history of hypertension, morbid obesity, AODM, sleep apnea, atrial fibrillation, status post pulmonary emboli related to hospitalization for the MVA, 03/22/08 and asthma. Past Surgical Hx: Status post cholecystectomy. Multiple orthopedic surgeries. Vitals: WT: 385 lbs. HT: 6'4". BMI: 46.9. Dx: 1) Status post work-related injury 01/26/08 specific; CT 04/28/11 - 04/11/12. 2) Torn medial and lateral meniscus of the left knee; torn ACL of the left knee status post arthroscopic surgery for injury date 01/26/08. 3) Recurrent tear of the posterior horn of the medial meniscus per MRI arthrogram 06/14/12. 4) Morbid obesity. 5) Asthma. 6) AODM. 7) Sleep apnea. 8) Atrial fibrillation. 9) Status post MVA 02/22/08 with fracture of the right tibia/fibula status post intramedullary rods; left ankle bimalleolar fracture status post ORIF. 10) Pulmonary embolism, DVT left lower leg post MVA 02/22/08. 11) Closed head injury and headaches deferred to Dr. Merman, Neurology. 12) Symptoms of depression and suicidal ideation deferred to appropriate QME in Psychiatry. Conclusion: Would conclude, based on clinical experience, that this initial weight gain was related to multiple factors including, his relative period of inactivity following his surgeries, his quitting smoking around his meniscal surgery, the weight gain normally attendant to smoking cessation (please see below), and of course appetite increase and refeeding from whatever weight loss he suffered during his 10 day hospital stay in bed. A second period of weight gain then ensues. From the available records. His weight on 04/27/12 was 289 lbs, not too much different than his weight on 07/27/08. His weights begin to increase to 325 lbs when he sees Dr. Rashti on 01/30/13. During this period of time he has seen two different orthopedic specialists, Dr. Julian Girod, and Dr. Rashti, both of whom are documenting persistent orthopedic deficits, which would naturally impact his ability to exercise. He states that when he was at Lindora he only last 20-25 lbs. He disputes Dr. Fell's contention that his weight decreased from 289 lbs when he saw Dr. Fell down to 238 lbs, which would be a loss of 51 lbs. It is known that obesity is a disease that has rapidly escalated over the past several decades and is caused by environmental, humoral, and genetic factors working in combination. Some of the environmental factors contributing to the increase in obesity include but are not limited to decreased physical activity as well as increased food consumption. With respect to him, first, in reviewing his physical activity, it is noted that in many of the notes he was swimming and biking. According to applicant, prior to the injury he used to play beach

volleyball as well as perform other aerobic activities in addition to working a physical occupation which required him to be active during the day. It certainly is clear from the notes that he has not resumed his pre-injury physical status. His records clearly indicate that following his left knee injury and motor vehicle accident, he was performing modified duty with his employer, basically administrative types of functions, with the change of an occasional light bulb. In fact, he feels he was terminated because he could not perform the physical activities of the job. Reviewing his orthopedic issues indicates that even following his first left knee surgery, performed in 02/2008 a subsequent MRI performed 09/09/08 disclosed a likely retear of the ACL and meniscal pathology. It is noted that he was also seeing Dr. Avrom Gart, a pain management specialist, for his ongoing lumbar spine issues. These lumbar spine issues ultimately resulted in him being given a DRE Class III rating by Dr. Smith in the most recent Orthopedic QME. His medical records indicate continued knee complaints while following up with Dr. Mandelbaum. Dr. Fell, himself on 07/27/09, indicated that he should perform no more than occasional squatting and kneeling, and recommended quadriceps and hamstring strengthening exercises. Additional restrictions included no very prolonged walking and no very prolonged standing. In addition, Dr. Fell described residual left knee instability and indicated a possible need for ACL reconstruction in the future if symptoms became significantly symptomatic at that time. Following up with several different physicians, he indicated to Dr. Mandelbaum continued stiffness in the knee on 10/01/09. Dr. Komberg, on 04/17/12, he had pain in the left knee with chronic postsurgical pain and the pain could go from a 1/10 to a 9/10 with activity. Referral to Dr. Julian Girod, another orthopedist, on 0608/12, indicated that the knee was locking and giving-way. Dr. Girod noted increased translation of the left knee joint. On 06/14/12, an MRI arthrogram disclosed a complex tear of the posterior horn of the medial meniscus extending to both the superior and inferior articular surface. On 08/17/12, Dr. Girod provided a Medrol Dosepak for the attendant left knee pain. He was also encouraged to continue bicycle exercises. On 09/05/12, he saw Dr. Leynes, who noted the weight gain of 308 lbs. Subsequently, in 10/2012, he came under the care of Dr. Rashti, who, on 10/02/12, noted pain in the low back with radicular symptoms and left knee pain. On 01/30/13, following up with Dr. Rashti, he stated he was losing mobility of his lower extremities. His weight was then up to 325 lbs. He was then evaluated again by Dr. Fell on 07/30/13 who increased his disability rating for the left knee. Dr. Fell then was deposed as above. He of course, has continued with complaints in the left knee and lower back, as well as a non-industrially related right lower extremity and left ankle. Reviewed the above chronology because increased physical activity is an essential component and comprehensive lifestyle intervention in the obese. The American Heart

Association Guidelines for managing obesity typically prescribe increased aerobic physical activity such as brisk walking for greater than 150 minutes per week or greater than 30 minutes per day most days of the week. This echoes the American College of Sports Medicine Position Stand developed in 2001 and again in 2009, which also supported 200-300 minutes per week for long-term weight loss and moderate intensity physical activity between 150-250 minutes per week to be effective to prevent weight gain, although that intensity would provide only modest weight loss. He has a known unstable left knee, in addition to the lumbar spine which is producing nerve root irritation down the left lower extremity, and has been classified as a DRE Class III by the AMA Guides. This would imply that there are significant effects on his ADLs, enough to impact his exercise capacity and ability to continue prolonged endurance exercises of the type needed to prevent any weight gain from increased appetite. Dr. Fell has opined that quitting smoking would account for the 60-100 lbs weight gain at that time. However, studies clearly show that the average weight gain for someone quitting smoking is approximately 15-20 lbs. In clinical experience, someone who is obese, and quit smoking, this might increase to 30-40 lbs. However, to implicate a 100 lbs weight gain slowly to quitting smoking and eating too much, in someone who claims to be physically active, is ignoring the medical evidence of his ongoing complaints, objective findings, and opinions of his treater's during the timeframe in question. In addition, weight gain can occur as a result of chronic pain. Chronic pain is one of the major reasons that obese patients list for their weight gain. In fact, he continues to have multiple orthopedic complaints and his medical records are replete with complaints referable to his low back as well as his left knee. Frustration associated with functional limitations may lead to overeating. The other common adverse effects of chronic pain include poor sleep, obesity as related to physical disability, and psychological distress in chronic pain patients. Compared to non-obese patients, obese back patients appear to be more functionally impaired, have greater comorbid problems, and have more radicular symptoms than their non-obese counterparts. In summary, believe the obesity in this patient is multifactorial and includes: 1) His history of chronic obesity. 2) Probable effect of smoking cessation. (Only for his early weight gain). 3) Appetite increase related to chronic pain. 4) An element of orthopedic causation from his non-industrially related MVA as well as his industrial injury to the left knee and recently added lumbar spine injury. In summary, believe enough substantive evidence exists to opine that his obesity has some basis in industrial contribution. Obesity itself is not a ratable impairment. Generally, one looks to other chapters of the AMA Guides to ascertain the effect of obesity on the various organ systems. Before opining on his comorbidities of hypertension, sleep apnea, atrial fibrillation, diabetes, and asthma,

please forward me the medical records from his private physician, and any other private physicians he may have been seeing during the timeframe from his injury date until present. Would also like to see his medical records from the Lindora Weight Loss Clinic if available. He recollects for specifics is understandably somewhat impaired due to the length of time and multiplicity of medical issues he is dealing with. Further medical-legal analysis is deferred until can review the above medical records. Answers to Interrogates: 1) At this time, he can be considered Permanent and Stationary from the effects of his industrially caused obesity. He became Permanent and Stationary on 08/10/17, the date of his gastric sleeve. 2) Current diagnoses are limited at this time to morbid obesity. Have deferred discussion of his comorbidities until can receive further medical records. 3) Subjective complaints are supported by the objective findings. Did not find any evidence of dysfunctional behavior. 4) The injuries and aggravation or contribution to a pre-existing problem. He has a known history of obesity; however, body mass index at the time of his left knee surgery and auto accident in 2008 was approximately 30. 5) Regarding temporary disability. Based on review of his obesity alone, he was not temporary partially or temporarily totally disabled, except for a period of 1-2 weeks following the gastric sleeve procedure, which would have been a reasonable time for recovery. He would have been capable of performing his full active duties on an internal medicine basis alone and on an obesity basis alone. 6) Physical examination documents his obesity. Review of his medical records documents his progressive weight gain throughout the years. As AMA Guides, Fifth Edition, note, obesity itself is not ratable as AMA impairment; however, the effect on other comorbidities has yet to be established. 7) Spinal impairment is deferred to the orthopedist. Lower extremity injuries are deferred to the orthopedist. 8) Physical examination findings of morbid obesity are consistent with those of other examiners. 9) AMA impairment rating has been deferred. 10) Based on obesity alone, work restrictions and loss of pre-injury capacity would not be applicable. 11) Deferred issues of apportionment or permanent disability until can review medical records from his private physician. 12) Issues of future/further medical treatment are deferred until can review medical records from his private doctors. Regarding the treatment he has received to date: Current treatment for obesity is not commonly found in the ACOEM practice guidelines. However, subspecialty guidelines indicate that bariatric surgery is the approved method of choice for failure of conservative treatment of obesity.

305. 08/28/19 Yelena Vaynerov, MD Progress Note. CC: Patient gained weight again. He developed depression. He c/o joints pain. He c/o dizziness especially with changing (illegible) position. He c/o nocturia x2-3. His last urologic visit is more than 1 year ago. Exam: BP: 144/77. WT: 375 lbs. HT: 6'4". HR: 78. RR: 15. Temp: 97.8 degree F.

SpO2: 96%. Dx: 1) Dizziness. 2) Morbid obesity. 3) Depression. 4) Enlarged thyroid. 5) Hepatomegaly. 6) BPH. Tx plan: Ordered prostatic ultrasound and thyroid ultrasound. (Illegible Handwritten Note)

306. 08/28/19 George Mednik, MD - West Coast Medical Diagnostic Service, Inc. Radiology/Diagnostics. Prostatic Ultrasound. Impression: Enlarged prostate. Correlation with PSA and transrectal ultrasound is recommended.

307. 08/29/19 Medicare Well Patient Physical. CC: Patient presents for physical exam. PMH: Hypertension, morbid obesity. Past Surgical History: Gastric bypass. Vitals: BP: 142/80. WT: 375 lbs. HT: 6'4". HR: 70. Assessment/plan: Patient was performed with physical exam. (Illegible Handwritten Note)

308. 08/29/19 Physicians Diagnostic Reference Laboratory Laboratory. High RBC of 6.17, glucose of 112. Low MCV of 70.5, MCH of 20.6, MCHC of 29.3.

309. 08/29/19 George Mednik, MD - Olympic Imaging Services Radiology/Diagnostics. Complete Abdominal and Retroperitoneal Ultrasound. Impression: 1) Status post cholecystectomy. 2) Hepatosplenomegaly. 3) Increased echogenicity of the liver consistent with fatty infiltration. 4) Right renal cyst. 5) Soft plaques in the proximal, mid, and distal abdominal aorta.

310. 08/29/19 Mednik, MD - Olympic Imaging Services Radiology/Diagnostics. Thyroid Ultrasound. Indication: 1) Thyroid gland is mildly enlarged. 2) Hypoechoic lesion in the upper pole of the right lobe of the thyroid. 3) Clinical correlation and f/u ultrasound in 6-8 months is recommended.

311. 09/16/19 Yelena Vaynerov, MD Correspondence. Patient has been under care since 11/25/14. Familiar with his medical history and with the functional limitations imposed by his disability and confirm that he indeed meets the definition of disability under the American with Disabilities Act, the Fair Housing Act, and the Rehabilitation Cart of 1973. Due to his disability, he has certain limitations regarding his mobility. In order to help alleviate these difficulties, and to enhance his ability to live independently, and to fully use and enjoy his dwelling, recommended him to request the HRC and the Department of Disability to verify that ADA is in compliance and keep us informed about progress on these matters. Also, advised to avoid driving a vehicle that is not suitable for use by people with disabilities.

312. 01/30/20 Unknown Medical Provider Laboratory. **High** RBC of **6.4**, absolute monocytes of **1.10** and glucose of **132**. **Low** Hgb of **13.0**, MCV of **66.3**, MCH of **21.2** and absolute lymphocytes of **0.60**.

313. 01/30/20 Julie Sun, MD Radiology/Diagnostics. X-ray of Chest. Indication: Chest pain, cough. Comparison: CR chest 05/17/19, 11/20/17. Impression: No acute cardiopulmonary abnormality.

314. 01/31/20 Laboratory. Urinalysis showed **moderate** amount of squamous epithelial cells.

315. 03/05/20 Progress Note. CC: Patient presents with upper respiratory infection. He still has weakness, dizziness. He has gained weight. He is back to preop. He c/o pain in lower extremities with walking and left joints pain. Exam: BP: 138/78. WT: 387 lbs. HT: 6'4". HR: 75. RR: 15. Temp: 97.8 degree F. SpO2: 98%. Dx: 1) Morbid obesity. 2) Fatigue. 3) Dizziness. 4) Multinodular goiter. 5) Pain lower extremities. Tx plan: Ordered labs and carotid doppler. F/u in 1 month. (Illegible Handwritten Note)

316. 03/05/20 Physicians Diagnostic Reference Laboratory Laboratory. **High** RDW-CV of **18.2**, glucose of **113**, BUN of **18**, uric acid of **8.7**, triglycerides of **186** and hemoglobin A1c percent of **6.2**. **Low** MCV of **68.3**, MCH of **21.6**, MCHC of **31.7** and calculated LDL of **62**.

317. 03/06/20 George Mednik, MD - West Coast Medical Diagnostic Service, Inc. Radiology/Diagnostics. Carotid Duplex Scan Examination. Impression: Spectral broadening of the bilateral internal carotid arteries consistent with 15-49% stenosis.

318. 03/09/20 George Mednik, MD - West Coast Medical Diagnostic Service, Inc. Radiology/Diagnostics. Duplex Scan of Lower Extremity Arteries. Impression: 1) Multiple plaques in the bilateral common femoral arteries, superficial femoral arteries, and popliteal arteries with 20-30% stenosis. 2) Monophasic flow in the bilateral peroneal arteries and left posterior tibial artery that could be due to more proximal lesions.

319. 08/26/20 Alexander Gershman, MD - Institute For Advanced Urology Established Patient Visit. CC: BPH, lower back pain. HPI: Patient reports slow or weak stream. He c/o back pain. He also c/o incomplete emptying. Meds: Cipro, Valium, metformin, Invokana, atorvastatin, Toprol XL, Diovan HCT, Benicar HCT and lisinopril. Exam: BP: 104/74. WT: 355 lbs. HT: 6'4". HR: 72. RR: 16. Temp: 97.2 degree F. BMI: 43.2. Dx: 1) Frequency of micturition. 2) Enlarged prostate with lower urinary tract symptoms. 3) Urgency of urination. 4) Nocturia. 5) Feeling of incomplete bladder emptying. Tx plan: Ordered labs and radiology. Also recommended prostate specific antigen testing, since a combination of digital rectal examination and PSA determination provides the most acceptable means for excluding prostate cancer. Alpha-1-adrenergic antagonists were recommended as they act against the dynamic component of bladder outlet obstruction by relaxing smooth muscle in the bladder neck, prostate capsule, and prostatic urethra.

Recommended the use of saw palmetto as it is approved in Germany for stage I and II (mild-to-moderate) BPH. F/u in 6 months.

320. 08/26/20 Sergey Lyass, MD Initial Consultation. CC: Morbid obesity, failure of previous weight loss surgery, failed gastric sleeve and weight regain after weight loss surgery. HPI: Patient had previous weight loss. Maximum weight loss achieved is 10-30 lbs. He states increased hunger. PMH: Patient reports a history of back problem, GERD, hypertension, diabetes, depression, sleep apnea, cholesterol high, asthma, heart disease, arthritis, anxiety, gastritis, liver disease, gallstones. Past Surgical Hx: He reports a history of Cholecystectomy, numerous leg surgery and sleeve gastrectomy. Meds: Xarelto, metformin, metoprolol tartrate. Exam: BP: 114/80. WT: 365 lbs. HT: 6'4. Dx: 1) Morbid (severe) obesity due to excess calories. 2) Bariatric surgery status. 3) Abnormal weight gain. 4) Body mass index (BMI) 40.0-44.9, adult. 5) Essential (primary) hypertension. 6) Type 2 diabetes mellitus without complications. 7) Abnormal coagulation profile. Tx plan: Recommended laparoscopic bilio-pancreatic diversion with duodenal switch. Recommended Psychological evaluation and Nutritional evaluation. Recommended upper endoscopy. Ordered labs and radiology. Also recommended weight loss (bariatric) surgery.

321. 08/26/20 Laboratory. Urinalysis showed high specific gravity.

322. 09/23/20 Anthony G. Rodas, MD Supplemental Report. We start with the concept that work activity which accelerates, aggravates, and lights up a pre-existing condition is sufficient to be deemed a contributing cause of alleged injury for purposes of compensability. As the parties are aware, performed an initial Qualified Medical Evaluation on 07/20/19 on this applicant. There were 2 dates of injury given, the first a specific injury date of 01/26/08. He alleged injuries to his back, knee, body systems, and head. In addition, he had filed a CT claim dated 04/28/11 through 04/11/12. He had alleged a CT injury to the same orthopedic body parts and body systems. Our diagnoses established at the time of the Qualified Medical Evaluation included the following: 1) Status post work-related injury of 01/26/08, specific; CT 04/28/11-04/11/12. 2) Torn medial and lateral meniscus of the left knee; torn ACL of the left knee; status post arthroscopic surgery for injury date 01/26/08. 3) Recurrent tear of the posterior horn of the medial meniscus per MRI arthrogram 06/14/12. 4) Morbid obesity. 5) Asthma. 6) AODM. 7) Sleep apnea. 8) Atrial fibrillation. 9) Status post MVA 02/22/08 with fracture of the right tibia and fibula status post intramedullary rods; left ankle bi-malleolar fracture status post ORIF. 10) Pulmonary embolism, DVT left lower leg post-MVA 02/22/08. 11) Closed head injury and headaches deferred to Dr. Merman, Neurology. 12) Symptoms of depression and suicidal ideation deferred to the appropriate QME in

psychiatry. At the time of the initial Qualified Medical Evaluation in the discussion section, postulated the following question "Is there AOE/COE for his weight gain." Felt this was an important question to answer since many of his most recent comorbidities had a connection to the obese state including diabetes, hypertension, and sleep apnea. In the original QME, reviewed the chronology of medical records that were available for review. This included approximately 1600+ pages of medical data including the most recent orthopedic QME performed on 03/05/18 by Dr. Michael Smith. In that Qualified Medical Evaluation Dr. Smith diagnosed him with a lumbar spine injury; left knee injury; left ankle and foot injury. Dr. Smith opined that 100% of the disability was a result of the specific injury of 01/26/08 with none of the disability being apportioned to the CT. Dr. Smith felt that the findings were consistent with the injuries claimed by him. In addition it was concluded that 100% of his current causation of the back, left knee, left ankle and foot disability was a result of the 01/26/08 with 0% apportionment to pre-existing causation of injuries. The conditions were at MML The combined orthopedic impairment was felt to be 27%. He of course had continued with complaints in the left knee, lower back, as well as non-industrially related right lower extremity and left ankle pain. Had reviewed the chronology of medical records provided at that time, because increased physical activity was an essential component in comprehensive lifestyle intervention in the obese patient. The American Heart Association Guidelines for managing obesity, typically prescribed increased aerobic physical activity such as brisk walking for greater than 150 minutes per week, or greater than 30 minutes per day most days of the week. This echoed the American College of Sports Medicine position developed in 2001 and again in 2009 which also supported 200-300 minutes per week for long term weight loss and for moderate intensity physical activity between 150-250 minutes per week to be effective to prevent weight gain, although that intensity would provide only modest weight loss. He had a known unstable left knee, in addition to the lumbar spine which was producing nerve root irritation down the left lower extremity. This had been classified as a DRE Class III by the AMA Guides. This would imply that there were significant effects on his ADLs, enough to impact his exercise capacity and ability to continue prolonged endurance exercise of the type needed to thwart any weight gain from increased appetite. I then addressed Dr. Fell's contention that quitting smoking would account for the 60-100 lbs weight gain. However studies clearly show that the average weight gain for someone quitting smoking is approximately 15-20 lbs. In clinical experience someone who is obese and quit smoking might increase to 30-40 lbs. However, to implicate a 100 lbs weight gain solely to quitting smoking and eating too much in someone who claims to be physically active, was ignoring the medical evidence of his ongoing complaints, objective findings, and opinions of his treat during

the time frame in question. Noticed also that weight gain can occur as a result of chronic pain. Chronic pain is one of the major reasons that obese patients list for their weight gain. In fact, he continues to have multiple orthopedic complaints and his medial records are replete with complaints referable to his low back as well as his left knee. It is well known that frustration associated with functional limitations may lead to overeating. The other common adverse effects of chronic pain including poor sleep, obesity as related to physical disability, psychological distress in chronic pain patients. Compared to non-obese patients, obese back patients appear to be more functionally impaired, have greater co-morbid problems, and have more radicular symptoms than their non-obese counterparts. In summary, at the time of the QME, believed that the obesity in this patient was multifactorial and included: 1) His history of chronic obesity. 2) Probable effect of smoking cessation (only for his early weight gain). 3) Appetite increased related to chronic pain. 4) An element of orthopedic causation from his non-industrially related MVA as well as his industrial injury to the left knee and recently added lumbar spine injury. In summary, believed there was enough substantive evidence to opine that the obesity had some basis in industrial contribution. Obesity itself was not a ratable impairment however. Generally one looks to the other chapters of the AMA Guides to ascertain the effect of obesity on various organ systems. Before opining on his co-morbidities of hypertension, sleep apnea, atrial fibrillation, diabetes, and asthma, requested more medical records be forewarned from his private physician and any other private physicians he may have seen during the timeframe from the injury date until present. Also wanted to see his medical records from the Lindora Weight Loss Clinic if available. Found that his recollections for specifics was understandably somewhat impaired due to the length of time and multiplicity of medical issues he was dealing with.

323. 12/18/20 Anthony G. Rodas, MD Supplemental Report. Of the aforementioned studies, the echocardiogram performed by Dr. Mednik on 07/23/20 demonstrates left ventricular hypertrophy. In addition, it also illustrates dilation of the left atrium. In comparison to the echocardiogram that was performed on 05/31/16 and upon which Dr. Rodas relied for his initial determination of this hypertensive heart disease, he did not have left atrial dilation. The only reported abnormality at the time of the 05/2016 echo is mild left ventricular hypertrophy. It is axiomatic that left atrial enlargement contributes to atrial fibrillation and indeed is a consequence of his hypertensive heart disease. Therefore, Dr. Rodas has changed his AMA impairment rating related to left ventricular hypertrophy and hypertensive heart disease from the prior rating of 30% to 35%. The increase of 5% taking into account the new finding of left atrial enlargement. The remainder of his studies does not impact the remainder of Dr. Rodas' prior opinions

proffered in his most recent supplemental report. Therefore, sleep apnea is 5%. Dr. Rodas hope this information is of benefit. Anticoagulant use is 1%. Hypertensive heart disease with left ventricular hypertrophy left atrial enlargement is 35%. Atrial fibrillation is 20%. Adult onset diabetes mellitus is 6%.

324. 02/12/21 Anthony G. Rodas, MD Supplemental Report. As parties are aware, have previously issued 3 reports on this applicant. The first, the original QME on 07/20/19, and 2 supplemental reports 09/23/20, and 12/18/20, respectively. For those reports multiple medical records in excess of thousands of pages were reviewed spanning the time-frames from the original injury in 2008 through the last report reviewed which was 07/27/20. Referred the parties to QME and supplemental reports concerning my analyses and conclusions. Have now had the opportunity of reviewing a further 610 pages of medical records. They span the timeframe from 01/17/13 through 01/31/20. They include the following problems: Several ER admissions for chest pain. 11/27/13. Chest pain: Cardiac workup include 2D echo which showed left ventricular hypertrophy and impaired diastolic function; however, his left atrium was normal size, he had a negative myocardial profusion scan, a pharmacologic stress test. There was no evidence of ischemic cardiac disease. 01/13/15. ER visit for atypical chest pain. 11/20/17. ER admission for exertional chest pain and was released on blood pressure medications. Several ER admissions for abdominal pain. 09/13/15. ER visit for gastritis. 03/04/16. ER visit for presumed duodenal ulcer. 05/17/19. ER visit for right upper quadrant pain diagnosed with steatosis of the liver on ultrasound. Several ER visits for orthopedic complaints. 10/06/14. Right calf muscle cramps. 12/24/15. Visit for low back pain diagnosed with acute lumbar radiculopathy. 11/2017. Diagnosed with back pain NOS. One visit for respiratory tract issues. 01/31/20. Diagnosed with influenza. After reviewing the records, have not changed the opinions originally expressed in the above medical-legal reports of 07/20/19, 09/23/20, and 12/18/20.

Interpretation of Medical Records Reviewed:

The medical records date back to before 2009 including his job description for property manager with RHB Property Company. It appears that he was significantly injured around 2012 walking on an uneven ground with a slip and fall injury. As of 2005, he is noted to also be a cigarette smoker. He had a history of cholecystitis requiring cholecystectomy. This appears to have been performed without complications.

February 28, 2008, he was assessed at Cedars-Sinai Medical Center and noted to have a right comminuted fracture of the midshaft to the tibia and fibula as well as a left bimalleolar fracture

of the ankle. He has also sustained a mild traumatic head injury. Subsequent diagnostic imaging showed his left ankle to have multiple screws in place, some extending into the distal fibula. Subsequent years, he was seen also again for orthopedic followup of this injury which was felt to be related to employment. His job as a property manager for the Roberts Company for 10 years was noted on October 31, 2012 by Jalil Rashti, M.D., who focused upon orthopedic issues. He also had lumbar radiculitis and lumbar osteoarthritis and degenerative disc disease. Elevated blood pressure treated with hydrochlorothiazide has been noted. Hypertension has been associated with obesity. He was admitted to telemetry on November 27, 2013, by Roger C. Lai, M.D. due to chest pain. The records also show documentation of placement of an inferior vena cava filter and removal.

As of November 20, 2017, his hemoglobin and hematocrit were somewhat low at 13.1 for the hemoglobin and his MCV was 66 which is microcytic. Most of the records through 2019 have been dominated by concern about his orthopedic issues and specific.

As of September 23, 2020, Anthony G. Rodas, M.D., noted that he had morbid obesity, asthma. The lower extremity previously described fractures and also reference is made to possible prior atrial fibrillation. His body mass index reached 45 on September 23, 2020 in the supplemental report by Dr. Rodas.

Overall, the medical records are consistent with the diagnoses outlined in this report.

REVIEW OF DIAGNOSTIC STUDIES:

None ordered.

LABORATORY TESTS:

None ordered.

DIAGNOSES:

Of note, this examinee has diagnoses in the field of orthopedic surgery relative to motor vehicle accident trauma with lower extremity left tibia-fibula fracture, status post open reduction internal fixation; right ankle fracture, status post open reduction internal fixation along with secondary degenerative changes of lower extremities, lumbar spine and cervical spine. These would be referred to an orthopedic QME for further evaluation for either the QME process or

potentially for the SIBTF process. This is due to a period of insignificant injuries. There is no inflammatory rheumatological disease in this case and specifically no evidence of rheumatoid arthritis or systemic lupus. Therefore, we are left with the following internal medicine-related diagnoses which will be the focus of this assessment for the SIBTF process:

1. Extreme obesity with sleep apnea.
2. Restrictive lung disease.
3. Essential hypertension with left ventricular hypertrophy.
4. History of cardiac arrhythmias (PVCs, atrial fibrillation).
5. Microcytic anemia.
6. Traumatic brain injury.
7. History of tobacco dependence with chronic secondary asthma.
8. Type 2 diabetes mellitus.
9. Gastritis/gastroesophageal reflux disease.
10. Peripheral vascular disease.
11. History of cholecystitis, status post cholecystectomy.

PERMANENT AND STATIONARY:

1. Extreme obesity with sleep apnea – he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.
2. Restrictive lung disease – he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.

3. Essential hypertension with left ventricular hypertrophy – he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.

4. History of cardiac arrhythmias (PVCs, atrial fibrillation) - he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.

5. Microcytic anemia – he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.

6. Traumatic brain injury – he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.

7. History of tobacco dependence with chronic secondary asthma – he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.

8. Type 2 diabetes mellitus – he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.

9. Gastritis/gastroesophageal reflux disease – he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.

10. Peripheral vascular disease – he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.

11. History of cholecystitis, status post cholecystectomy – he has reached a plateau. This is not critical for SIBTF evaluations, but is nonetheless provided for your consideration.

CAUSATION:

Industrial Causation:

1. Extreme obesity with sleep apnea – industrial.

2. Restrictive lung disease – industrial.

3. Essential hypertension with left ventricular hypertrophy – industrial.

4. History of cardiac arrhythmias (PVCs, atrial fibrillation) – industrial.

5. Microcytic anemia – industrial.

6. Traumatic brain injury – industrial.

7. Type 2 diabetes mellitus – industrial.

8. Gastritis/gastroesophageal reflux disease – industrial.

9. Peripheral vascular disease – industrial.

Pre-Existing Causation:

1. History of tobacco dependence with chronic secondary asthma – non-industrial.

2. History of cholecystitis, status post cholecystectomy – non-industrial.

Comment: I believe that the traumatic injuries which he suffered led to obesity causing this so-called "metabolic syndrome," with associated diagnoses including restrictive lung disease, obstructive sleep apnea, hypertension, cardiac arrhythmia and then consequently he also was more prone to microcytic anemia due to medications used to treat pain. The traumatic injury to the brain apportions to his previous injury of 2008 in that respect. Peripheral vascular disease is classified as orthopedic disruption of his lower extremities. Smoking and cholecystectomy are unrelated to work.

AMA IMPAIRMENT RATING:

Industrial Impairment:

1. Extreme obesity with sleep apnea. Table 13-4, given his daytime somnolence, he would be justified as being Class 2, **8% Whole Person Impaired** contemplating with some of his activities of daily living would be impaired. These would include, for example, travel, dressing and neurocognitive activities related to performing business activities.

2. Restrictive lung disease. Table 5-12, Class 2, **16% Whole Person Impaired** contemplating some chronic shortness of breath, which is significant and would impair his activities.

3. Essential hypertension with left ventricular hypertrophy. Table 4-2, Class 3 for left ventricular hypertrophy, **36% Whole Person Impaired.**

4. History of cardiac arrhythmias (PVCs, atrial fibrillation). Table 3-11, Class 1, **8% Whole Person Impaired** contemplating history of both atrial fibrillation and PVCs.

5. Microcytic anemia. Table 9-2, mild decrease in hemoglobin and hematocrit, **3% Whole Person Impaired.**

6. Traumatic brain injury. Table 13-2, Class 1, **5% Whole Person Impaired** for subtle neurocognitive impairment.

7. Type 2 diabetes mellitus. Table 10-8 for diabetes, Class 1, **6% Whole Person Impaired.**

8. Gastritis/gastroesophageal reflux disease. Table 6-3 for upper GI condition, Class 1, **5% Whole Person Impaired.**

9. Peripheral vascular disease. Using Table 4-4, his peripheral brawny edema justifies 20% lower extremity rating converting under Table 17-3 to **8% Whole Person Impairment** rating for right, **8% Whole Person Impairment** for left lower extremity due to peripheral vascular disease.

Pre-Existing Impairment:

1. History of tobacco dependence with chronic secondary asthma. Table 5-9 for occasional use of inhaler score of 1, Table 5-10, therefore asthma score would be justified **12% Whole Person Impairment Rating.**

2. History of cholecystitis, status post cholecystectomy. Table 6-8 for biliary tract disease, **0% Whole Person Impairment** rating at end of cumulative trauma interval.

The described whole person impairments described his overall level of functioning at the end of his cumulative trauma period of April 11, 2012.

FACTORS OF PERMANENT DISABILITY/DISABILITY STATUS:

Disability Status: I believe he is 100% disabled and unemployable.

With respect to his disability at the end of the cumulative trauma period through April 11, 2012, that would be, in my judgment, a permanent partial disability as of the end of that cumulative trauma date. I believe he did soldier on to get through his total date of employment, but then was unable to continue to work further.

Subjective Factors of Disability: Constant, Moderate-to-Severe symptoms.

Objective Factors of Disability: Physical deformity, diagnostic imaging abnormalities, lab abnormalities. I am unaware of EMG nerve conduction study abnormalities.

APPORTIONMENT:

Industrial Apportionment:

1. Extreme obesity with sleep apnea – 60% apportionable to cumulative trauma through April 11, 2012, 20% apportionable to traumatic injury of January 26, 2008, and 20% idiopathic.

2. Restrictive lung disease – 60% apportionable to cumulative trauma through April 11, 2012, 20% apportionable to traumatic injury of January 26, 2008, and 20% idiopathic.

3. Essential hypertension with left ventricular hypertrophy – 60% apportionable to cumulative trauma through April 11, 2012, 20% apportionable to traumatic injury of January 26, 2008, and 20% idiopathic.

4. History of cardiac arrhythmias (PVCs, atrial fibrillation) – 60% apportionable to cumulative trauma through April 11, 2012, 20% apportionable to traumatic injury of January 26, 2008, and 20% idiopathic.

5. Microcytic anemia – 60% apportionable to cumulative trauma through April 11, 2012, 20% apportionable to traumatic injury of January 26, 2008, and 20% idiopathic.

6. Traumatic brain injury – 100% apportionable to January 26, 2008 traumatic head injury.

7. Type 2 diabetes mellitus – 60% apportionable to cumulative trauma through April 11, 2012, 20% apportionable to traumatic injury of January 26, 2008, and 20% idiopathic.

8. Gastritis/gastroesophageal reflux disease – 60% apportionable to cumulative trauma through April 11, 2012, 20% apportionable to traumatic injury of January 26, 2008, and 20% idiopathic.

9. Peripheral vascular disease – 100% apportionable to injury of January 26, 2008 with disruption of lower extremity circulation.

Pre-Existing Apportionment:

1. History of tobacco dependence with chronic secondary asthma – 100% non-industrial.

2. History of cholecystitis, status post cholecystectomy – 100% non-industrial.

FUTURE MEDICAL TREATMENT:

Current Treatment: Continued current medications which appear appropriate.

Consultations: Future followup for treatment purposes would include primary care, internal medicine, cardiology, vascular surgery, nutrition, endocrinology and other relevant specialists. He is clearly a qualified worker, cannot return to his previous employment.

WORK STATUS/RESTRICTIONS:

These work restrictions reflect work-disabling conditions that would have necessitated these interventions prior to Date of Injury. They are not prophylactic in nature, but rather provided consistent with the requirements of the SIBTF process, reflecting a decreased capacity to compete in the labor market due to existing medical conditions that required some accommodations, whether granted or not.

The following work restrictions are reviewed appropriate at the end of the cumulative trauma period of April 28, 2011 through April 11, 2012 based on the above-described diagnosis. These restrictions are not prophylactic but based on existing pathology present at that time.

1. Extreme obesity with sleep apnea. Disability parking. Wheelchair access to clinic. No stair cases. No working at heights greater than 2 feet. No lifting greater than 10 pounds. Ergonomically correct desk environment. Work day limited to 4 hours. Doctor's appointment every month.

2. Restrictive lung disease. Disability parking. Wheelchair access to clinic. No stair cases. No working at heights greater than 2 feet. No lifting greater than 10 pounds. Ergonomically correct desk environment. Work day limited to 4 hours. Doctor's appointment every month. HEPA filter and no exposure to toxic substances such as gasoline fumes or diesel fumes or second-hand cigarette smoke.

3. Essential hypertension with left ventricular hypertrophy. Disability parking. Wheelchair access to clinic. No stair cases. No working at heights greater than 2 feet. No lifting greater than 10 pounds. Ergonomically correct desk environment. Work day limited to 4 hours. Doctor's appointment every month. HEPA filter and no exposure to toxic substances such as gasoline fumes or diesel fumes or second-hand cigarette smoke.

4. History of cardiac arrhythmias (PVCs, atrial fibrillation). Disability parking. Wheelchair access to clinic. No stair cases. No working at heights greater than 2 feet. No lifting greater than 10 pounds. Ergonomically correct desk environment. Work day limited to 4 hours. Doctor's appointment every month. HEPA filter and no exposure to toxic substances such as gasoline fumes or diesel fumes or second-hand cigarette smoke.

5. Microcytic anemia. Temperature controlled environment. Disability parking. No lifting greater than 10 pounds. Doctor's appointment every three months.

6. Traumatic brain injury. No working greater than 4 hours a day. Limited focus on complicated cognitive task such as learning, teaching, or memorizing beyond what is absolutely necessary, probably to a level that preclude working successfully as an actor. Doctor's appointment every six months.

7. History of tobacco dependence with chronic secondary asthma. Temperature controlled air-conditioned environment. No exposure to dust, debris, pollen or second-hand cigarette smoke. Doctor's appointment every three months.

8. Type 2 diabetes mellitus. Access to medications. Access to snacks. No working greater than 4 hours a day. Temperature controlled air-conditioned environment. Disability parking. Doctor's appointment every two months.

9. Gastritis/gastroesophageal reflux disease. Access to medications. Access to snacks. Doctor's appointment every three months.

10. Peripheral vascular disease. Elevate legs for 1-1/2 hour after every one hour of working. No working for a total of greater than 4 hours per day due to fatigue and poor circulation. Disability parking. Ergonomically correct desk environment. No lifting greater than 10 pounds. No working at heights greater than 2 feet. No working on scaffolding. No use of staircases. Doctor's appointment every two months.

11. History of cholecystitis, status post cholecystectomy. Followup as needed for medical complications with primary care physician.

On a practical basis, these work restrictions would preclude successful employment in almost in any field whether it is property manager or as an actor. Therefore, this individual is clearly a strong candidate for SIBTF benefits.

ADDITIONAL QUESTIONS:

The following questions are relevant to the overall SIBTF process and will be answered at this time.

1. Did the worker have an industrial injury?

Yes. This worker had industrial injuries both with an acute specific injury and with subsequent cumulative trauma injuries as outlined in the dates of injury listed above.

2. Did the industrial injuries rate to 35% disability by themselves without modification of age and occupation?

Yes, his occupational injuries are quite significant and rated in excess of 35% by themselves.

3. Did the worker have a pre-existing labor disabling permanent disability?

Yes, this individual had pre-existing labor disabling permanent disabilities.

4. Did the pre-existing disability affect an upper or lower extremity or eye?

No, the pre-existing disabilities of internal medicine did not affect the upper and lower extremity or eye. His peripheral vascular disease appears to be part of his date of injury experience as does the orthopedic trauma to his lower extremities.

5. Did the industrial permanent disability affect the equal and opposite body part?

No, there is not an equal and opposite body part justification for SIBTF based on internal medicine related issues. It is possible that justification may exist in the field of orthopedic surgery, but I am not aware of that since I believe his injuries did occur while working were not present prior to working in his extremities.

6. Did the equal and opposite body part rate to 5% permanent disability or more?

No, that would not be applicable for this case.

7. Is the total disability equal to or greater than 70% after modification?

Yes, the total disability is equal to or greater than 70% after modification.

8. Is he 100% disabled or unemployable from a combination of pre-existing disability & work injury?

Yes, this individual is 100% disabled and unemployable from a combination of pre-existing disability and injury. If one looks at Table 1-2 of the AMA Guidelines for activities of daily living, he would be impaired for self-care and personal hygiene by obesity, orthopedic problems and hypertension, diabetes and overall poor health status. He would be impaired for communication by his blunt head injury and sleep disorder, he would be impaired for physical activity by hypertension, diabetes, obesity and restrictive lung disease. I am not aware of any sensory function deficit, but he is decreased in terms of his ability for non-specialized hand activity such as grasping, lifting and tactile discrimination by obesity, hypertension, arrhythmia, traumatic brain injury, diabetes

and hypertension, similarly travel is restricted by the same factors namely most of the diagnosis listed above. Sexual function and sleep are impaired by obesity, hypertension and diabetes.

Therefore, he fulfills the criteria outlined on page 5 for an individual between 90% and 100% whole person impaired mainly by having, "...a very severe organ or body system impairment requiring the individual to be fully dependent on others for self-care, and approaching death." Therefore, I strongly believe that this individual does fulfill the criteria for being considered 100% disabled or unemployable. He is, therefore, an excellent candidate for SIBTF benefits. I have no objection if the involved parties wish to pursue vocational counselor evaluation on this individual, but I feel that it would be unnecessary.

In closing, I strongly recommend prompt processing of this claim for SIBTF benefits in light of the severe life-altering effect of this examinee's multiple internal medicine pre-existing diagnoses combined with his grievous subsequent orthopedic and central nervous system injuries.

Thank you for the opportunity to evaluate Mr. Dmitri Boudrine. Please contact me if I can be of further assistance.

COMPLIANCE DISCLOSURE STATEMENT

I certify that I took the complete history from the patient, conducted the examination, reviewed all available medical records, and composed and drafted the conclusions of this report. If others have performed any services in connection to this report, outside of clerical preparation, their names and qualifications are noted herein. An initial excerpting of the medical records was completed by Althaf Hussain, who is trained in medical record excerpting. In combination with the examination, the excerpts and records were reviewed to define the relevant medical issues. The conclusions and opinions within this report are solely mine. 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 and, except as noted herein, that I believe it to be true. In accordance with Labor Code Section 5703(a) (2), there has not been a violation of Labor Code Section 139.3, and the contents of the report are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Pursuant to 8 Cal. Code Regs. Section 49.2-49.9, I have complied with the requirement for face-to-face time with the patient in this evaluation. If necessary, I have discussed apportionment in the body of this report. If I have assigned disability caused by factors other than the industrial injury, that level of disability constitutes the apportionment. The ratio of nonindustrial disability, if any, to all described disability represents my best medical judgment of the percentage of disability caused by the industrial injury and the percentage of disability caused by other factors, as defined in Labor Code Section 4663 and 4664.

Sincerely,

Scott T. Anderson, M.D., Ph.D., FACP, FACR
Clinical Professor, Division of Rheumatology, Allergy and Clinical Immunology,
University of California at Davis
American Board of Internal Medicine, Diplomate in Internal Medicine, Rheumatology and Geriatrics
CA License #A52090

Date Report Signed: August 27, 2022 County: Solano

STA:ANS/str:8/25/22

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CC: Office of the Director - Legal Unit
1515 Clay St Suite 701 Oakland, CA 94612

SIBTF
1750 Howe Avenue, Suite 370
Sacramento, CA 95825-3367

RE: DMITRI BOUDRINE vs THE ROBERTS COMPANIES, SIBTF
WCAB: ADJ8345007
SIBTF: SIF8345007

DATE: 06/20/2022

Attestation Pursuant to Cal Code Regs., Title 8, § 9793(n)

I, Natalia Foley, hereby declare:

I am licensed to practice before all the courts in the state of California.

I am the attorney for Workers Defenders Law Group and attorney of record for the above applicant.

Pursuant to Cal Code Regs., Title 8, § 9793(n), I declare that the provider of the documents has complied with the provision of Labor Code §4062.3 before providing the documents to the physician.

I declare that the total page count of the documents provide to the physician is 7162 pages. Total page count is based on the documents described in the attached list of the evidence.

We reserve our right to amend our exhibits upon further discovery in which case you might be requested to provide your supplemental report to address newly discovered medical evidence.

I declare under penalty of perjury under the laws of the States of California that the foregoing is true and correct to the best of my knowledge.

Executed 6/20/2022, at Anaheim, CA

_____
By Natalia Foley, Esq (SBN 295923)
attorney for Applicant

List of exhibits

DMITRI BOUDRINE vs THE ROBERTS COMPANIES, SIBTF
ADJ8345007
SIF8345007
DOB 06/26/1962
Date of Injury: 04/28/2011 – 04/11/2012
Date of C&R:

Ex #	Title	PAGES
1	C&R	35
2	All medical Records	7127
	TOTAL:	7162

All records can be downloaded here:

https://nataliafoleylaw.com/01%20-%20DMITRI%20BOUDRINE.html

WORKERS DEFENDERS LAW GROUP

751 S Weir Canyon Rd Ste 157-455
Anaheim CA 92808
Tel: 714 948 5054
Fax: 310 626 9632
workerlegalinfo@gmail.com
www.workerlegal.com

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

TO: Dr. Scott Anderson MD,
Rheumatology Specialty
ExamWorks
11010 White Rock Rd., Suite 120,
Rancho Cordova, CA 95670
SIBTF Line: 916.576.2977
Toll-Free: 800.458.1261 Ext. 181801
Fax: 916.576.2930

CC: Office of the Director - Legal Unit
1515 Clay St Suite 701 Oakland, CA 94612

SIBTF
1750 Howe Avenue, Suite 370
Sacramento, CA 95825-3367

RE: DMITRI BOUDRINE vs THE ROBERTS COMPANIES, SIBTF
WCAB: ADJ8345007
SIBTF: SIF8345007

DATE: 06/20/2022

COVER LETTER FOR SIBTF MEDICAL EVALUATION

DEAR Dr. Scott Anderson MD:

This office represents the above referenced applicant. You have been selected to act in the capacity of Medical Evaluator in regard to the applicant's Subsequent Injury Benefit Trust Fund Claim in your medical specialty.

You are specifically asked to provide a medical legal evaluation in your area of expertise. Please provide a medical legal evaluation and address the issue of causation of any injury within your area specialty.

Please provide your opinion if any other referral is necessary.

It is requested that a determination be made regarding any medical issues and disability within your area of specialty. Please provide a permanent impairment rating per the AMA guides 5th edition and address the issue of apportionment per LC section 4751 in regard to a particular period of time as follow:

1) **PRE-EXISTING CONDITION**
2) **SUBSEQUENT INJURY**
3) **CURRENT CONDITION** (post-industrial).

Please cover in your report the following topics:

- Subjective complaints
- Objective factors or findings

- Current diagnosis and impairment rating
- Occupational history
- Past medical history
- Prior injuries
- Pre-existing **labor disabling** condition
- Rating of pre-existing labor disabling conditions
- History of subsequent injuries
- Impairment rating of subsequent injuries
- Subsequent injuries causation
- Apportionment of current condition to pre-existing and subsequent injuries
- Disability status & permanent work restrictions if any
- Activities of daily living

PLEASE ANSWER THE FOLLOWING QUESTIONS WITHIN THE SCOPE OF YOUR SPECIALTY:

1. On the day of your evaluation does the worker have a permanent impairment of any body parts **within your specialty**?

2. **IF YES,** is the worker 'condition permanent and stationary as of today?

3. **IF YES,** what is this impairment rating as of today, the date of your evaluation?

4. What kind of current work restrictions worker has due to his permanent impairment?

5. Did worker have a preexisting condition **within the scope of your specialty**?

6. **IF YES,** please answers the following questions:

   (a) Was that preexisting condition partially labor disabling and could have been rated as permanent partial disability ("PPD") at the time worker suffered the subsequent industrial injury?
   (b) Was that preexisting condition aggravated during the time of the subsequent employment?
   (c) Did worker have a subsequent injury within the scope of your specialty?
   (d) Did the subsequent industrial injury result in additional PPD?

7. Please APPORTION worker's condition as of today to the following:
   (a) pre-existing condition
   (b) subsequent injury
   (c) post-subsequent injury

8. Is the combination of the preexisting disability and the disability from the subsequent industrial injury greater than that which would have resulted from the subsequent industrial injury alone?

9. Did the subsequent industrial injury rate to a 35% disability without modification for age and occupation:

(a) within the scope of your specialty?
(b) within the multidisciplinary combined rating (if known)?

10. Did the pre-existing disability affect an upper or lower extremity or eye?

11. Did the subsequent industrial permanent disability affect the opposite or corresponding body part?

12. Is the total disability equal to or greater than 70% after modification?
    (a) within the scope of your specialty?
    (b) within the multidisciplinary combined rating (if known)?

13. Is the employee 100% disabled or unemployable from other pre-existing disability and subsequent injuries together?
    (a) within the scope of your specialty?
    (b) within the multidisciplinary combined rating (if known)?

RATING DETERMINATION:

When you rate pre-existing condition, please remember, that the prior labor disabling disability is not rated separately in the SIBTF case. SIBTF liability is not determined by rating the prior disability alone.

The percentage of permanent disability from the prior disability is not a relevant factor in determining SIBTF eligibility [Subsequent Injuries Fund v. Industrial Acc. Com. (Harris) (1955) 44 Cal. 2d 604, 608, 20 Cal. Comp. Cases 114, 283 P.2d 1039].

Rather, the factors of disability or WPI from the prior disability are rated together with those from the subsequent industrial injury to produce the combined disability rating required by Labor Code section 4751

PRE-EXISTING DISABILITY DISCUSSION

Please note that prior labor disabling disability is rated as it exists at the time of the subsequent industrial injury; and the apportionment statutes applicable in an industrial injury case do not establish prior labor disabling disability in an SIBTF case. However the apportionment is important for the analysis of the combined degree of disability,.

Thus it is important that in your discussion of pre-existing disability and its labor disabling nature please discuss the following issues:

- Whether an applicant have been "permanently partially disabled" at the time of a subsequent industrial injury and if yes, please indicate which prior evidence show that non-industrial prior labor disabling disability had achieved permanency at the time of the subsequent industrial injury.

- Whether prior disability have impacted the applicant's ability to work in a **demonstrable way**, and if yes - please describe whether these limitations resulted or could result for applicant in loss of wages, change in jobs, and/or change in work duties or abilities and other impact of the applicant's ability to work.

DISCUSSION OF SUBSEQUENT INDUSTRIAL INJURY

Please note that per *Brown v. Workers*, a finding and award or a stipulated award is not necessary to prove the compensability of the industrial case, thus in SIBTF case your opinion about compensability of the subsequent injury is important.

Please note further, that for the purposes of SIBTF case, a C&R does not necessarily establish any fact in a case. C&R in the regular benefits case neither proves nor disproves compensability, nor does it prove any level of disability. Thus, you are expected to provide an impairment **rating within your specialty as of the date of the evaluation** and provide your opinion as to the apportionment to pre-existing conditions, subsequent industrial injury and post-subsequent industrial injury

Finally, it is expected that you would provide your answer to the following important questions:

- WHETHER THE DEGREE OF DISABILITY FROM PRIOR DISABILITY AND SUBSEQUENT INJURY COMBINED IS GREATER THAN THAT FROM SUBSEQUENT INJURY ALONE,
  and
- WHETHER SUBSEQUENT COMPENSABLE INDUSTRIAL INJURY RESULTING IN ADDITIONAL PERMANENT DISABILITY

In order to facilitate your evaluation, we provide medical records for the above applicant in our possession according to the exhibit list attached.

If you need any additional testing, please advise so.

If you believe that the applicant has health issues outside of your specialty, please defer these issued to the medical doctors of appropriate specialty, please indicate what specialty is recommended.

Thank you for your anticipated courtesy and cooperation herein.

Very truly yours,

By Natalia Foley, Esq
WORKERS DEFENDERS LAW GROUP

PROOF OF SERVICE

1. I am over the age of 18 and not a party of this cause. I am a resident of or employed in the county where the mailing occurred. My residence or business address is

751 S Weir Canyon Rd Ste 157-455
Anaheim CA 92808

2. I served the following documents:

COVER LETTER FOR SIBTF MEDICAL EVALUATION

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by enclosing a true copy in a sealed envelope addressed to each person whose name and address is shown below and depositing the envelope in the US mail with the postage fully prepaid.

- Date of Mailing: 06/20/2022
- Place of Mailing: Los Angeles, CA

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

Date: 06/20/2022

By Irina Palees, Legal Assistant
to Attorney Natalia Foley

Name and Address of each Person to whom Notice was Mailed

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

OD LEGAL
355 S. GRAND AVE STE 1400
LOS ANGELES CA 90071

SIBTF
1750 HOWE AVENUE, SUITE 370
SACRAMENTO CA 95825-3367

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: Dmitri Boudrine *(employee name)*

Claims Adjuster: Natalia Foley *(claims administrator name, or if none employer)*

Claim Number: SIF8345007

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

I, Alicia Escobar, declare:
(Print Name)

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

2. My business address is: 11010 White Rock Road, Suite 120 Rancho Cordova, CA 95670.

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 professional 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 address shown below.

Means of Service: *(For each address, enter A-E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
B	August 29, 2022	Natalia Foley, Workers Defenders Law Group, 751 S Weir Canyon Rd STE 157-455, Anaheim, CA 92808
B	August 29, 2022	Ms. Joanna Arizabal, Subsequent Injuries Benefits Trust Fund, 1750 Howe Avenue, Suite 370, Sacramento, CA 95825

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: August 29, 2022

(signature of declarant)

Alicia Escobar
(print name)

QME Form 122
Rev. February 2009

Phone: (800) 458-1261
Fax: (916) 920-2515

CalMed Evaluation Services, 11010 White Rock Road, Suite 120, Rancho Cordova, CA, 95670

Workers Defenders Law Group
Natalia Foley
751 S Weir Canyon Rd STE 157-455
Anaheim, CA 92808

W-9

(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

Print or type. See **Specific Instructions** on page 3.

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

CalMed Evaluation Services, LLC

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

CalMed Evaluation Services, LLC

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

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

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

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

☐ Other (see instructions) ▶

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

5 Address (number, street, and apt. or suite no.) See instructions.

11010 White Rock Road, Suite 120

Requester's name and address (optional)

6 City, state, and ZIP code

Rancho Cordova, CA 95670

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–			–				

or

Employer identification number

3	0	–	0	7	9	2	1	8	6

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here | **Signature of U.S. person** ▶ Maria Perez | **Date** ▶ **06/10/2022**

General Instructions

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

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

Purpose of Form

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

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

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

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