Babak Kamkar, OD

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September 8, 2022

Subsequent Injuries Benefits Trust Fund
SIBTF Sacramento
1750 Howe Avenue, Suite 370
Sacramento, CA 95825

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

COMPREHENSIVE MEDICAL-LEGAL EVALUATION

SUBSEQUENT INJURIES BENEFITS TRUST FUND

RE:	Boudrine, Dmitri
DOB:	06/26/1962
Social Security No.:	xxx-xx-7420
Date of Injury:	CT 04/28/2011 to 04/11/2012
Claim #:	SIF8345007
Employer:	The Roberts Companies
WCAB Case No.:	ADJ8345007
Date of Exam:	September 8, 2022
Interpreter:	Yes

To Whom It May Concern:

As requested, Mr. Dmitri Boudrine, was evaluated at my Glendale office, for a Subsequent Injuries Benefits Trust Fund Medical Evaluation – ophthalmic factors – on September 8, 2022.

I have received a cover letter dated June 20, 2022, from Natalia Foley, Esq., requesting a medical-legal report regarding the Ophthalmic aspects of Mr. Boudrine's case. The attorney's letter requests specific issues unique to this case and separate from the subsequent injury any prior industrial injuries and pre-existing conditions and disorders that were present before the subsequent injury. I am asked to provide an impairment rating within my specialty as of the date

of the evaluation and provide my opinion as to the apportionment to pre-existing conditions, subsequent industrial injury, and post-subsequent industrial injury.

According to the letter, Mr. Boudrine has a worker's compensation case with a WPI that eclipses the 35% threshold for SIBTF qualification. As such, I am instructed to evaluate his current vision impairment and determine with reasonable medical probability any labor disabling ocular impairment that existed before the injury of 04/11/2012. I am asked to address issues of causation, apportionment, labor disablement, and work restrictions, related to my specialty. Arrowhead Evaluation Services, Inc., Redlands, CA, facilitated this evaluation.

I had the opportunity to perform an evaluation for Mr. Dmitri Boudrine at my Glendale office. This was a Qualified medical evaluation under the Subsequent Injuries Benefits Trust Fund and was concerned with an ocular impairment which has been assigned the end date of injury of April 11, 2012. This report will focus on the ocular and visual conditions of the examinee. The appointment on September 8, 2022, began at 11:30 a.m. and concluded at 1:30 p.m. Diagnostic tests performed included retinal photography and automated visual fields.

Per the Official Medical-Legal Fee Schedule effective April 1, 2021, this evaluation qualifies for billing as ML-201-93, Comprehensive Medical Legal Evaluation with Interpreter. The interpretation services of Mr. Konstantin Mayatsky, Certificate # 102551 was used.

Moreover, the evaluation qualifies for medical record review, MLPRR, a total of 7,162 pages of medical records were reviewed, resulting an additional 6,962 pages not included, as part of the comprehensive evaluation. The evaluation included a detailed history taking 55 minutes in time, involving multiple body parts, comprehensive dilated eye examination including evaluation of visual fields, panoramic fundus photography, extensive medical records review, and the preparation and editing of the report. Causation and apportionment are discussed. The medical records were accompanied by an attestation from Natalia Foley, Esq. I, Babak Kamkar, OD, QME, verify under penalty of perjury, that I personally reviewed 7,162 pages of records received from the parties involved in this matter.

The appointment began with the explanation that the purpose of the visit was solely to evaluate and report on his case, and that a doctor-patient relationship was not established. He understood this purpose and had no questions. The following report contains my professional opinion and conclusions concerning this case.

PRE-EXISTING DISABILITY AND INDUSTRIAL DISABILITY

Mr. Boudrine's ocular complaints included poor vision.

Mr. Boudrine is greatly bothered by visual impairment for many years. He stated that his vision has been gradually worsening over the years, predating 4/11/2012. He avoids driving at night. He stated that he does not feel safe to drive due to the visual impairment. He also stated that he squints his eyes frequently.

He has been wearing prescription glasses since the age of 18. He uses separate glasses for computer. He takes off his glasses for reading small print and holds the printing material relatively close to his eyes.

HISTORY OF INJURY

Mr. Boudrine was working for Roberts Companies, in Santa Monica, CA from 2001 for a period of about ten years, as a property manager. His regular duties included being involved in renting apartment buildings, scheduling, and vendors. He stated that he sustained cumulative trauma injuries to multiple parts of his body including left knee, back, and upper extremities, with the end date of 4/11/2012.

He also sustained specific injury On January 26, 2008, while doing his regular duties he was attempting to fix a gate, when he slipped, fell on his left knee, and a gate hit him on his left shoulder. He was in a lot of pain but was able to get up and walked and went to his apartment. His left knee was painful and swollen. He reported the accident on the next day and sought medical attention. He went to UCLA MC, was treated, and paid by his insurance. Imaging studies were done, and he was diagnosed with left knee meniscal tear and ACL tear. He underwent left knee arthroscopic surgery. He was under the medical care and underwent multiple sessions of physical therapy but still experiences pain.

JOB HISTORY AND DESCRIPTION

Mr. Boudrine worked for Roberts Companies, in Santa Monica from 2001 to 2011.

Mr. Boudrine stated that he has worked in the film industry for more than 40 years.

He worked for several studios from 1997 to 2014 as an actor.

From 1992 to 1997 he was self-employed in TV and film productions as an actor.

From 1989 to 1991 he worked for Vakhtangov Theater in Moscow as an actor.

From 1986 to 1989 he was a student at Moscow Theater Institute and received a master's degree.

From 1980 to 1986 he was a student at Kiev Polytechnic Institute and has a master's degree in sound engineering.

HISTORY OF PRIOR INJURIES AND SURGERIES

On 2/22/2008, he was involved in a motor vehicle accident and received blunt head trauma, tibia/fibula fracture, scalp laceration. He reported history of coma, after being hit by a car in 2008. He lost consciousness and was transferred to the Cedar Sinai Hospital. He recovered after that injury and was out of work for months. He underwent Left knee surgery.

He developed post-surgical left lower leg deep vein thrombosis and pulmonary embolism on 2/28/2008.

In 2017, he underwent gastric sleeve surgery for morbid obesity.

In 2006, he underwent gallbladder surgery.

MEDICAL HISTORY

Mr. Boudrine suffers from hypertension, atrial fibrillation, asthma, and COPD for many years. He has history of pulmonary embolism, headaches, sleep apnea, peptic ulcer disease, and depression.

ALLERGIES

He did not report any allergies to medications.

PRESENT MEDICATIONS

Mr. Boudrine did not recall the names of his medications, but stated that he uses medications for cardiac arrhythmias, hypertension, depression, and diabetes. The records reviewed collaborate this.

FAMILY HISTORY

There is history of diabetes, heart disease, and hypertension in his mother.

SOCIAL HISTORY

The examinee is divorced since 2001. He does not have children. He stopped smoking since 2008, does not drink alcohol, and does not use illegal drugs. He stated that he feels that driving at night is not safe due to his ongoing vision problems.

RECORD REVIEW:

Please see the section at the end of this report.

PHYSICAL EXAMINATION

Examination revealed a 6 feet 4 inches and 250 pounds male, who appeared his stated age of 60. He was oriented to time, place, and person.

Uncorrected vision:

FAR:	Right eye 20/400	Left eye 20/400	Both eyes 20/400
NEAR:	Right eye RS 200	Left eye RS 80	Both eyes RS 80

Corrected vision: Mr. Boudrine had brought a pair of glasses with single vision glasses with him with the following powers.

Rt lens -4.25 -0.50 x 040
Left lens -2.25 -1.75 x 086

Visual acuity with these glasses were:

NEAR: Right eye RS 70 Left eye RS 80 Both eyes RS 70

Mr. Boudrine also uses glasses for computer but did not bring them.

Cover-uncover test showed no tropia. Extraocular muscles were smooth and unrestricted. Confrontation fields were full in each eye.

Refractive findings were as follows:

OD	-4.25 -1.25 x 093	20/40
OS	-2.75 -1.50 x 085	20/60

Near add of +2.25 OU resulted in near acuity of RS 40 at 40 cm.

External exam: The upper eyelids were positioned normally at primary gaze. The lashes and lid margins were healthy.

Slit lamp exam: Conjunctiva was clear in both eyes. Cornea was clear in both eyes. The irides were flat and brown in color in both eyes. The crystalline lens showed 2+ cortical and nuclear sclerosis cataract in the right eye.

The anterior chambers were deep and quiet in both eyes. The angles were open in both eyes.

Pupils were 4 mm in dim lighting in both eyes. Both eyes constricted to 2 mm in bright lighting. There was 3+ reactions to direct and consensual light in both eyes. They were regular in appearance. There was no afferent pupillary defect using the APD Tester™.

Intraocular pressure (IOP) was measured by Goldmann Applanation Tonometry. Right eye measured 13 mmHg; left eye measured 12 mmHg at 1:05 p.m.

The pupils were dilated with 1.0% tropicamide followed by 2.5% phenylephrine drops.

Binocular indirect ophthalmoscopy and slit lamp biomicroscopy with Volk Superfield lens were performed after full dilation.

The vitreous humor in both eyes was clear.

Retinal vasculature appeared with mild atherosclerosis without A/V defects. There were no retinal hemorrhages or exudates in either eye.

The macula in the right eye was homogenous and avascular. The macula in the left eye showed retinal pigment atrophy. There were chorioretinal punched out lesions in the posterior pole of both eyes.

There was peripapillary atrophy of the optic nerve head in the left eye. The cup-to-disc ratios was 0.2 in the right eye and 0.2 in the left eye.

The peripheral retina of both eyes was attached with no tears or holes.

DIAGNOSTIC STUDIES:

The following are Diagnostic Studies performed as part of this evaluation.

- Fundus Photography, CPT Code: 92250

Associated ICD-10 code: E11.3592

- Fundus photography was performed using Optos™ Imaging Technology. This technology allows detailed panoramic 200-degree views of the retina. Wide field red-green and auto-fluorescent images of both retinas were obtained.

  Chorioretinal punched out lesions changes in both eyes were documented. The peripapillary atrophy and maculopathy in the left eye was documented. No other retinal abnormalities were identified in both eyes.

  The finding supports the diagnosis of Presumed Ocular Histoplasmosis in both eyes with macular involvement in the left eye.

Figure 1 Optomap Retinal Image of the Right Eye – Posterior Pole

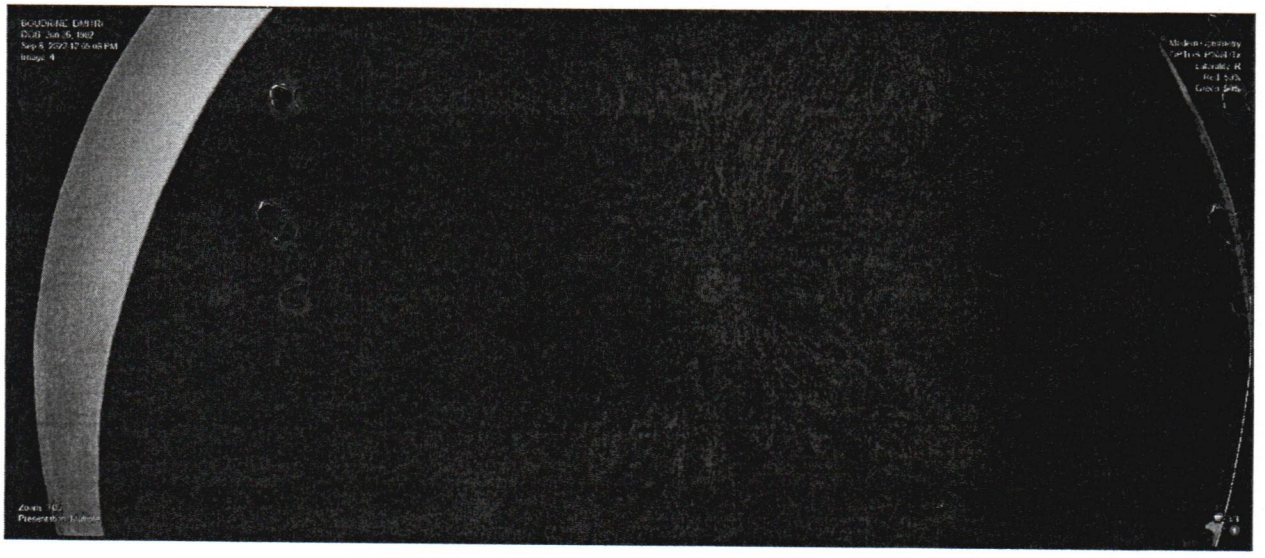


Figure 2 Optomap Retinal Image of the Left Eye – Posterior Pole

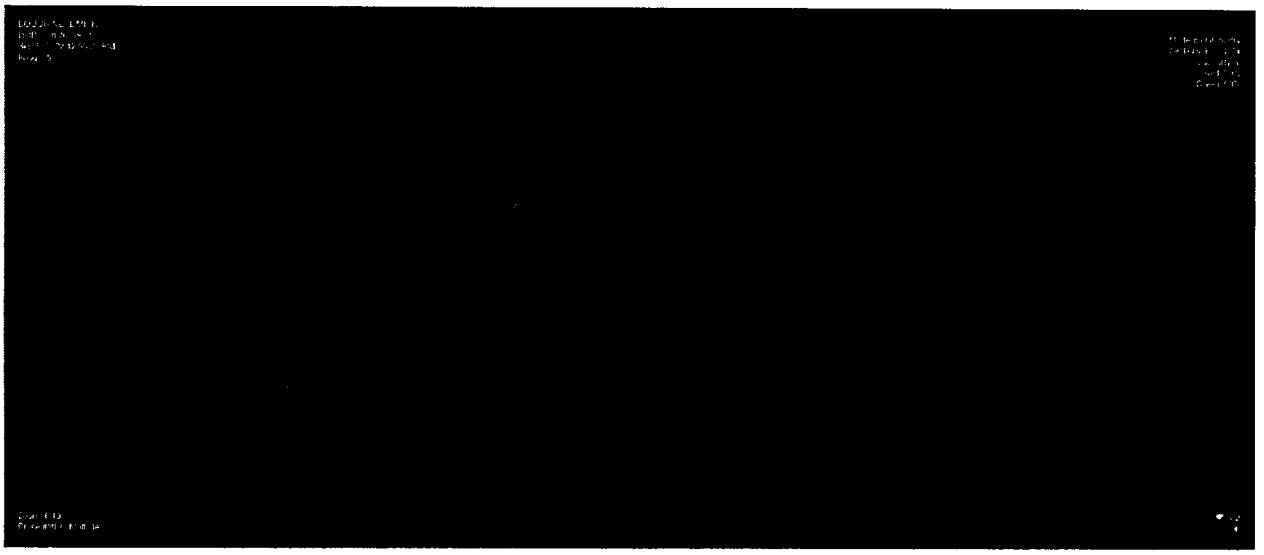
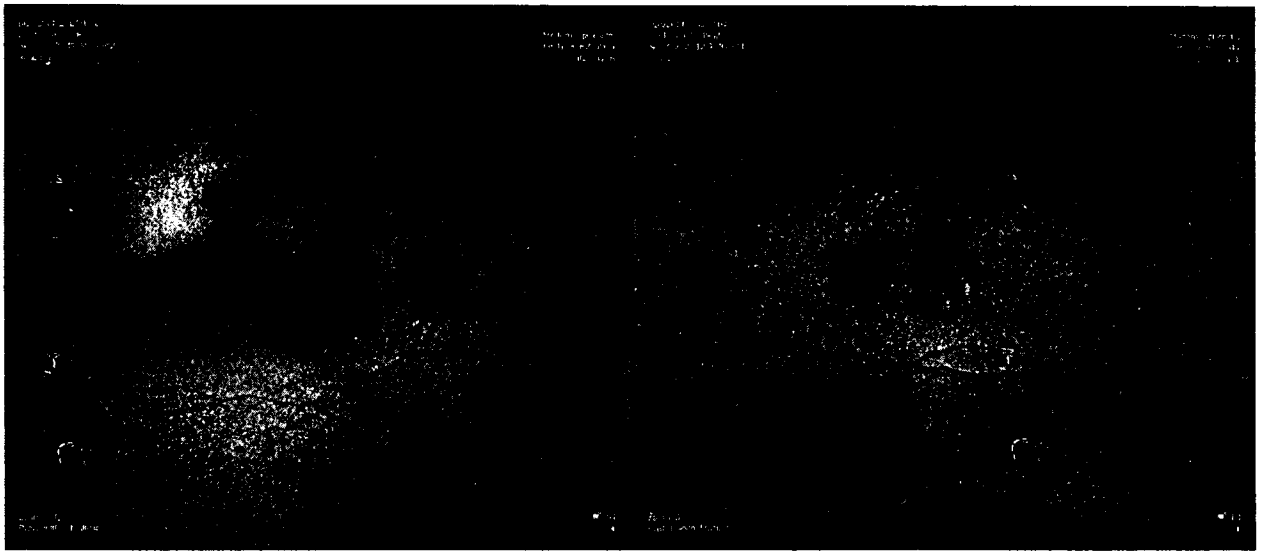


Figure 3 Optomap Autofluorescence Image of Both Eyes



- Visual Fields, CPT code: 92082

Associated ICD-10 code: E11.3592

Visual Field Studies was performed using a kinetic strategy from non-seeing to seeing along 16 meridians for the left eye. The kinetic method is used to quantify defects in the visual fields in accordance with the disability rating system of the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. The result of the left eye is plotted in the figure below and interpreted as nearly full. Their reliability was excellent. Visual field testing of the right eye was not possible due to the intravitreal hemorrhage.

Figure 4 Left Eye Kinetic Visual Field

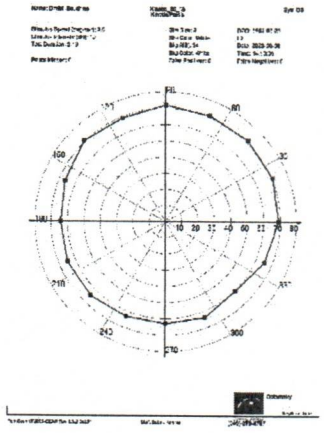
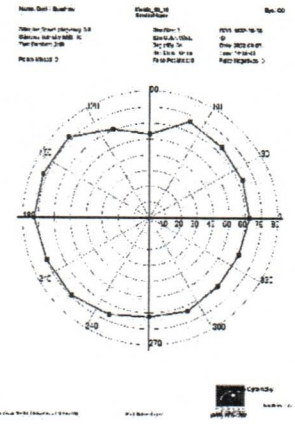


Figure 5 Right Eye Kinetic Visual Field



The impairment related to the visual acuity loss and field restrictions in this case are considered further in this report.

DIAGNOSES

1. Cortical age-related cataract, bilateral, ICD-10 code: H25.013
2. Histoplasmosis, pre-existing, ICD-10 code: B39.9
3. Myopia, bilateral, ICD-10 code: H52.13
4. Regular astigmatism, bilateral, ICD-10 code: H52.223
5. Presbyopia, natural, ICD-10 code: H52.4

DISCUSSION OF FINDINGS

In this SIBTF case, each impairment prior to the subsequent injury date of 4/11/2012 and its cause must be identified and quantified. Furthermore, current impairments and their causes must also be identified and quantified. I will consider those visual impairments that are labor disabling and the level of impairment that likely existed before the industrial injury.

Mr. Boudrine has subnormal vision in both eyes. He has been wearing glasses for correction of myopia since his late teens. He reported noticing his visual acuity gradually decreasing over the past decade, predating 4/11/2012, to the point that he avoids driving at night. He reported squinting but still having difficulty seeing signs at far. He removes his glasses for reading small print and holds the reading material relatively close to his eyes.

These symptoms correlate well with the examination findings. In his right eye, he has 2+ age-related cataract that reduces the overall vision and increases glare. His best corrected visual acuity in the right eye is 20/40. The increase in cataract in his right eye has contributed to his perception of his poor overall vision, especially at far and at night. After reviewing his medical records, I conclude that it is likely that over the past decade, his best-corrected visual acuity in the right eye has decreased from 20/25 to 20/40.

He has maculopathy in the left eye with the best-corrected visual acuity of 20/60. The examination findings support the likely diagnosis of Presumed Ocular Histoplasmosis. It is likely that he has had this condition for most of his life, as this condition is commonly caused by a fungus in soil. It is correlated with growing up in areas with chicken or bird farms nearby. Mr. Boudrine exhibits chorioretinal punched out lesions in both eyes, peripapillary atrophy, and maculopathy in the left eye which support this diagnosis.

Mr. Boudrine depends on his high level of near sightedness to read small print by holding reading materials relatively close to him, using relative distance magnification. However, he is limited in seeing distance objects to the level of 20/40 binocularly with prescription glasses. As stated above, with the available medical records, it is likely that prior to 4/11/2012, he had best-corrected visual acuity of 20/25 binocularly.

Visual fields studies reported above show full fields in both eyes. His visual fields were likely full in both eyes prior to 4/11/2012. I will consider these values when calculating the pre-existing visual impairments below.

- Reduced vision

The AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, has detailed instructions on calculating visual impairment. As described in detail above, I will consider the following best-corrected visual acuity levels for prior to 4/11/2012 and for the current period in this case.

Pre-existing level: 20/25 in the right eye, 20/60 in the left eye, and 20/25 binocularly.

Current level: 20/40 in the right eye, 20/60 in the left eye, and 20/40 binocularly.

In the Guides, visual acuity of 20/60 is assigned a Visual Acuity Score (VAS) of 75 (Visual Acuity Impairment Rating of 25%), visual acuity of 20/40 is assigned a Visual Acuity Score (VAS) of 85 (Visual Acuity Impairment Rating of 15%) and 20/25 is assigned a Visual Acuity Score (VAS) of 95 (Visual Acuity Impairment Rating of 5%).

Using Table 12-3 of AMA Guides, on Page 284, the Functional Acuity Score (FAS) for the pre-existing period is calculated as follows:

VASOU : 95 x 3 = 285

VASOD : 95 x 1 = 95

VASOS : 75 x 1 = 75

ADD OU, OD, and OS = 455

Divide by 5 = 91 This is Functional Acuity Score (FAS)

Pre-existing acuity-related Impairment Rating is 9% (calculated as 100 – FAS).

The current Functional Acuity Score (FAS) is calculated as follows:

VASOU : 85 x 3 = 255

VASOD : 75 x 1 = 75

VASOS : 85 x 1 = 85

ADD OU, OD, and OS = 415

Divide by 5 = 83 This is Functional Acuity Score (FAS)

Current acuity-related Impairment Rating is 17% (calculated as 100 – FAS).

Peripheral vision must also be considered. The automated visual field test result for each eye was presented earlier in this report. The visual fields are full currently and were likely full prior to the subsequent industrial injury.

The AMA Guides, 5th Edition, has specific instructions on how to score the visual fields, starting on page 287. The guidelines dictate plotting the fields in 10 meridians, 2 in each upper quadrant and 3 in each lower quadrant. In this rule, the following meridians divide the 360-degree field: 25°, 65°, 115°,155°, 195°, 225°, 255°, 285°, 315°, and 345°. In this case, the following points were likely perceivable to Mr. Boudrine in each eye prior to 7/12/2019.

Right Eye

25° Meridian → 10 points are seen = 10

65° Meridian → 10 points are seen = 10

115° Meridian → 10 points are seen = 10

155° Meridian → 10 points are seen = 10

195° Meridian → 10 points are seen = 10

225° Meridian → 10 points are seen = 10

255° Meridian → 10 points are seen = 10

285° Meridian → 10 points are seen = 10

315° Meridian → 10 points are seen = 10

345° Meridian → 10 points are seen = 10

Adding all the values, the visual field score for right eye (VFS_{OD}) is 100.

Left Eye

25° Meridian → 10 points are seen = 10

65° Meridian → 10 points are seen = 10

115° Meridian → 10 points are seen = 10

155° Meridian → 10 points are seen = 10

195° Meridian → 10 points are seen = 10

225° Meridian → 10 points are seen = 10

255° Meridian → 10 points are seen = 10

285° Meridian → 10 points are seen = 10

315° Meridian → 10 points are seen = 10

345° Meridian → 10 points are seen = 10

Adding all the values, the visual field score for left eye (VFS_{OS}) is 100.

According to the 5th Edition of the AMA Guidelines, to calculate the visual field score for both eyes, an overlay grid is placed over the combination of the right and left visual fields. This grid contains points at the following radial locations: 1°, 3°, 5°, 7°, 9°, 15°, 25°, 35°, 45°, 55°, and 65°. Each meridian is then assessed to see if the point at that radial position is theoretically seen by the subject. The seeing locations are added together to find the visual field score for both eyes (VFS_{OU}).

Both Eyes

25° Meridian → 10 points are seen = 10

65° Meridian → 10 points are seen = 10

115° Meridian → 10 points are seen = 10

155° Meridian → 10 points are seen = 10

195° Meridian → 10 points are seen = 10

225° Meridian → 10 points are seen = 10

255° Meridian → 10 points are seen = 10

285° Meridian → 10 points are seen = 10

315° Meridian → 10 points are seen = 10

345° Meridian → 10 points are seen = 10

Adding all the values, the visual field score for both eyes (VFS_{OU}) is 100.

Subsequently, FFS for both current and the pre-existing period is calculated as follows:

VFSOU : 300 x 3 = 300

VFSOD : 100 x 1 = 100

VFSOS : 100 x 1 = 100

ADD OU, OD, and OS = 500

Then divide by 5 = 100 This is Functional Field Score (FFS)

Field Related Impairment Rating is 0% (calculated as 100 – FFS).

With known FFS and FAS values the FVS is calculated as follows: FVS = (FAS x FFS)/100

FVS for the pre-existing period equals: (91 x 100) /100 = 91% Functional Vision Score (FVS)

By these calculations, the **pre-existing** level of impairment rating based on the visual acuity loss and visual field loss is **9%**.

Similarly, the current FVS is calculated as follows: FVS = (FAS x FFS)/100

FVS for the current period equals: (83 x 100) /100 = 83% Functional Vision Score (FVS)

The **current** level of impairment rating based on the visual acuity loss and visual field loss is **17%**.

- Reduced stereopsis

In many ocular disability cases, there are additional considerations related inability to perform physical tasks due to reduced visual perception that is not represented in best-corrected visual acuity or in restrictions of peripheral vision. Examples of these diminished perceptions include reduced stereopsis (or binocular depth perception), photophobia, glare sensitivity, or reduced dark adaption.

The AMA Guides allows for individual adjustment for conditions such as reduced steropsis. It allows up to the maximum of 15% for individual adjustment. Specifically, on page 297, it states:

> "Although visual acuity loss and visual field loss represent
> significant aspects of visual impairment, they
> are not the only factors that can lead to a loss of

> functional vision. This edition of the Guides does not provide detailed scales for other functions, such as: …Glare sensitivity (veiling glare), delayed glare recovery, photophobia (light sensitivity), and reduced or delayed light and dark adaptation... Binocularity, stereopsis, suppression, and diplopia.
>
> If significant factors remain that affect functional vision and that are not accounted for through visual acuity or visual field loss, a further adjustment of the impairment rating of the visual system may be in order. The need for the adjustment, however, must be well documented. The adjustment should be limited to an increase in the impairment rating of the visual system (reduction of the FVS) by, at most, 15 points."

In the precedence case of Michele Tousley vs. Dept of Interior, State of Utah, the individual adjustment for glare and decrease in contrast sensitivity was determined as 15%.

In this case, Mr. Boudrine has long-standing reduce central vision in his left eye. Although he has general binocular vision, his detailed depth perception is reduced below normal because of this significant reduction in the central in the left eye. Although there is no direct measurement of his stereopsis prior to 4/11/2012, with the available medical records, I can infer the likely level of stereopsis present prior to the subsequent industrial injury. Since it is likely that his best-corrected visual acuity in the left eye has been 20/60, he also likely has not had better stereopsis than 100 seconds of arc. This estimate is based on my clinical experience of over 35 years. Therefore, I see reasonable justification of assigning **5% pre-existing and current** Individual Adjustment for reduced stereopsis in this case.

Having considered all the aspects of the visual impairment in this case, we can combine them to achieve a total visual impairment rating for both current and pre-existing periods. The impairments are additive according to the AMA Guides.

Pre-existing: 5% (Individual Adjustment) + 9% (visual acuity and visual field impairment) = **14%**.

Current: 5% (Individual Adjustment) + 17% (visual acuity and visual field impairment) = **22%**.

Table 12-10, The Classification of Impairment of the Visual System (expanded) of AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, is shown on page 298 of the Guides. With the pre-existing impairment rating of 14%, the table categorizes Claimant's visual impairment as Class 2, in the range of 10-29%. From an ocular standpoint, Whole Person Impairment Rating (WPI), with an estimate of overall Activities of Daily Living ability loss, was 14% prior to 4/11/2012.

This value is additive to all other impairments of the body since there is no overlap in the function of the eyes with respect to other body parts. The visual impairments in this case are labor disabling due to the reasons cited in each case above.

MAXIMUM MEDICAL IMPROVEMENT

From an ocular disability standpoint, it is my opinion that the examinee's ocular condition had reached maximum medical improvement on 4/11/2012.

Similarly, his ocular condition has reached maximum medical improvement at the current time. The lenticular cataracts present in his eyes are likely going to progress over time and there will reach a point when it will be medically sensible to undergo cataract extraction with intraocular lens implants at that time.

There is no known effective treatment for ocular histoplasmosis.

SUBJECTIVE FACTORS

Subjective factors of examinee's ocular conditions include reduced vision.

OBJECTIVE FACTORS

1) Reduced stereopsis
2) Reduced visual acuity

CAUSATION:

With the available medical records and professional opinions already rendered in this case, it is likely that the visual and ocular impairments identified in this report are due to non-industrial causes.

APPORTIONMENT:

Concerning visual impairments, apportionment is not an issue with regard to the industrial injury. However, the pre-existing visual impairments levels are not the same as the current levels as discussed in detail above.

WORK PRECLUSIONS

Mr. Boudrine is precluded to work that requires good binocular vision. Jobs that require good depth perception, such as dental assistant, electronic assembly, sports referee, manufacturing small parts, etc. are precluded.

These work preclusions existed prior to the subsequent industrial injury, limiting his ability to compete in the workplace.

FUTURE MEDICAL TREATMENT

Mr. Boudrine needs eye examinations every six months to monitor the progression of lenticular cataract.

SUMMARY

Pre-existing: 5% (Individual Adjustment) + 9% (visual acuity and visual field impairment) = **14%.**

Current: 5% (Individual Adjustment) + 17% (visual acuity and visual field impairment) = **22%.**

The visual impairments are 100% due to natural causes.

REASONS FOR OPINIONS

1. Review of available medical records.
2. Physical examination findings, which support the examinee's condition.
3. Correlation of the examinee's oral history compared to the records.
4. Credibility of the examinee.
5. Clinical experience and research.

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. Partial compilation and excerpting of the medical records were completed by trained staff at Arrowhead Evaluation Services. 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.

Date of Signing of Report: October 30, 2022, in Orange County, California

Babak Kamkar, OD, QME

Signature
Babak Kamkar, OD, QME
Optometry

RECORD REVIEW:

Undated #1 – Postoperative Instructions by David E Fermelia, MD.

Undated #2 - Referral Form by Maciej Majzel, DC. Dx: 1) L/S pain. 2) L knee pain. Requested PT.

Undated #3 - Industrial Testing and Reports. On Oswestry Index Questionnaire, pt scored 32. Pt experiences a disability level of 64%. Experiences moderate difficulty with personal care, lifting, walking, sitting and sleeping. Pain intensity is not grossly affected at this time. Comparatively, pt's disability index score has lowered by 2% since the last report.

Undated #4 - Letter of Medical Necessity. Requested back disability index.

Undated #5 - PR-2 by Julian Girod, MD. Pt c/o L knee pain, cannot squat. Has stabbing pain with a tingling sensation. Dx: L knee injury with ligament injury with an ACL tear. Plan: Advised to lose weight. Recommended weight loss program.

Undated #6 – Order at United Medical Imaging Healthcare. Ordered x-ray of L knee.

Undated #7 - Back Disability Index Questionnaire.

07/22/05 – Pathology Rpt by Juan Lechago, MD at Department of Pathology & Laboratory Medicine.

07/22/05 - Physiologic Monitoring/Intake and Output at Cedars-Sinai Medical Center.

07/22/05 - Medical/Surgical Flowsheets/Interdisciplinary Plan for patient care and education/Patient/Caregiver Education Record at Cedars-Sinai Medical Center.

07/22/05 - Ambulatory Surgery/Short Stay H&P Note by David E. Fermelia, MD at Cedars-Sinai Medical Center. Visit for RUQ abdominal pain, and cholelithiasis on ultrasound.

07/22/05 - Physician's Preop Order Sheet/Intra-Operative Orders/Physician's Order Sheet at Cedars-Sinai Medical Center.

07/22/05 - Post-Procedure/Post-Operative Orders at Cedars-Sinai Medical Center.

07/22/05 - EKG Strip Mounting at Cedars-Sinai Medical Center. SV rhythm.

07/22/05 - Anesthesia Record at Cedars-Sinai Medical Center.

07/22/05 - Nursing Notes at Cedars-Sinai Medical Center. Discharge criteria met, pt is discharged.

07/22/05 - Operating Room Patient Care Record/Safety Check Surgical Documentation at Cedars-Sinai Medical Center.

07/22/05 - Scrip by Marjorie R. Chelly, MD at Cedars-Sinai Medical Center. Prescribed Vicodin.

07/22/05 - Pain Management Flow Sheet/24-Hr. Medication Administration Record at Cedars-Sinai Medical Center.

07/22/05 - Patient Progress Interdisciplinary Plan of Care at Cedars-Sinai Medical Center. Visit for s/p lap chole, feels well, pain control.

07/22/05 - Pre- Anesthesia Assessment at Cedars-Sinai Medical Center. The proposed surgery is lap chole. ASA II.

07/22/05 - Procedure Report by David E Fermelia, MD at Cedars-Sinai Medical Center. Procedure Performed: Laparoscopic cholecystectomy with intraoperative cholangiography.

07/23/05 - Admission Information at Cedars-Sinai Medical Center.

07/23/05 - Patient Progress Interdisciplinary Plan of Care at Cedars-Sinai Medical Center. POD#1, pain well controlled, discharged to home.

07/22/05-07/23/05 - Pneumonia Vaccine Admission Orders at Cedars-Sinai Medical Center.

07/22/05-07/23/05 - Nursing Notes at Cedars-Sinai Medical Center.

07/23/05 - Medical/Surgical Flowsheet, Patient/Caregiver Education Record, Pain Management Flow Sheet at Cedars-Sinai Medical Center.

07/25/05 - Pain Management Flow Sheet at Cedars-Sinai Medical Center.

01/30/06 - Admission Information at Cedars-Sinai Medical Center.
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04/03/07 - Admission Information at Cedars-Sinai Medical Center.

04/25/07 - Admission Information at Cedars Sinai Medical Center.

05/03/07 - Admission Information/All Orders at Cedars Sinai Medical Center.

05/03/07 - Procedure Note by Avrom Gart, MD at Cedars-Sinai Medical Center. Pre/Post-Procedure Dx: 1) Lumbar facet syndrome. 2) Lumbar disc herniation. 3) Lumbar radiculitis. Procedure Performed: 1) B/L L4-L5 facet injection. 2) B/L L5-S1 facet injection. 3) L4-L5 LESI. 4) Fluoroscopic imaging. 5) Intraoperative epidurogram.

11/15/07 – Correspondence. DOI: 01/26/08. Pt is not able to return to his regular work as a building manager. Recommended PT and rehab. Light duty now until 03/08/09.

12/20/07 - Admission Information at Cedars-Sinai Medical Center.

01/10/08 - PT Note from Westside Spine & Joint Rehabilitation. Pt feels okay since the last visit. Continue therapy. Tolerated exercises well.

01/27/08 - Emergency Service Rpt by Marshall T. Morgan, MD/Emergency Medicine at UCLA Med Ctr. Pt slipped and fell on the wet pavement last night and had pain in L knee. Now the knee has swollen and is more painful. Pain level is 7-8/10. PMH: HTN. SH: Occasional ETOH and tobacco 1/2 PPD. Dx: Knee injury with acute hemarthrosis. Plan: Pt refused knee immobilizer and crutches. Needs a referral to ortho. Disposition: Discharged.

01/28/08 - MRI of L Knee at Tower Saint John's Imaging.
Impression: 1) Deformity and foreshortening of the posterior horn of the medial meniscus compatible with a bucket handle tear. The anterior horn appears intact. 2) Degenerative tear of the anterior horn of the lateral meniscus. The 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.

01/29/08 - Progress Note by Bert R. Mandelbaum, MD at Santa Monica Orthopaedic and Sports Medicine Grp. Requested PT for L knee.

01/31/08 - Letter from RHB Management. On 01/26/08 at around 10:30 PM, pt was told that the south gate in the garage came off its trucks and stays open. He went into the garage and put it back on the trucks. When he was doing this, he slipped because it was raining and hurt his L knee. On Sunday, he could not move at all and had to go to ER at UCLA Med Ctr where he was seen by a doctor and told that he do not have any broken bones, but had an internal ligament injury and have to see an orthopedic surgery specialist the next day. He went to see doctor B. R. Mandelbaum and from that day he is under his tx.

02/11/08 - PR-2 by Bert R. Mandelbaum, MD. Pt slipped while on a filming set injuring his L knee. Since this time, he has had severe and constant pain. Dx: 1) L knee ACL injury. 2) L knee medial meniscus tear. 3) L knee bone bruise with 2+ edema. Plan: Recommended arthroscopy medial meniscectomy which is scheduled on 02/18/08, post-op PT, ice and crutches.

02/11/08 - Letter by Bert R Mandelbaum, MD. Reviewed MRI. Discussed options and this examiner thinks that arthroscopy with meniscus-only management will be appropriate.

02/11/08 - Request for Preop Clearance from Surgery Ctr of the Pacific. The date of surgery is 02/18/08. Dr. Mandelbaum is planning to do L knee arthroscopy. Requested labs, ECG, PT, and surgical clearance.

02/13/08 - Review Determination by Elaine S. Sanders, RN at Anthem. Requested Polar unit/cold therapy and PT for arthroscopy knee meniscectomy were certified.

02/15/08 - WC Pre-Authorization Request by Bert R. Mandelbaum, MD. Requested outpatient arthroscopy lateral meniscectomy, polar ice and crutches, PT and surgical clearance. Pt is disabled since 02/18/08.

02/15/08 - Amended Request Documentation from Blue Cross of California WC Services. The requested polar unit has been withdrawn.

02/18/08 - Operative Rpt by Bert R. Mandelbaum, MD at Surgery Ctr of the Pacific. Pre-op Dx: 1) L knee ACL tear. 2) Medial meniscus tear. Operation Performed: 1) L knee arthroscopy. 2) Partial medial and lateral meniscectomy. 3) Debridement of articular cartilage defects. Post-op Dx: 1) L 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.

02/22/08 - Emergency Medical Service Rpt from Los Angeles Fire Department. Pt c/o R leg tib-fib fx, 5" laceration to the right side of the head. PE: Eyes: PERL. He went to the trauma center due to the mechanism of the accident. Had ECG monitoring, pulse oximetry and IV insertion.

02/22/08 - ED Note by Nathan J. McNeil, MD/Emergency Medicine at Cedars-Sinai Med Ctr. Pt was brought in by paramedics from an auto versus pedestrian who c/o R leg, tibia/fibula swelling as well as lacerations of the right side of the face. He had a positive LOC at the time of the accident. 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. He was transported secondary to mechanism here and was able to recall his name. He was talking and c/o R leg and right-sided head pain. SH: Denies smoking, alcohol or drug use. ROS: Eyes: Negative. PE: Eyes: Pupils are 2 mm and active. ED Course: Ordered and reviewed labs, EKG, an x-ray of the pelvis, CT of abdomen and pelvis, CT of C/S, and CT of the brain. Pt was placed on cardiac monitoring, continuous pulse ox and an IV was started. Oxygen was administered. Dx: 1) Blunt head trauma. 2) Scalp laceration. 3) Tibia/fibula fx of RLE. 4) Observation for compartment syndrome. Disposition: Admission to surgery in stable condition.

02/22/08 - H&P Note by Justin D. Saliman, MD at Cedars-Sinai Med Ctr. Pt was brought in by paramedics. GCS in field 15, eye-opening 4, verbal 5, motor 6, and breathing spontaneously. C/o R leg pain. He is amnestic to the event s/p auto vs peds with damage to the car. Has head laceration, bleeding, and R LE pain. Obtained x-ray of the chest, and pelvis, CT of the head, C/S, and abdomen and pelvis. Dx: 1) S/p auto vs peds. 2) Head laceration. 3) R tib/fib fx. Plan: Admit to the floor.

02/22/08 – Trauma Surgery Consult by Ali Salim, MD at Cedars-Sinai Med Ctr. Pt was hit by a car. 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 in R head with obvious laceration and bleeding from the site, as well as R leg pain. Dx: 1) S/p auto versus pedestrian. 2) Head

laceration. 3) R tibial-fibular closed fracture. Plan: Admission to the floor. Orthopedic surgery has been consulted. The head laceration will be closed at the bedside in ER. The leg has already been splinted. The trauma team will follow closely.

02/22/08 - X-ray of Pelvis interpreted by Navid Mehrpoo, MD at Cedars-Sinai Med Ctr.
Findings: Overlying objects obscure some of the radiographic detail. No definitive evidence of a displaced pelvic fx or dislocation is shown.

02/22/08 - X-ray of L Tibia and Fibula interpreted by Navid Mehrpoo, MD at Cedars-Sinai Med Ctr.
Findings: Slightly displaced fx of the medial malleolus is noted. Nondisplaced fx is seen at the lateral malleolus. Correlation with ankle is suggested.

02/22/08 - X-ray of R Tibia and Fibula interpreted by Navid Mehrpoo, MD at Cedars-Sinai Med Ctr.
Findings: Comminuted fx of mid-shaft of R tibia and fibula is noted with moderate displacement.

02/22/08 - X-ray of R Tibia and Fibula interpreted by Barry D. Pressman, MD at Cedars-Sinai Med Ctr.
Impression: Operative views of placement of tibial fixation, fx site is not well-evaluated on this examination.

02/22/08 - X-ray of Chest interpreted by Navid Mehrpoo, MD at Cedars-Sinai Med Ctr.
Findings: 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.

02/22/08 - X-ray of R Knee interpreted by Navid Mehrpoo, MD at Cedars-Sinai Med Ctr.
Findings: No evidence of a displaced fx or dislocation is seen at R knee. Mild degenerative changes are evident.

02/22/08 - CT of C/S interpreted by Navid Mehrpoo, MD/Kamron Izadi, MD at Cedars-Sinai Med Ctr.
Impression: 1) No CT evidence of acute fx or subluxation. 2) No hemorrhage is seen within the spinal canal. 3) These findings were communicated to the surgical resident Dr. Ng taking care of this pt at 0200 on 02/22/08.

02/22/08 - CT of Brain w/o contrast interpreted by Navid Mehrpoo, MD/Kamron Izadi, MD at Cedars-Sinai Med Ctr.
Impression: 1) No CT evidence of acute fx, hemorrhage, or mass. 2) Extensive right-sided scalp laceration. 3) Fluid in L maxillary sinus, and mucoperiosteal thickening of R maxillary sinus. 4) A CT of the face may be of benefit if a facial fx is suspected clinically.

02/22/08 - X-ray of L Ankle interpreted by Rick Sukov, MD at Cedars-Sinai Med Ctr.

Impression: Soft tissue swelling and a nondisplaced bimalleolar fx.

02/22/08 - Oxygen Usage Record from Cedars-Sinai Med Ctr.

02/22/08 - Patient Profile from Cedars-Sinai Med Ctr. Pt arrived by stretcher. He had MVA and reports pain in BUE. He has s/p multiple traumas. Pertinent Medical History: Smoked in the last 12 months. PSH: L knee surgery.

02/22/08 - Nurse Admission Notes from Cedars-Sinai Med Ctr. Pt admitted with s/p peds vs MVA with head laceration with some blood and sutured in ER with ACE bandage in BLE. C/o pain. RLE immobilized. R temporal laceration suture in progress.

02/22/08 - Pre-Operative/Pre-Procedure Note from Cedars-Sinai Med Ctr. Preop Dx: 1) L ankle ORIF. 2) R tibia IM nailing.

02/22/08 - Admission Orders Trauma Service from Cedars-Sinai Med Ctr. Pt admitted to the surgical floor. Condition: Stable.

02/22/08 - Medication Reconciliation List from Cedars-Sinai Med Ctr. Pt on no meds.

02/22/08 – Trauma Progress Note from Cedars-Sinai Med Ctr. Pain controlled. NPO. Reports L calf pain. Dx remains unchanged. Plan: F/u with ortho.

02/22/08 - Ortho Progress Note from Cedars-Sinai Med Ctr. Ped struck this AM and sustained R tib/fib midshaft fx and L medial/lateral mal fx with minimal displacement. Dx: R tib and L medial mal fx. Plan: Will require fixation. Taken to OR for R IM nailing and L ORIF.

02/22/08 - Immunization Screening and Standing Order Form from Cedars-Sinai Med Ctr. Pt refused vaccination.

02/22/08 - Intra-Operative Orders from Cedars-Sinai Med Ctr. Ordered fluoroscopy with image amplification for ORIF. Triple antibiotic solution.

02/22/08 - Anesthesia Orders Pre-Post Procedure/Operative from Cedars-Sinai Med Ctr.

02/22/08 - Trauma/Resuscitation Flowsheet from Cedars-Sinai Med Ctr. Pre-Hospital Information: C-Collar, oxygen, and backboard.

02/22/08 - Pre-Procedure/Surgery Checklist from Cedars-Sinai Med Ctr.

02/22/08 - Pain Management Flowsheet from Cedars-Sinai Med Ctr.

02/22/08 - Scheduled Med Record from Cedars-Sinai Med Ctr. Folate, Thiamine, Mag Sulfate, Ancef, Dilaudid, Tylenol ES, Vicodin, Droperidol, Zofran, and Tylenol.

02/22/08 - Orders from Cedars-Sinai Med Ctr.

02/22/08 - Laboratory Rpt from Cedars-Sinai Med Ctr. Glucose (H) 118.

02/22/08 - CT of Abdomen Pelvis with contrast interpreted by Ashley M. Wachsman, MD at Cedars-Sinai Med Ctr.
Impression: 1) Mild dependent atelectasis in both lung bases. 2) S/p cholecystectomy. 3) No CT evidence of visceral or vascular injury in the abdomen or pelvis. 4) Direct inguinal hernia on right side.

02/22/08 - Nursing Preop Record/Main OR PACU Nursing Record/Adult Patient Safety Alert from Cedars-Sinai Health System.

02/22/08 - Physiologic Monitoring/Neurological Check Flow Sheet/24° Medical/Surgical Flow Sheet/Interdisciplinary plan for Patient Care and Education from Cedars-Sinai Med Ctr.

02/22/08 – Flowsheet at Cedars Sinai Medical Center. Discharge instruction/education on pain management.

02/22/08 - Operative Rpt by Justin D. Saliman, MD at Cedars-Sinai Med Ctr. Pre/Postop Dx: 1) L medial malleolar shear fx. 2) R tibia and fibula fx. Operations Performed: 1) R tibia intramedullary nailing. 2) L ankle open reduction and internal fixation.

02/22/08-03/04/08 All Orders, 24 hours Med/Surgical Flowsheets at Cedars Sinai Med Ctr.

02/22/08-03/04/08 – ECG Strips at Cedars Sinai Med Ctr.

02/23/08 - Progress Note at Cedars-Sinai Med Ctr. Pt's HCT decreased to 25 given 1 unit of PRBCs, decreased HCT to 22.6. Further at 8 am pt's HR increased to 140. BP 126/60. RR 26. O2 sat 95% on 8 L. Confused. Confused. Temp 103.2. Transfusing 2 units PRBCs. Given Tylenol. EKG sinus tachycardia. Requested chest x-ray. Given 1 L NS bolus: HR 120s. BP 116/58 and temp 100.4. Pt c/o BUE stiffness. Dx: Tachycardia, decreased O2 sat, s/p auto versus peds and ortho surgery. Ordered Dilaudid for pain. Ordered stat labs. Condition guarded. Advised bed rest. Strict I and O. Referred for dressing PRN. Keep pt NPO. Ordered D5 ½ NS and 20 mg KCl at 100. Ancef. Polysporin ointment to abrasions. Zofran. Heparin. Vicodin. Calcium Gluconate. Morphine Magnesium Sulfate Repeat PTT in 6 hrs. Zantac. Ordered a Duplex of BLE. Stat CT abdomen and pelvic. Transfer to ICU.

02/23/08 - Ortho Progress Note by Justin D. Saliman, MD. Pt transferred to the unit for tachycardia/hypoxia. CT angio results positive. R anterior knee pain is controlled. PROM/AROM B/L feet and ankle with significant discomfort. Dx: 1) S/p R tibial IM nailing and L tibia ORIF. 2) S/p L knee arthroscopic meniscus surgery. Plan: F/u CT angio. Requested BLE dopplers. Dispensed L posterior mold splint. NWB BLEs. Follow HCT.

02/23/08 - Scheduled Med Record at Cedars-Sinai Med Ctr. Polysporin Topical, Tylenol, KCL, Magnesium Sulfate, Thiamine, Folic acid, Hydromorphone, Acetaminophen ES, Vicodin, Lortab, Droperidol and Ondansetron.

02/23/08 - Vascular Duplex Ultrasound Rpt at Cedars-Sinai Med Ctr.
Impression: 1) DVT: R calf veins. Tip of thrombus located at upper calf. 2) L WNL. 3) R subacute thrombus was seen in one of the paired posterior tibial veins.

02/23/08 – Laboratory Rpt at Cedars-Sinai Med Ctr. At 2343: Glucose (H) 128. At 1352: Glucose (H) 119.

02/23/08 - X-ray of Venous BLE interpreted by Willis Wagner, MD at Cedars-Sinai Med Ctr.
Impression: R: Imaging revealed patency of the deep venous system of the LE 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 DVT. Doppler: A normal phasic Doppler signal is noted in the common femoral vein. There is no evidence of iliac obstruction. L: 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 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.

02/23/08 - CT of Chest, Pulmonary Artery Angiogram with IV contrast interpreted by Cindy E. Kallman, MD at Cedars-Sinai Med Ctr.
Impression: Multiple right-sided pulmonary emboli. Findings have been discussed with the covering surgical service.

02/23/08 - X-ray of Chest interpreted by Daniel Lee, MD at Cedars-Sinai Med Ctr.
Findings/Impression: This is a limited portable examination with an L costophrenic angle cut off from the field of view. The remainder of the lungs is grossly unremarkable. No evidence of pneumothorax or infiltrates. The heart is normal in size. Visualized osseous structures are intact. No R pleural effusion identified.

02/23/08 - CT of Abdomen Pelvis Without Contrast interpreted by Cindy E. Kallman, MD at Cedars-Sinai Med Ctr.

02/23/08 - Blood Bank Transfusion Record at Cedars Sinai Med Ctr.

02/24/08 - Progress Note at Cedars-Sinai Med Ctr at 0716. No acute events overnight. NPO. Pain is controlled with meds for some time. Dx: S/p auto vs ped s/p ORIF, R tib/fib, L ankle, s/p PE now on heparin. Plan: Consider FCS for better pain control. Electrolyte replacement. Requested PT/OT. NWB BLE. Consider diet.

02/24/08 - Progress Note at Cedars-Sinai Med Ctr at 920. Pt admitted to ICU for PE, presently on heparin. Dropped hemoglobin and required 4 units of PRBCs. Hemoglobin stable since yesterday. NWB as per ortho. Requested advanced diet.

02/24/08 - Ortho Progress Note at Cedars-Sinai Med Ctr at 7 pm. Pt is resting comfortably. States pain yesterday. Dx: S/p L ankle ORIF and R tib IM nailing now with R DVT with controlled PE. Plan: Ruled out for compartment syndrome. Will follow the RLE exam carefully. Elevate BLEs at the level of the heart. Continue heparin tx.

02/24/08 – Laboratory Rpt at Cedars-Sinai Med Ctr. Glucose (H).

02/25/08 - Progress Note from Cedars-Sinai Med Ctr. No acute events. Transfused PRBC. Pain controlled. Dx: Auto vs ped. Plan: Continue ICU care.

02/25/08 - Ortho Progress Note by Cedars-Sinai Med Ctr. Resting comfortably. Dx: S/p L ankle ORIF and R tib IM nailing with postop DVT/PE and unstable HCT. Plan: Continue f/u with the SICU team. Elevate BLEs at the level of the heart. NWB BLE.

02/25/08 - Pre/Post-Operative Note from Cedars-Sinai Med Ctr. Preop Dx: L tibial DVT and R tibial fx.

02/25/08 - Social Work Consultation/Progress Note by Lucy Kim, MSW at Cedars-Sinai Med Ctr. Pt admitted s/p auto vs. peds. He had an L ankle ORIF and R tibia IM nailing on 02/22/08. Pt does not remember the accident, his wife informed him they were walking home after a concert and a car hit both of them, they were brought to different hospitals, and the wife was discharged from the ER the same evening. Discharge Plan: Home with HHC.

02/25/08 - Anesthesia Record at Cedars-Sinai Med Ctr.

02/25/08 - Time Out Procedure Documentation at Cedars-Sinai Med Ctr. Procedure: IVC filter placement.

02/25/08 - Laboratory Rpt at Cedars-Sinai Med Ctr. Glucose (H) 119.

02/25/08 - X-ray of Chest interpreted by Rick Sukov, MD at Cedars-Sinai Med Ctr.
Impression: Interval development of B/L mid-lung zone subsegmental atelectasis.

02/25/08 - Image Guided IVC Filter Placement with IVC Gram interpreted by Richard J. Van Allan, MD at Cedars-Sinai Med Ctr.
Impression: Successful uncomplicated fluoroscopy-guided placement of a retrievable Cook-Tulip inferior vena cava filter. Although this filter 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.

02/25/08 - 03/03/08 (5 visits) Inpatient PT Note at Cedars-Sinai Med Ctr. Completed 5 sessions of inpatient PT L ankle and R tibia and fibula fx. Pt transferred the bed to w/c with lateral approach, SBA. He propelled w/c 1000 ft on a level surface with BLE elevated.

02/26/08 - Progress Note at Cedars-Sinai Med Ctr. Pt reports pain overnight R>L. Dx remains unchanged. Plan: NWB BLE. IVC filter placed.

02/26/08 - Progress Note from Cedars-Sinai Med Ctr. Pt reports RLE pain. Dx remains unchanged. Plan: Pain control. Elevate RLE.

02/26/08 - Ortho Progress Note at Cedars-Sinai Med Ctr. Resting comfortably. Dx remains unchanged. Plan: Continue to follow HCT with management. NWB BLEs. Requested anticoagulation and analgesia.

02/26/08 - Patient Controlled Analgesia Adult at Cedars-Sinai Med Ctr.

02/26/08 – Laboratory Rpt at Cedars-Sinai Med Ctr.

02/26/08-03/01/08 (3 visits) Inpatient OT Notes at Cedars-Sinai Med Ctr. Completed 3 sessions of inpatient OT L ankle and R tibia and fibula fx. Pt at the highest functioning level available given NWB of BLE. Plan to WBAT from 03/07/08 will benefit from further interventions at that time. He has orders for a drop arm commode.

02/27/08 - Progress Note at Cedars-Sinai Med Ctr. Pain controlled. Dx remains unchanged. Plan: Elevate RLE. Regular diet. Transfer to the floor.

02/27/08 - Progress Note at Cedars-Sinai Med Ctr. HCT stable.

02/27/08 - Scheduled Med Record from Cedars-Sinai Med Ctr. Polysporin, Acetaminophen ES, Percocet, Vicodin, Dilaudid, Morphine and Zofran.

02/27/08 – Laboratory Rpt at Cedars-Sinai Med Ctr.

02/28/08 - Trauma Progress Note at Cedars-Sinai Med Ctr. Pain is worse with PT. Did not sleep well. Tolerating a regular diet. Dx: POD#5 s/p R tibia/fibula ORIF, L malleolar plating, doing well. Plan: PT/OT. Fragmin. Pain control.

02/28/08 - Ortho Progress Note at Cedars-Sinai Med Ctr. Pt is POD #6. Pt is comfortable. Dx remains unchanged. Plan: Will change dressing tomorrow. NWB BLE. Continue Fragmin and analgesia.

02/28/08 - RN Note at Cedars-Sinai Med Ctr. L ankle and R tibia x-rays done. Given Morphine Sulfate and Vicodin for pain x 2 this duty. Pt refusing an airflow mattress. Continue POC.

02/28/08 - Laboratory Rpt at Cedars-Sinai Med Ctr.

02/28/08 - X-ray of R Tibia and Fibula interpreted by E. James Tourje, MD at Cedars-Sinai Med Ctr.
Findings: Intramedullary rod is in place fixing an fx of the tibia in good alignment. Fx fragments are seen projecting anteriorly. Soft tissue swelling anterior is noted. Fx of the fibula is seen in several locations. The intramedullary rod is fixed proximally by two screws and distally with two screws.

02/28/08 - X-ray of L Ankle interpreted by E. James Tourje, MD at Cedars-Sinai Med Ctr.
Findings: Metallic plate and multiple screws are seen fixing distal tibial fx. One of the screws extends into the distal fibula. The ankle Mortis is normally aligned in this study. Distal fibular fx is still identified. The medial malleolus is now well aligned.

02/28/08 - Physical Medicine and Rehab Consult by Srikanth Rao, DO/Shirley Chi, MD at Cedars-Sinai Med Ctr. Pt 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 ED, he was found to have an R comminuted fracture of the mid-shaft of the tibia and fibula, as well as L bimalleolar fractures. As a result, he was taken to OR on 02/22/08 for intramedullary nailing of the R tibiofibular fracture and ORIF of L bimalleolar fracture. Postoperatively, he developed sudden tachycardia and a CT chest angiogram was performed, which displayed evidence of pulmonary embolism. A BLE Doppler displayed a DVT in L posterior tibia. As a result, he was started on a heparin drip; however, unfortunately, while on a Heparin drip, he evidenced acute bleeding and needed multiple transfusions. As a result, the 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 he is currently being evaluated for comprehensive rehabilitation and consideration of transfer to the acute rehabilitation unit. Meds: Polysporin, Fragmin 5000 units, Zantac 150 mg. PMH: HTN. Social Hx: Smoked approx. 8 cigarettes per day. Quit 2 weeks ago for meniscal surgery. Drinks 2-3 glasses of wine per weekend. ROS: Eyes: Wears glasses. Denies any blurred vision, diplopia or visual loss. PE: Eyes: Pupils equal, reactive to light. EOMs are intact. Dx: 1) Mild TBI secondary to pedestrian versus auto accident. 2) R tibiofibular fx, s/p intramedullary nailing on 02/22/08. 3) L bimalleolar fracture 1 s/p ORIF fixation on 02/22/08. 4) Pulmonary embolus, currently not on therapeutic anticoagulation due to acute bleeding with anticoagulation. 5) LLE DVT, s/p inferior vena cava filter placement, 02/25/08. Plan: Continue with supportive care. Recommend airflow mattress, turn q2 hours while in bed and continue with Fragmin for DVT PPx, as well as Ranitidine for GI PPx. Incentive Spirometry as able. Cut of bed to chair for all meals as able. Progressive mobilization with PT/OT. May consider nutrition eval. Currently too low level functionally for ARU level of care. If function improves and able to tolerate 3 hours of acute level therapies, he may be a candidate in that instance.

02/28/08 - Flow Sheet/Intake and Output at Cedars-Sinai Med Ctr.

02/29/08 - Trauma Progress Note at Cedars-Sinai Med Ctr. Today POD #6. Pain is better controlled. Slept better. Tolerating a regular diet. ARU will follow. Worsening with PT. Dx remains unchanged. Plan: Continue Fragmin, pain control and PT/OT.

02/29/08 - Ortho Progress Note at Cedars-Sinai Med Ctr. Denies complaints. Comfortable. Assessment: POD #7. Plan: Sutures removed. Steri-strips applied. PT/OT, begin L knee and R ankle ROM. Prescribed L short leg cast. May begin WBAT RLE starting 03/07/08.

02/29/08 - Blood Culture at Cedars-Sinai Med Ctr.

03/01/08 - Trauma Progress Note at Cedars-Sinai Med Ctr. No events. Assessment: POD #6. Plan: Continue PT/OT, Fragmin, and pain control. ARU placement.

03/02/08 - Trauma Progress Note at Cedars-Sinai Med Ctr. No acute events. Low-grade fever. Assessment: POD #7. Plan: Continue PT/OT, Fragmin, and pain control. ARU placement.

03/03/08 - Medical Social Work Note by Sydney C. Abich, MSW at Cedars-Sinai Med Ctr. Pt was seen for LOS, ongoing support, and d/c planning. Currently NWB BLE. He does not currently qualify for ARU at this time. He is requesting either attendant care at home or short-term SNF placement until he can bear weight on one or BLEs.

03/03/08 - RN Note at Cedars-Sinai Med Ctr. C/o pain noted. RLE cream applied. ARU placement. Continue present POC.

03/03/08 - Flowsheet at Cedars-Sinai Med Ctr.

03/04/08 - Medical Social Work by Sydney C. Abich, MSW. Pt presents for d/c planning f/u. He would prefer to have caregiver services at home. Ordered DMEs. The plan is to clear for d/c today.

02/22/08 - 03/04/08 - Medication Record at Cedars-Sinai Med Ctr.

03/04/08 - Trauma Progress Note at Cedars Sinai Med Ctr. There are no events. Pt is doing well and tolerating PO. PE: PERRLA. EOMI. Dx: S/p ORIF B/L tib-fib, POD #12. Plan: ARU on approval. Continue supportive care and PT/OT.

03/04/08 - Discharge Summary by Franklin Westhout, MD/Ali Salim, MD at Cedars-Sinai Med Ctr. Pt brought in by paramedics after sustaining an auto versus pedestrian accident. He came in c/o R leg pain and also had tibiofibular swelling, as well as lacerations on R side of face. Pt just received L knee surgery. Apparently, he 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 higher level of care. His R leg was reduced in the ER. Imaging obtained showed comminuted fractures of the mid shaft of R tibia and fibula with moderate displacement. CT of C/S was negative. He was taken to OR by Dr. Justin Saliman for ORIF. Pt tolerated the procedure well and was transferred to the ICU in stable condition. His

ICU course was further complicated by the development of DVT for which he then underwent an IVC filter placement. Discovered a PE on the following day, on 02/23. As such, he then had an IVC filter placed on 02/25. Unfortunately, he has now become non-weightbearing in BLE due to the fact of the previous knee surgery and latest ORIF. 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 B/L extremities. As such, he cannot be started in acute rehab at this time. He will, more than likely, receive weightbearing status in his L extremity on 03/07. There are no surgical orthopedic interventions to be done at this time. Rx: Fragmin 5000 units and Vicodin 7.5/750 mg. Plan: Discharged to home with home health aide nurse to assist with ADL.

03/04/08 - Pain Management Flow Sheet at Cedars-Sinai Med Ctr.

03/07/08 - X-ray of R Tibia and Fibula interpreted by Jeffrey Dym, MD at Cedars-Sinai Med Ctr. Impression: Hardware through a tibial fx with two fibular fractures, near anatomic alignment is seen.

03/07/08 - X-ray of L Ankle interpreted by Jeffrey Dym, MD at Cedars-Sinai Med Ctr. Findings/Impression: 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 fx cannot be excluded as well. There is near anatomic alignment seen.

03/12/08 - Post-op Visit Note by Justin D. Saliman, MD. S/p L ankle ORIF and R 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 PT. Pt has been NWB of BLE. His pain is well controlled but he is having difficulties with ADLs, as he has no one nearby to assist him except for his girlfriend whom is unavailable for most of day. Pt is on Fragmin since d/c. Plan: WBAT on RLE and NWB on LLE. Taught standard walker use. Prescribed PT and standard walker. Send home with wheelchair. Advised to not begin weight bearing on R leg on his own, start under therapist guidance.

03/20/08 - Post-op Visit Note by Justin D. Saliman, MD. Pt has been WBAT on R and NWB on L, which is casted. He is, as of late, doing well with home PT three times a week and six hours per day aid. He is unable to walk long distances secondary to fatigue, but short distances do not hurt his R leg. Dx: 1 month s/p R tibia inter medullary nailing and L ankle ORIF, doing well. Plan: Weight bearing of BLE as tolerated with L ankle in a CAM walker. Requested outpatient small open procedure to remove the spike of bone that is projecting anteriorly to prevent heterotopic ossification into the anterior compartment musculature and medical clearance.

03/20/08 – Chart Summary at Cedars-Sinai Medical Center. Requested Vicodin ES.

03/24/08 - H&P by Norman Solomon, MD. Pt is here for pre-op consult. He is scheduled to have some debridement of his R tibia to be done by Dr. Justin Saliman at Cedars-Sinai on 02/28. He has been previously cleared preoperatively for a knee surgery done by Dr. Mandelbaum for a meniscal issue back in February. At that point, he was deemed a low risk for surgery. Since that time, he was hit in a crosswalk by a car. He apparently had a R tibial fracture as well as a L ankle

fracture and he had what sounds like a pin and plate placed in each leg. He is currently wearing a boot on his L ankle. According to his wife, he was in the ICU for 11 days and had head trauma, and there are obvious signs of that with a scar around his R ear. It was completely evaluated in ER. He was unhappy with the care he received at Cedars. There was a Dr. Ali who sounds like he had evaluated him at some point in time and apparently did not diagnose the ankle fracture in his L 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 blood clots. He previously had h/o leukocytosis which had been evaluated by hematology a number of years ago. He had h/o prostatodynia, which had been evaluated by numerous physicians without any clear-cut etiology. He has had borderline blood pressures that have not been exerted with medication. PSH: Gallbladder surgery. Dx: 1) S/p R tibial fx. 2) S/p L ankle fx. 3) By history DVT and possibly pulmonary emboli s/p vena cava filter by history. 4) Meralgia paresthetica by history. Rx: Neurontin. Plan: Ordered labs per Dr. Saliman. With regard to clearance status for surgery, examiner would like to get some information about his hospitalization.

03/24/08 – Laboratory Rpt at MPTF Hospital Laboratories.

03/28/08 - All Orders, Patient/Caregiver Education Record at Cedars-Sinai Med Ctr.

03/28/08 - Operative Note by Justin D. Saliman, MD at Cedars-Sinai Med Ctr. Pre/Post-op Dx: R superficial tibia bone shard. Procedure Performed: Right tibia excision of displaced superficial tibial bone shard.

03/28/08 - Anesthesia Orders, Intra-op Orders at Cedars-Sinai Med Ctr.

03/28/08 - Physician's Orders at Cedars-Sinai Med Ctr. Gentle WBAT of LLE with walker, Vicodin. Discharged to home.

03/28/08 - ECG at Cedars-Sinai Med Ctr.
Impression: Sinus rhythm, WNLs.

03/28/08 - Anesthesia/PACU Nursing/Nursing Pre-op/Patient Profile Record at Cedars-Sinai Med Ctr.

03/28/08 - Surgical Pathology Rpt by Dusan Lukic, MD at Cedars-Sinai Med Ctr. Specimen: R tibial bone shard. Dx: R tibial bone excision: Bone with focal osteoblastic activity.

03/28/08 - Medication Reconciliation List at Cedars-Sinai Health System.

03/31/08 - X-ray of L Ankle interpreted by Jeffrey Dym, MD at Cedars-Sinai Med Ctr.
Comparison: 03/20/08.

Impression: Hardware through the distal tibia and a distal fibular fx is seen, there is near anatomic alignment without significant change.

03/31/08 - X-ray of R Tibia and Fibula interpreted by Jeffrey Dym, MD at Cedars-Sinai Med Ctr. Impression: Intramedullary rod through a tibial fx and two mid fibular fractures are seen with evidence of healing, there is near anatomic alignment present.

04/22/08 - Progress Note by Hany M. Nasr, MD/Avrom Gart, MD at Institute for Spinal Disorders. Pt presents regarding LBP. Had two surgeries in BLE. He has been complaining recently of increasing pain shooting down from lower back to BLE, at the front of the thighs, aggravated while he was hospitalized for his surgery. He presents today for increasing pain for further recommendation and evaluation. He has an old MRI study, which is not available at the time of exam. He has prescription to do MRI, but he did not do it, so he does not have it done so far. PE: Alert, awake and oriented x3. Dx: Lumbosacral DDD, lumbosacral radiculitis. Plan: Ordered new MRI of L/S.

04/24/08 – Laboratory Rpt at MPTF Hospital Laboratories. Glucose (H) 107.

04/28/08 - Ortho Progress Note by Justin D. Saliman, MD. Pt is s/p R tibia IM nailing and L ankle ORIF on 02/22/08. His R 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 c/o some anterior thigh pain and paraesthesia bilaterally. His L knee is being followed by Dr. Mandal on s/p knee arthroscopy a couple of days after he was struck by the vehicle. Dx: There is callous formation and it appears that he is doing well. Plan: Advised to continue taking it easy on his RLE and using the cane in his contralateral hand while WB on that extremity. Referred to Dr. Avrom Gart for B/L anterior thigh pain and paraesthesia. Referred to PT.

04/28/08 - Patient/Caregiver Education Record, Pre-Procedure/Surgery Instructions, Nurse Note, Medication Reconciliation List at Cedars-Sinai Med Ctr.

04/28/08 - Progress Note at Cedars-Sinai Med Ctr. Filter placed on 02/28/08. Pt now presents for filter retrieval.

04/28/08 - Anesthesia Orders/Records, Nurse Note, Intake/Output, Flowsheets at Cedars-Sinai Med Ctr.

04/28/08 - Post Angiogram Orders at Cedars-Sinai Med Ctr. Complete bed rest with side rails up x 2 hrs. Check q 15 min x 12 hrs, then q hrs x 4 hrs of puncture site bleeding, hematoma, pulse, distal pulse and vital signs. Regular diet. Discontinue IV. Discharge to home.

04/28/08 – US and Fluoroscopy Guided Inferior Vena Cavogram and Percutaneous Retrieval of Intravascular Foreign Body (IVC Filter) by Richard J. Van Allan, MD at Cedars-Sinai Med Ctr. Impression: Successful, uncomplicated, image-guided percutaneous retrieval of Cook-Tulip IVC filter performed.

04/28/08 - Pre-procedure/Surgery Checklist at Cedars Sinai Medical Center.

05/06/08 - PR-2 by Bert R. Mandelbaum, MD. Pt has no c/o significant pain. He only has stiffness and soreness in L knee. He was involved in an MVA sustaining L tibial fx and R pilon fx. Pt is s/p ORIF at Cedars-Sinai. Dx: 1) L knee ACL injury. 2) L knee medial meniscus tear. 3) L knee bone bruise with 2+ edema. Tx: Incompletely rehabilitated knee. Plan: Recommended post-op PT.

05/14/08 – Progress Note by Justin D. Saliman, MD. Pt is doing well and ambulating without assistive devices. He still has some mild to moderate discomfort in RLE at knee and mid-shaft regions. 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 L ankle is doing well without any symptoms. Assessment/Plan: Pt is doing well, s/p R tibia and L ankle ORIF. He is to concentrate on ambulating with a normal gait. F/u w/ Dr. Gart tomorrow to discuss ways to improve his rehabilitation. Released him to begin swimming, biking and nonimpact-type activities.

05/14/08 - CT of Chest w/o contrast interpreted by Katherine M. Haker, MD at Cedars-Sinai Med Ctr.
Impression: 1) Small cystic lesion in the medial aspect of R 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.

05/14/08 - X-ray of L Ankle interpreted by Thomas Learch, MD/Kamron Izadi, MD at Cedars-Sinai Med Ctr.
Impression: Healing medial malleolar fx with stable hardware positioning.

05/14/08 - X-ray of R Tibia Fibula interpreted by Thomas Learch, MD/Kamron Izadi, MD at Cedars-Sinai Med Ctr.
Impression: Progressive healing of comminuted diaphyseal fractures of R tibia/fibula with some callus formation.

05/19/08 - Progress Notes by Hany M Nasr, MD/Avrom Gart, MD. C/o LBP and BLE pain. Pt had an MRI study done of the L/S and is here for further eval and assessment. He continues to experience pain at the lower back, occasionally shooting down to the BLE at the side of his leg all the way down to the foot, R>L. Denies any abnormality in his gait or recent falls, slips or trip. Dx:

1) Lumbosacral radiculitis. 2) Lumbar DDD. Plan: Continue his home regimen/program and try to lose weight. Continue OTC meds.

06/12/08 - Post Op Visit Note by Justin D Saliman, MD. C/o inability to dorsiflex his L foot to the same degree as he can dorsiflex his R foot. 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. Repeat imaging of the R tibia and L ankle are obtained, which demonstrates excellence callous and healing of the R tibia fx and well healed L medial distal tibia fx. Dx: S/p significant trauma to BLE and ORIF to L ankle. Plan: Continue PT. Prescribed Dyna splint.

06/23/08 - PR-2 by Hany M Nasr, MD/Avrom Gart, MD. Pt continues to experience some pain although he is improving at a slower rate than expected. Pt had multiple traumas to BLE as a result of an MVA. Dx remains unchanged. Plan: Continue PT.

07/16/08 - PT Notes at Westside Spine & Joint Rehabilitation. Pt participated in PT for neck and L/S. C/o cervical strain and lumbar radiculopathy. Pt had 10% improvement since his initial eval. Now weightbearing independently. Now able to use his bike for exercise. Able to complete most daily activities including dressing and putting on/off his shoes with minimal pain. Continue therapy.

07/17/08 - PR-2 by Bert R. Mandelbaum, MD. Pt's L knee was complicated by the fact that he did have his MVA and ORIF for R pilon fx and L tibia fx at Cedars-Sinai. Pt gained 60 lbs. Presently he is in PT and is swimming and biking on a daily basis. Dx remains unchanged. Plan: Continue therapy and continue with the present therapy to get fit, lose weight and optimize his overall function levels.

07/18/08 – 08/10/08 (8 Visits) PT Notes at Westside Spine & Joint Rehabilitation. Pt completed 8 visits of PT for L/S and B/L ankle. Pt feels fine since last visit. Tolerated tx. Continue with ankle and knee mobility and strengthening. Continue therapy.

07/21/08 - Letter by Ellen Doocy-Welch, RN at Employers. Pt's employer has modified, sedentary work available for this pt such as sitting and answering phones. Pt is able to return to work in sedentary position such as answering phones.

08/13/08 - Correspondence Signed by Elaine S. Sanders, RN at Anthem. Requested additional PT visits, which was approved.

08/29/08 - Correspondence Signed by Ellen Doocy-Weleh, RN at Employers. Pt is able to spend 2 hours on feet. Seated light duty. No kneeling, crouching, climbing, squatting. Recommended to repeat MRI of L knee. Pending MRI results.

08/29/08 - Knee Arthroscopy Postop Note by Bert R. Mandelbaum, MD. Date of surgery is 02/18/08.

09/09/08 - MRI of L Knee interpreted by Gail M. Schlesinger, MD at MDIA.
Impression: Scarring Identified within Hoffa's fat pad compatible with pt's h/o previous surgery. Abnormal appearance to the posterior horn of the medial meniscus as well as the anterior horn of lateral meniscus possibly reflecting previous partial meniscectomies. Correlation with pt's previous operative report for the extent and nature of the pt's previous surgery may be helpful for further eval. Likely tear of the anterior cruciate ligament. Please correlate clinically. Mild medial compartment degenerative changes.

09/30/08 - Emergency Service Report at UCLA Med Ctr. Pt slipped and fell on wet pavement. Last night had pain in L ankle. Now knee was swollen and more painful. Pt has a large effusion in his L knee. Knee is stable to stress. Able to bear weight and walk but has obvious discomfort. Pt refused knee immobilizer and crutches. Dx: Knee injury with acute hemarthrosis. Plan: Needs referral to orthopedics.

10/03/08 - PR-2 by Bert R Mandel Baum, MD. Pt is doing much better and rehabilitating well. His MRI indicates only chronic ACL tear and no new meniscal tear. Dx: 1) L knee ACL injury. 2) L knee medial meniscus tear. 3) L knee bone bruise with 2+ edema. Plan: Continue PT. Continue modified duty. No action roles. Not able to stand on his L leg more than 4 hrs.

10/06/08 - 10/15/08 (4 Visits) PT Notes at Orthopedic Physical Therapy Associates. Pt completed 4 sessions of PT for B/L knees, neck and R ankle. Feels better. Still feels discomfort at L knee. Continue therapy.

10/17/08 - 11/05/08 (8 Visits) - PT Notes at Orthopedic Physical Therapy Associates. Pt completed 8 sessions of PT for B/L knees, neck and B/L ankles. Experienced pain and limitation at L ankle with BLE muscles functional weakness at hips, knees, and ankles. Also presents for functional balance and coordination deficits.

11/07/08 – Correspondence Signed by Becky Winchester, RN at Anthem. Requested additional 12 PT visits were approved.

11/10/08 - X-ray of R Tibia Fibula Interpreted by Michon Halio, MD at Cedars Sinai Medical Center.
Impression: Healing fractures of the R tibia and fibula s/p intramedullary rod placement, R tibia. Interval healing demonstrated normal alignment seen.

11/10/08 - X-ray of L Ankle Interpreted by Michon Halio, MD at Cedars Sinai Medical Center
Impression: S/p ORIF distal L tibia. Stable interval appearance since the prior study 12/06/08.

11/18/08 - Knee Arthroscopy Postop Note by Bert R. Mandelbaum, MD. Performed surgery on 02/18/08. No generalized c/o significant pain, only stiffness and soreness. Now taking appropriate and usual pain meds and anti-inflammatories. Dx: Doing well/on schedule/no significant problems. Plan: Continue protocol including rehab, stationary biking, PT and sports progression.

11/18/08 - PR-2 by Bert R Mandelbaum, MD. Pt is doing much better at this time. Pt still has not had any significant therapy. Only has stiffness and soreness. Dx: 1) L knee ACL injury. 2) L knee medial meniscus tear. 3) L knee bone bruise with 2+ edema. Plan: Overall recommended a combination of PT and conditioning therapies. Modified duty. No action roles. Not able to stand on his L leg more than 4 hrs.

11/19/08 – Email. Regarding PT referral.

12/08/08 – Patient Message. Pt requested for two days off as he had to meet his lawyer.

12/18/08 - Preadmission Record/Nurse Note at Cedars-Sinai Health System. Pt is having arthritis of L ankle. C/o back pain and depression. Metal rod placed in L ankle and R leg. Dx: L ankle removal of screw. Plan: Provided pre-procedure instructions.

12/19/08 – Pre-Procedure Note by Justin D Saliman, MD. Pre-Op Dx: Painful L ankle hardware. Planned Procedure: L ankle ROH.

12/19/08 – Nursing Intra Op Record at Cedars Sinai Medical Center. Ordered fluoroscopy with image amplification.

12/19/08 – Pre-Op Orders at Cedars Sinai Medical Center.

12/19/08 - Nursing Preop Record at Cedars Sinai Health System.

12/19/08 - Operative Report by Justin D Saliman, MD at Cedars Sinai Medical Center. Pre/Post-Op Dx: L ankle retained hardware. Operation Performed: L ankle syndesmotic screw removal.

12/19/08 - Patient/Caregiver Education Record at Cedars Sinai Medical Center.

12/19/08 - Short Stay H & P at Cedars Sinai Medical Center. C/o painful L ankle hardware. Plan: Recommended surgery.

12/19/08 - Post-Procedure Note at Cedars Sinai Medical Center. Operation Performed: L ankle syndesmosis screw removal.

12/19/08 - Physician's Orders at Cedars Sinai Medical Center. Discharged to home. F/u in 1 week.

12/19/08 - Outpatient Medication Reconciliation List at Cedars Sinai Medical Center.

12/19/08 - Patient Profile at Cedars Sinai Health System. C/o recent cold and cough. H/o back pain, arthritis and depression.

12/19/08 - PACU Nursing Record at Cedars Sinai Health System.

12/22/08 - Correspondence Signed by Nicole Sherfy, RN at Anthem. Request for additional 12 PT sessions were not approved.

01/14/09 - 01/26/09 (3 Visits) PT Notes at Orthopedic Physical Therapy Associates. Pt completed 3 sessions of PT for R ankle. Feels fine. Tolerated tx. Continue therapy.

01/28/09 - PR-2 by Bert R. Mandelbaum, MD. Pt has no pain, only soreness and stiffness. Still has not had any significant therapy. Pt is taking appropriate meds. Dx remains unchanged. Plan: Continue post-op PT. Continue modified duty.

02/11/09 - Post-Op Visit Note by Justin D Saliman, MD. Pt is s/p removal of syndesmotic screw on 12/19/08. He did not f/u previously because he was out of the country. Pt is doing well. He has minimal complaints at present. Dx: S/p removal of syndesmotic screw.

04/14/09 - Correspondence Signed by Nicole Sherfy, RN at Anthem. Request for 8 additional PT was not approved.

06/30/09 - Patient Questionnaire. Pt injured L knee while fixing gate, slipped. Sought medical attention at UCLA emergency. Received PT. C/o very limited mobility, back pain and knee pain. Slow walking. Activities make symptoms worse. Pt had multiple surgeries for legs and ankle. Pt has some difficulty with dressing and getting on and off the toilet. Pt had much difficulty with taking bath, climbing up 1 flight of stair up to 10 steps, standing, reclining and rising from a chair, light housework, getting in and out of a car and sleep. Unable to do work outdoors on a flat ground, run errands and engage in sexual activity.

06/30/09 - Employee's Disability Questionnaire. DOI: 01/26/08. He was working as Apartment Building Management for maintenance of the building. He has extremely limited mobility and he is overweight. States, "in every way not just my work my life." He sustained broken meniscus and ligaments.

06/30/09 - Note. Knee swollen. Increase in L knee pain. Has plantar pain. Cannot squat due to L ankle pain.

06/30/09 - Ortho PQME Rpt by Thomas W. Fell, Jr, MD/Orthopedic Surgery. DOI: 01/26/08. At the time of incident, pt was employed as a property manager by the Roberts Companies. He also has a side job as an actor. While working at a property, the sliding gate was struck late at night. He was trying to get it back on the track when he slipped and fell on his L knee, hitting his L knee on the track. That night he noted some swelling on the L knee, and the next morning it was very swollen, went to UCLA, evaluated and had x-ray of knees. He decided to seek an orthopedist and was referred to Dr. Mandelbaum. He had an MRI and was diagnosed with tears of meniscus and ACL, had surgery of 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, spent 11 days in ICU, had fxs to both legs, had surgery 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. Few months ago, had surgery and screws removed from L leg. Had PT for L knee. He is not working. Pt has pain in both legs in L knee after brief walking. Particularly, the L ankle gives him pain after 5-7 minutes of walking. Pt has plantar fascial pain in R leg in early morning. He feels that the screws are causing pain, swelling and numbness distally. Regarding L leg, due to his ankle, he cannot squat fully. Standing is difficult. Has limited motion of the ankle. PSH: L knee surgery due to work injury and the remaining for the non-industrial incident with the car. Auto Accidents: Ran over by car on 02/22/08. SH: Denies smoking cigarettes but admits to drinking alcoholic beverages. Dx: 1) S/s of L knee with meniscal tear and ACL tear. S/p arthroscopic partial medial and lateral meniscectomies. 2) Pilon fx, L ankle, non-industrial. S/p ORIF with multiple surgeries. 3) Mid shaft tibia fx, R, non-industrial. S/p ORIF and multiple surgeries. Disability Status: With regard to L knee injury of 01/26/08, he is at MMI. L knee restrictions are no more than occasional squatting, kneeling and ladder climbing. No very prolonged standing and no prolonged walking on uneven ground. Impairment Rating: L knee 13% WPI. Causation and Apportionment: ACL and meniscal injuries were due to work incident and existed prior to him being hit by the car. Apportioned 5% to pre-existing pathology and 95% to the aggravation and further injury as a result of the work incident of 01/26/08. Future Medical Care: Pt should continue doing his exercise at home including quadriceps and hamstring strengthening exercises. For both his knee injury and his leg injuries and his general conditioning and health, recommended aerobic conditioning program. Bicycle exercises program would be excellent for him. Allowance should be made for ACL 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 visits, as well as surgical intervention.

08/10/09 - Notice regarding Temporary Disability Benefits from Employers. This is to notify pt that temporary disability payments are ending and this is his final and being sent separately. The total benefits paid to pt is $37,869.66 from 02/18/08 through 06/30/09. Based on records pt was overpaid temporary disability benefits totaling $1,993.04 from 07/01/09 to 07/27/09.

08/10/09 - Notice Regarding Permanent Disability Benefits from Employers. Payment for permanent disability are beginning as of 07/01/19 and will continue until $10,637.50 has been paid based on PQME Dr. Fell's report dated 06/30/09. The first payment in the amount of $1,347.14 was sent.

08/27/09 - E-mail. As per state evaluation report, pt has been stopped TD benefits based on state doctor's opinion.

10/01/09 - PR-2 by Bert R. Mandelbaum, MD. Pt has no pain, only soreness and stiffness. Still has not had any significant therapy. Pt is taking appropriate meds. Now taking appropriate and usual pain meds and anti-inflammatories. Dx remains unchanged. Plan: Recommended home exercise. Requested stationary biking, strengthening exercises and sports progression. Continue modified duty. He is not to take part in action roles. He will not be able to stand on his L leg for more than 4 hours.

10/03/09 - PR-2 by Bert R Mandelbaum, MD. Pt doing much better at this time, rehabilitating well. Dx remains unchanged. Plan: Continue postop PT, incompletely rehabilitated knee. He will keep the present program to get fit, lose weight and optimize his overall functional levels. Continue modified duty.

11/19/09 – Correspondence. Pt is not able to return to regular work as a Building Manager. PT and rehab tx needed. Modified duty until 03/08/09.

11/23/09 - Request for Leave. Pt requests week off on Friday and Saturday as he is going to Canada. He has worked last Thursday.

03/25/10 – Correspondence from patient. Pt would like to switch day off for the next week to 03/29/10. Pt has to attend court hearing today. Pt has worked on 03/18 and 03/25.

06/01/10 – Correspondence by Bert R Mandelbaum, MD. Pt is P&S. Agree pt's L knee is impaired 17% whole person.

07/09/11 – Procedure Orders. PACU orders.

08/27/11 – 08/28/11 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

08/29/11 – 09/04/11 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

09/20/11 – 09/25/11 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

09/26/11-10/02/11 - Weekly Time Sheet from The Roberts Companies. Total hours to pay: 40.

10/03/11 – 10/09/11 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

10/10/11 – 10/16/11 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

10/17/11 – 10/23/11 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

10/24/11 – 10/3011 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

11/02/11 – Laboratory Rpt from Motion Picture and Television Fund Hospital Laboratory.

11/08/11 – Correspondence from patient. Pt needs to go to Ukraine for several days to assist with mother who is sick. Need to fly on 11/15/11. Pt will be back on 11/22/11.

01/02/12 – 01/08/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

01/09/12 – 01/15/12 - Weekly Time Sheet from The Roberts Companies. Total hours to pay: 40.

01/16/12 – 01/22/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

01/23/12 – 01/29/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

01/30/12 – 02/05/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

02/06/12 – 02/12/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

02/13/12 – 02/19/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

02/20/12 – 02/26/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

02/27/12 – 03/04/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

03/04/12 - Disability Slip by Edward Komberg, DC. Pt is unable to return to work until 06/01/12.

03/05/12 – 03/11/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

03/12/12 – 03/18/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

03/19/12 – 03/25/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

03/26/12 – 04/01/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

04/02/12 – 04/08/12 - Weekly Time Sheet from The Roberts Companies. Total holiday and hours worked: 40.

04/09/12 – 04/15/12 - Weekly Time Sheet from The Roberts Companies. Total hours worked: 40.

04/13/12 - Order from United Document Imaging. Requested claim file and employment file.

04/17/12 – PTP's Initial Comprehensive Rpt by Edward Komberg, DC/Chiropractic. DOI: 02/01/08. Pt 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. Pt reported the injury to his employer. He was referred to the insurance appointment medical provider. He was eventually informed that his injury would require surgery. Pt proceeded with surgery on 02/2008. Approximately one week after the surgery, pt states that he was hit by a car. He underwent multiple surgeries to correct damage to the right side of his body. Therefore tx and rehabilitation for his left knee were postponed. Pt 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 tx. 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, pt 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. PMH: Borderline HTN, car accident, left knee surgery. Dx: 1) S/p left knee surgery. 2) Chronic post-surgical pain in the left knee. Plan: Ordered PT, kinetic activities, and MRI of the left knee. Ortho and psych referral. TTD through 06/01/12. Causation: Industrial injury of 02/01/08.

04/25/12 – MRI of L Knee interpreted by Sean Johnston, MD at California Imaging Network. 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. A Baker's cyst is noted on this examination measuring 23 x 8 x 48 mm.

05/29/12 – PR-2 by Edward Komberg, DC. Pt c/o minimal 0/10 dull left knee pain and weakness radiating to the left thigh with numbness and tingling becoming severe 9/10 sharp. Also c/o difficulty sleeping and psychological complaints due to pain. Dx: 1) S/p left knee surgery. 2) Chronic postsurgical pain. 3) Meniscus thinning, left knee. 4) Baker's cyst with joint effusion, left knee. 5) Difficulty sleeping. 6) Psychological complaints. Plan: PT, kinetic activities, MR arthrogram of the left knee, ortho surgeon referral. Off work until 07/13/12.

06/08/12 – STP's Initial Evaluation Rpt by Julian Girod, MD/Orthopedic Surgeon. DOI: 02/01/08. Pt sustained a work injury to L knee and had left knee arthroscopic surgery. Was involved in an auto/pedestrian accident where he suffered multiple injuries to RLE requiring IM rodding and intensive PT. He describes persistent symptoms. Has difficulty descending stairs. Describes weakness and inability to squat on left knee. Describes a rare episode of locking and giving way. C/o activity-dependent L knee pain. Dx: L knee injury with ligament injury with an ACL tear. S/p arthroscopic surgery. Plan: Recommend x-ray of the left knee.

06/14/12 - Consultation Rpt by Ronald S Grusd, MD at California Imaging Network. Pt admits to a work-related injury sustained to the L knee on 04/11/12. He has had previous surgery on the L knee in 2008. C/o pain and weakness in the L knee. There is occasional popping and grinding sensation in the L knee. Plan: Ordered MRI/MR arthrography evaluation of the L 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 the pt. Side effects explained. The pt may experience a pinching feeling in the superficial tissues or skin upon withdrawal of the needle. The post-injection procedure was explained to the pt. The pt 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 an allergic reaction was explained to the pt. The pt was informed that there was a possibility, albeit low, of an allergic reaction to the local anesthetic and/or the contrast.

06/14/12 – MRI Arthrogram of L Knee interpreted by Sean Johnston, MD at California Imaging Network.
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.

06/14/12 - X-ray of L Knee interpreted by Ronald S Grusd, MD at California Imaging Network.
Impression: There are no fractures or dislocations. There are no other focal bones, joint or soft tissue abnormalities identified.

06/14/12- Review of Records by Edward Komberg, DC. MRI of left knee dated 05/01/12 and doctor's first report dated 06/08/12 reviewed.

06/15/12 – PR-2 by Edward Komberg, DC. Pt is c/o minimal dull 0/10 L knee pain and weakness radiating to L thigh with N/T becoming severe 9/10 sharp. Also c/o difficulty sleeping and

psychological complaints due to pain. Dx: 1) Difficulty sleeping. 2) Psychological complaints. Plan: PT, kinetic activities. Obtain MRI arthrogram of L knee. F/u with ortho surgeon. Off-work until 07/27/12.

06/15/12 – Correspondence by Edward Komberg, DC. Pt is being treated in the office for injuries sustained in a work-related accident on 02/01/08. He is TTD. He is currently involved in very specific PT with our 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 the outside exercise in the future.

07/17/12 – Review of Records by Edward Komberg, DC. STP's initial evaluation report by Dr. Julian Girod was reviewed.

07/20/12 –PR-2 by Julian Girod, MD. Pt reports L knee pain. Cannot squat. Squatting increases pain, stabbing, and tingling sensation. Dx remains unchanged. Plan: Lose weight first. Recommended weight loss program.

07/26/12 – PR-2 by Edward Komberg, DC. Pt c/o constant severe 7-8/10, achy, sharp throbbing L knee pain. C/o moderate constant LBP compensatory to L knee pain. Dx: 1) Lumbar musculoligamentous injury. 2) Lumbar myospasm. Plan: PT, kinetic activities. Ordered x-ray of L/S and L knee. Internal medicine referral for weight loss. F/u with ortho surgeon. Off-work until 09/07/12.

08/01/12 - Initial Internal Medicine Evaluation Rpt by Maria Ruby Leynes, MD/Internal Medicine. DOI: 02/01/08. Pt began working for RHB Management in 2001. States he was in a perfect state of health when he started employment with the company. Was not taking meds prior to his injury. On 02/2008, pt sustained an injury to L knee. Had surgery. One week following surgery, was hit by a car on the right side of his body and underwent multiple surgeries to correct the damage. Explains he had to learn how to walk and his tx took 1.5 years. By the time he was well enough to continue with tx, the insurer told him he had exhausted his tx and was offered 12-15% disability which he denied because he feels his L 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. He has borderline HTN after gaining weight following his work injury. Pt states his limitation in physical activity and walking increases the pain in his legs. ROS: Denies vision problem. PE: Pupils are equal, round and react to light and accommodation. The optic fundi are benign. The disc is flat. (Partial document).

08/08/12 - Progress note by Maria Ruby Leynes, MD. Pt developed anxiety and depression due to ongoing ortho pain and inability to work. He sought help and has seen his private doctor with regards to losing weight and was referred to Lindora weight Loss Program about a year ago at which time he lost about 50 lbs from this program. He quit three months ago because his weight was up again. He feels that Lindora is not a program. He wants to be referred to another program

such as UCLA Weight Loss. Recommend to continue with weight loss program. Dx: 1) Obesity. 2) Weight gain secondary to ortho dx. 3) H/o increased WBC and blood count. 4) Ortho dx. Plan: Continue a low-fat diet and exercise regularly. Recent lab tests, thyroid tests and EKG from Lindora will be requested. Psych tx if this has not been done is also recommended.

08/13/12 - Biofeedback Session Note. Completed 1 biofeedback session. Pain 8-9/10. Mood/affect at the start of session anxious. Depression 6-10. Anxiety 6. Insomnia 9. Stressed 8. Affect neutral. Pain in the left leg, L/S. Mood/affect at end of session stressed, anxious, agitated. Affect neutral.

08/17/12 – PR-2 by Julian Girod, MD. Pt reports constant severe pain. Dx: L knee pain with ligamentous injury with an ACL tear. Plan: Ordered L knee x-ray. Obtain medical records.

08/24/12 – PR-2 by Edward Komberg, DC. Pt c/o activity-dependent to moderate 6/10 achy, sharp, throbbing low back pain becoming severe 8/10 radiating to B/L legs. He has c/o activity-dependent to constant moderate 6/10 achy, sharp throbbing left knee pain severe 8/10. Dx: Complex tear medial meniscus. Plan: Advised home exercises. F/u with ortho and internal medicine. Refer to Dr. Justin Saliman, the ortho surgeon. Off-work until 10/08/12.

08/24/12 – X-ray of L Knee interpreted by Nayyer U Islam, MD at United Medical Imaging.
Impression: No acute osseous injury with moderate medial and mild patellofemoral compartment narrowing.

08/31/12 – PR-2 by Julian Girod, MD. Pt continued with constant severe pain. Dx: 1) L knee injury with a ligament injury. 2) ACL tear s/p A/S. Plan: Recommended PT, bicycle exercises, and weight loss.

09/05/12 – PR-2 by Julian Girod, MD. Pt states cannot lose weight because he cannot exercise. He appealed to UCLA for a weight loss program. Dx remains unchanged. Plan: Resume a weight loss program. Discussed surgery, pt states last option.

09/20/12 – Correspondence. Dr. Edward Komberg is requesting auth for pt to have a consultation with Dr. Justin Saliman, the ortho surgeon.

09/26/12 – PR-2 by Edward Komberg, DC. Pt has c/ activity dependent constant moderate 6/10 achy, sharp, throbbing low back pain becoming severe 8/10 radiating to bilateral legs. C/o activity-dependent to constant moderate 6/10 achy, sharp, throbbing left knee pain becoming severe 8/10. Dx remains unchanged. Plan: Advised home exercises. Recommend weight loss program, MRI of L/S and BLE EMG/NCV. Include C/S pain as compensatory. F/u with ortho. Off-work until 11/09/12.

10/03/12 – MRI of the C/S w/o contrast interpreted by Andrew Thierry MD at United Medical Imaging.
Impression: 1) At the C5-6 and C6-7 levels there are 1 mm broad-based posterior disc protrusions which do not result in central canal stenosis or neural foraminal narrowing. 2) Mild straightening

of the normal cervical lordosis which may be secondary to muscle spasm. 3) Minimal spondylosis at the C5-6 and C6-7 levels.

10/03/12 – MRI of the L/S w/o contrast interpreted by Andrew Thierry MD at United Medical Imaging.
Impression: 1) L4-5: 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 B/L 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 flavum results in mild to moderate B/L neural foraminal narrowing and mild central canal stenosis. 3) L3-4: 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 B/L neural foraminal narrowing and mild central canal stenosis. 4) There is mild spondylosis at the L1-2 and L4-5 levels. 5) There is straightening of the normal lumbar lordosis which may be secondary to muscle spasms.

10/29/12 – PR-2 by Edward Komberg, DC. Pt still c/o constant LBP 6/10, becoming severe 9/10 sharp with tingling. Mild 3/10 dull L knee pain and weakness becoming moderate 4/10 achy. C/o loss of pain due to sleep. There are psychological complaints. Dx: 1) S/p L knee surgery. 2) Chronic post-surgical pain. 3) Meniscus thinning, L knee. 4) Baker's cyst with joint effusion, L knee. 5) Difficulty sleeping. 6) Psychological complaints. 7) Lumbar musculoligamentous injury. 8) Lumbar disc protrusion. 9) Complex tear medial meniscus. 10) Cervical musculoligamentous injury. 11) Cervical disc protrusion. Plan: Requested PT 2-3 per week for 6 weeks for lumbar strengthening and weight loss and balance. Kinetic activities. Recommend weight loss program. F/u with ortho. Off work until 12/13/12.

10/31/12 – Dr's 1st Rpt by Jalil Rashti, MD/Orthopedic Surgery. DOI: 01/26/08; CT 04/28/11 – 04/11/12. Pt indicated that on 01/26/08, he fell on a slippery surface while trying to fix an entrance gate. He injured his L knee. C/o constant LBP that radiates to legs with numbness of thigh. L knee constant pain, occasional swelling. Has headaches and depression. PMH: Multiple surgeries in the leg. Hit by a car in 2008. Job Description: Pt had worked as a Property Manager for The Roberts Company for 10 years. His job duties required him to perform renting apartment buildings and scheduling and contacting vendors. Physically, he was occasionally required to perform walking and crawling. He was required to drive a vehicle, walk on uneven ground, be exposed to dust, working at heights. Dx: 1) S/p left knee surgery by history with an ACL tear. 2) S/p ORIF of the R leg and L ankle by history. 3) Lumbar radiculitis as a compensable consequence. 4) Obesity as a compensable consequence. Plan: Recommend a weight loss program. Advised gym exercise program. Continue taking meds. Remain TTD through 12/19/12. Causation: Industrial injury.

12/19/12 – PR-2 by Jalil Rashti, MD. Pt reports constant LBP, 8/10, radiates with N/T, pins and needles. L knee pain, constant 4/10. Dx: 1) Internal derangement of L knee. 2) Lumbosacral neuritis. 3) Sprain of the lumbar region. Plan: Weight loss program, HEP, gym membership with a personal trainer. Off-work until 02/01/13.

12/26/12 - Order Requisition. Ordered a Barium swallow and bone scan whole body.

12/27/12 – Industrial Testing/Functional Data Rpt by Jalil Rashti, MD. Pt's pain is bad but managed without taking painkillers. He can lift only very light weights. Pain prevents pt from walking more than a mile, sitting for more than an hour, or standing for more than 10 mins. He sleeps well but only when taking meds. Pain has restricted pt's social life. Oswestry Index score 28, disability level of 56%. Pain remains a problem with lifting, standing, social life, changing the degree of pain, and traveling. He experiences moderate difficulty with personal care and sitting. His disability index score has risen by 0% since the last report.

01/17/13 - Esophagram interpreted by David P Reiner, MD at Providence Saint Joseph Medical Center.
Impression: No evidence of stricture or mass.

01/17/13 - NM Bone Scan Whole Body Interpreted by David P Reiner, MD at Providence Saint Joseph Medical Center.
Impression: No increased activity to suggest metastatic disease.

01/30/13 - PR-2 by Jalil Rashti, MD. Pt has increasing LBP and L knee pain due to weight gain and inactivity. Has N/T of both legs. He is losing mobility of his lower extremities. The requested gym membership and an adult weight loss program have been denied. Dx: 1) S/p L knee surgery by history with anterior cruciate ligament (ACL) tear. 2) S/p ORIF of R leg and L ankle by history. 3) Lumbar radiculitis as a compensable consequence. 4) Obesity as a compensable consequence. Plan: Continue HEP and meds. Any help in getting authorization to attend an active treatment program and gym membership as well as an adult weight loss program would be appreciated. TTD.

01/30/13 – Electrodiagnostic Report Interpreted by Jalil Rashti, MD.
Comments: The highest rated Class III impaired conduction is the primary pathology with 95% sensitivity. Ratings above +3 suggest central disc etiologies while lower ratings are more suggestive of facet syndrome. In the absence of clear impairment, the 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).3 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.5 At no fee up to six additional controls are included to ensure sensitivity.

02/06/13 - Back Functional Data by Jalil Rashti, MD. Pt's pain is bad, but they manage without taking painkillers. He needs some help but manages most of his care. Pain prevents him from lifting heavy weights, but they can manage light weights if they are conveniently positioned. Pain

prevents him from walking more than 1/2 mile. Pain prevents him from sitting for more than 1/2 hour. Pain prevents him from standing for more than 10 minutes. Even when he takes medication, he sleeps less than 6 hours. He has no social life because of pain. His pain is bad, but they manage journeys over 2 hours. Points scored: 30. Pt experiences a disability level of 60%. Moderate disability. Pain remains the main problem with Standing, social life, and changing degrees of pain. Those ADLs are greatly affected. He experiences moderate difficulty with Personal care, lifting, walking, sitting, sleeping, and traveling. Pain intensity is not grossly affected at this time. Comparatively, his disability index score has risen by 4 % since the pt's last report.

02/08/13 – Referral. Ordered STAT Troponin I.

02/08/13 - Laboratory Rpt at Providence Saint Joseph Med Ctr.

03/16/13 - PR-2 by Jalil Rashti, MD. Pt is losing mobility at an extremely fast rate, numbness of both legs, LBP, pain in the L knee, weight gain, 325 lbs now. Dx remains unchanged.

04/10/13 - PR-2 by Jalil Rashti, MD. Pt has knee 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 half an hour and stand for up to 10 minutes. Dx remains unchanged. Plan: Ordered FCE. Continue conservative care. Recommended to lose weight. TTD.

05/09/13 - Back Functional Data by Jalil Rashti, MD. Pt's pain is bad, but they manage it without taking painkillers. He needs some help but manages most of his care. Pain prevents him from lifting heavy weights, but they can manage light weights if they are conveniently positioned. Pain prevents him from walking more than 1/2 mile. Pain prevents him from sitting for more the 1 hour. Pain prevents him from standing for more than 10 minutes. Even when he takes medication, he sleeps less than 6 hours. Pain has restricted his social life in their home. His pain restricts them to necessary journeys under 1/2 hour. Total points possible: 50. Points scored: 30. Pt experiences a disability level of 60%. Moderate disability. Pain remains the main problem with standing, social life, changing the degree of pain, and traveling. Those ADLs are greatly affected. He experiences moderate difficulty with personal care, lifting, walking, sitting, and sleeping. Pain intensity is not grossly affected at this time. Comparatively, his disability index score has lowered by 0% since his last report.

05/15/13 - PR-2 by Jalil Rashti, MD. Pt's 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 remains unchanged. Plan: Pt will start 10 weeks of an endurance weight loss program. He will get a personal trainer and gym membership. Continue with conservative care. TTD.

05/29/13 - Back Functional Data by Jalil Rashti, MD. Pt's pain is bad, but they manage without taking painkillers. He needs some help but manages most of his care. He can lift only very light weights. He can walk only if they use a cane or crutches. Pain prevents him from sitting for more than 1/2 hour. Pain prevents him from standing for more than 10 minutes. Even when he takes meds, he sleeps less than 4 hours. He has no social life because of pain. His pain restricts them to

necessary journeys under 1/2 hour. Total points possible: 50. Points scored: 36. He experiences a disability level of 72%. Severe disability. Pain remains the main problem with lifting, walking, standing, social life, changing the degree of pain, and traveling. Those ADLs are greatly affected. He experiences moderate difficulty with personal care, sitting, sleeping, and pain intensity are not grossly affected at this time. Comparatively, his disability index score has risen by 12 % since pt's last report.

06/26/13 - PR-2 by Jalil Rashti, MD. Knee pain and weakness. Back pain, and numbness in both legs. Weight gain. Difficulty standing from a sitting position. Dx remains unchanged. Plan: Recommended Lindora for weight loss before L knee surgery. He is now at 320 lbs. Recommended PT to L knee 2 x 6. Off work until 08/09/13.

07/10/13 - Back Functional Data by Jalil Rashti, MD. Back Conclusion: Total points possible: 50. Points scored: 32. He experiences a disability level of 64 %. Severe disability. Pain remains the main problem with lifting, standing, social life, changing the degree of pain, and traveling. Those ADLs are greatly affected. He experiences moderate difficulty with personal care, walking, sitting, and sleeping. Pain intensity is not grossly affected at this time. Comparatively, his disability index score has lowered by 8% since his last report.

07/24/13 - PR-2 by Jalil Rashti, MD. C/o knee pain and discomfort, extreme LBP. Extreme muscle weakness and weight gain. Dx remains unchanged. Plan: Pt is 100 lbs overweight and now has compensation in developing the L/S and the R knee. He will benefit from a weight loss program (Lindora) before going forward with L knee surgery. Off work until 09/06/13.

07/30/13 - Ortho PQME Re-Eval by Thomas W. Fell, Jr, MD/Orthopedic Surgeon. DOI: 01/26/08; CT 04/28/11 to 11/04/12. Since last seen, pt went back to work on limited duty as a property manager, but not doing any crawling, lifting or bending. This continued until April of 2012 when he was terminated. He feels the main reason for termination is that he was not doing enough work. He lost weight to 238 lbs in 2012 and gained 100 lbs since that time. He felt his knee pain increase in 2012. He was seen under his Screen Actors Guild insurance. He has an MRI and his nerves were checked. Also had sleep tests. He has been doing walking, and swimming and has a personal trainer. L knee feels weak and very little swelling is present with walking or biking. C/o LBP which he attributes to weight gain and his doctor told him because he limped a little. Pain in the left is equal to the right. He has N/T in L lateral thigh. Dx: 1) S/s of the L knee with a meniscal tear and ACL tear, s/p arthroscopic partial medial and lateral meniscectomy. Recurrent tearing of the posterior horn of the medial meniscus. 2) Previous fx of the L ankle and R tibia. 3) LBP. 4) Meralgia paresthesia secondary to obesity. AMA Impairment: Knee – 13% WPI. Pain – 3% WPI, a total of 16% WPI. Work Status: Permanent restrictions with L knee for only occasional squatting and kneeling and he should not do climbing. He should not be on unprotected heights. Causation and Apportionment: Weight gain is secondary to the cessation of smoking. LBP due to age and possibly due to some of his weight gain. Limping is minimal and cannot contribute. L knee injury is secondary to the 01/26/08 work incident. No evidence of CT. The torn meniscus is due to the motion of the knee due to ACL tear, tearing the meniscus with ADL and this is also secondary to the 01/29/08 knee injury. Apportionment for L knee disability – 5% to pre-existing pathology and

the remaining 95% to aggravation and further injury in the 01/26/08 work incident. Future Medical Care: A gym membership is a reasonable alternative Tx. 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. Recommended no ACL reconstruction. Also, be allowed to use NSAIDs. Regarding the Lindora program, weight gain is more likely due to stopping smoking than lack of activities given the amount of work he has been doing on his own with a personal trainer. Regarding L/S, do core strengthening exercises. Should use ice after he walks or exercises.

07/31/13 - Back Functional Data by Jalil Rashti, MD. Back Conclusion: Total points possible: 50. Points scored: 33. He experiences a disability level of 66%. Severe disability. Pain remains the main problem with lifting, standing, social life, changing the degree of pain, and traveling. Those ADLs are greatly affected. He experiences moderate difficulty with personal care, walking, sitting, and sleeping. Pain intensity is not grossly affected at this time. Comparatively, his disability index score has risen by 2% since his last report.

10/09/13 - P&S Orthopedic Eval Rpt by Jalil Rashti, MD. DOI: 01/26/08 and CT 04/28/11 to 04/11/12. Pt was initially seen by the examiner on 10/21/12 for examination and treatment of his industrial injury of 01/26/08 and continuous trauma from 04/28/11 to 04/11/12. Currently c/o constant pain of L knee with instability. Has LBP that radiates to legs with N/T. Has weight gain. He can walk up to a quarter of a mile. He is unable to squat or kneel. PSH: Multiple surgeries for the legs. Previous Injury: Hit by a car in 2008. Dx: 1) S/p L knee surgery with anterior cruciate ligament (ACL) tear. 2) S/p open reduction, internal fixation of R leg and L ankle by history. 3) Lumbar radiculitis as a compensable consequence. 4) Obesity as a compensable consequence. Disability Status: Reached MMI and P&S. Subjective Factors of Disability: 1) Constant pain of L knee, which is slight and becomes moderate. 2) Constant pain in 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 ROM. 5) Weakness of L knee. 6) Tenderness at the lumbosacral region and L knee. Impairment Rating: 35% total WPI. Work Restrictions: L knee: Avoid squatting, kneeling, repetitive climbing stairs, prolonged walking and standing. Should refrain from walking on uneven ground. L/S: Avoid staying in one position such as prolonged sitting, standing, and walking and repeated bending and stooping. Avoid lifting, pushing and pulling heavy objects. Vocational Rehabilitation: Considered QIW. Apportionment: 100% to work injury dated 01/26/08 and CT 04/28/11 to 04/11/12. Future Medical Care: Future re-eval, consultations, and diagnostic studies. PT, aquatic therapy, and acupuncture PRN. Meds 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 L/S 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 current clinical status relative to L knee.

10/15/13 - Back Functional Data by Jalil Rashti, MD. Back Conclusion: Total points possible: 50. Points scored: 32. He experiences a disability level of 64%. Severe disability. Pain remains the main problem with standing, social life, changing the degree of pain, and traveling. Those ADLs

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

11/23/13 – ML102 Rpt with Polysomnogram and Sleep Disability Determination by Masoud Sadighpour, MD at California Sleep Disorder Center. Pt did not schedule an overnight sleep study. Plan: Pt should refrain from driving when he feels sleepy. He scored in the mild range of sleepiness on the Epworth Scale which is a subjective test scored by the patient. Sleep hygiene. The above rating is only for his sleep-related problem. PSG/MSLT. EPSS score 14. Subjective factors of disability: The patient notes continuing sleep-related issues which appear to stem from both stress-related concerns over, the work environment and occupational injury, as well as objective sleep study results. The Epworth Sleepiness Scale notes 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 the patient appears to suffer from work-related sleep deprivation. The opinion is based, in part upon the patients' noted complaints of being groggy after a night of attempted rest and daytime sleepiness, which impedes normal functioning in their activities of daily living. The person has no problems or has superior functioning in several areas OR is admired and sought after by others due to positive qualities. A person has few or no symptoms. Good functioning in several areas. No more than "everyday" problems or concerns. A person has symptoms/problems, but they were temporary, expectable reactions to stressors. There is no more than slight impairment in any area of psychological functioning.

11/27/13 - ED Note by Roger C. Lai, MD. H/o HTN and asthma who came in c/o constant chest pain that started today around 3:30 pm after a walk. Yesterday, he developed a pressure-like headache, located in the periorbital region 4/10. He checked his BP and it was 150/90; therefore, he went to his primary doctor's office and checked the pressure there. It was 165/105. He has been 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 intermittent, dull chest pain located on the left side of the chest, 2/10 radiating to the L shoulder. He admits to sweatiness and palpitation with this. Social History: No cigarettes. No drugs. Positive occasional alcohol. PE: Pupils are equal, round and reactive to light. EOMs are intact. ED Course: Given Aspirin 162 mg, Nitroglycerin pastes 1 inch to the chest. With that, pt is 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. He needs to be ruled out and would possibly benefit from cardiac risk stratification. On-call physician, Dr. Sharad agreed to admit pt to the hospital for further inpatient evaluation and observation. Dx: 1) Chest pain, r/o MI. 2) HTN. 3) Obesity. Plan: Admitted to telemetry observation under Dr. Sharad Patel for further inpatient evaluation, workup, and tx.

11/27/13 - H&P Note by Sharad S Patel, MD. Pt started to have a constant intermittent headache involving the periorbital region. He checked his blood pressure, and it was elevated. Therefore, he went to his PCP'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 weight. He developed left-sided chest pain

radiating to his L shoulder. 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 ER here. He was evaluated by the ER physician. Since he has not had any significant cardiac workup and since he has a h/o HTN, which is uncontrolled, at the recommendation of the ER physician he is being hospitalized for further care. Past medical and surgical history: Appendectomy, cholecystectomy, arthroscopic surgery, h/o asthma, h/o hypertension. Social History: Smoking: He does not smoke. Drinking: He drinks on rare occasions. Dx: 1) Chest pain, r/o acute coronary syndrome. 2) HTN, uncontrolled. 3) Obesity. Plan: Pt was hospitalized. Ordered serial troponin levels. If they are negative, will order a stress test. In the meantime, he will be on nitroglycerin ointment.

11/27/13 - Laboratory Report by Providence St. Joseph Med Ctr. Glucose (H) 115.

11/27/13 - X-ray of Chest Interpreted by David P. Reiner, MD at Providence St. Joseph Med Ctr. Impression: No evidence of acute cardio-pulmonary process.

11/28/13 - Laboratory Report by Providence St. Joseph Med Ctr. Glucose (H) 105.

11/28/13 - X-ray of Chest interpreted by Donald S. Litvak, MD at Providence St. Joseph Medical Center.
Impression: Slightly prominent bibasal markings with no acute disease in the chest.

11/28/13 - NM Myocardial Perfusion Interpreted by Donald S Litvak, MD at Providence St. Joseph Medical Center.
Impression: 1) No areas of stress-induced reversible L ventricular myocardial ischemia or fixed L ventricular myocardial scarring were seen. 2) L ventricular EF is calculated at 51% on stress images and 65% on resting images. The L ventricular wall motion appears within normal limits in all areas.

11/28/13 - Discharge Summary by Sharad S. Patel, MD. Hospital Course: Pt's serum troponin levels were within normal limits. Pt had a Cardiolite cardiac stress test. It did not show any evidence of stress-induced reversible L ventricular myocardial ischemia or fixed L 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 PCP either on 11/29/13, or 12/02/13. His discharging medications will be as per the medication reconciliation form.

02/03/14 - PTP's Initial Rpt by Philip H. Conwisar, MD. DOI: 01/26/08. Pt sustained a work injury to his L knee. It was raining and he was repairing a garage gait. He states that the rain was heavy and he slipped and fell striking his left knee against the cement flooring. He reported the injury to his employer. He went home following the injury. C/o continuous LBP all across the low back with radiation into his buttocks and into both LE with the left leg getting numb." He does walk with a limp because of the L knee injury. He is awakened at night by LBP. He c/o dull medial L knee pain and weakness of the L knee. He is afraid to use it. Alcohol: He occasionally consumes alcoholic beverages. Cigarettes: He denies smoking cigarettes. PE: Pt is alert, responsive, and

cooperative. He does not appear to be in any acute distress. X-rays of the L/S were obtained in the office today. There is moderate DDD at L1-L2, L2-L3, L3-L4 and L4-L5. X-rays of the L knee, including weight-bearing views, were obtained in the office today. There is mild early DJD with a 2 mm joint space in the medial compartment and a 3 mm joint space in the patellofemoral joint. Medical records were reviewed. Dx: 1) S/p L knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy, and chondroplasty. 2) Early DJD, L knee. 3) L/S myoligamentous s/s. 4) Lumbar DDD. Plan: Recommended a course of PT, 2 a week for 4 weeks for the L knee and the L/S. TTD.

02/24/14 - RFA Form by Philip H. Conwisar, MD.

05/22/14 - RFA by Philip H. Conwisar, MD. Requested PT.

05/22/14 - PTP's Interim Rpt by Philip H. Conwisar, MD. DOI: 01/26/08. CT: 04/28/11-04/11/12. Pt was last seen 3 months ago. Pt continues to have L knee pain. He underwent L knee surgery approximately three to four weeks after the injury. He was then struck by a car one week after. He had severe injury involving the R leg and also had L ankle fx. He was hospitalized for a long period of time. He has gained approximately 100 lbs since the industrial injury. He has not received PT or rehab after the surgical procedure on the L knee. PE: Pt is alert, responsive and cooperative. He does not appear to be in any acute distress. Dx remains unchanged. Plan: The L/S injury would be considered a compensable consequence of altered gait mechanics due to the L knee injury. He also had a severe R leg injury. Apportionment would be an issue but there is evidence of relationship to the left injury and therefore a compensable consequence of this L knee injury. Recommended a course of PT 2 x a week for 4 weeks. He would also be taught a HEP so he could continue on his own after the session of PT. He has gained 100 lbs since the industrial injury. It is noted that he had an injury involving the R leg. The weight gain would be attributable to both injuries involving the LE, both the L knee industrial injury and the R leg injury from the MVA. His PCP has stated that his weight gain has caused and contributed to high BP and has contributed to respiratory problems. This is beyond the area of expertise 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 his L knee pain and L/S pain. Recommended a medically supervised weight loss problem as pt 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. TTD.

06/02/14 - Ortho QME Supplemental Rpt by Thomas W. Fell, Jr, MD. DOI: 01/26/08; CT 04/28/11 to 11/04/12. Medical records reviewed. No essential changes from previous report. In regards to L/S, pt does not have multilevel disc problems. He has 1.0 to 2.0 mm bulges of no clinical significance. Regarding causation, the limp was no minimal, it would not cause a compensatory pain in the L/S. It certainly would not cause multilevel disc pathology. Given the fact that he has normal MRI of L/S, the limp has nothing to do with the findings of L/S.

06/16/14 – PTP's P&S Rpt by Philip H. Conwisar, MD. DOI: 01/26/08. CT: 04/28/11-04/11/12. Pt has persistent L knee pain. He has LBP. He had an industrial injury to the L knee on 01/26/08. He underwent L knee arthroscopic surgery. He developed LBP after the industrial injury to the L knee, which he feels is related to altered gait mechanics. He also suffered a non-work-related injury involving the R leg and L ankle fx. He has also gained approximately 100 lbs since the industrial injury of 01/26/08. He can now be considered P&S and has reached MMI. X-ray of L/S today revealed moderate DDD at L1-2, L2-3, L3-4 and L4-5. X-ray of L knee revealed mild early DJD with 2 mm joint space in the medial compartment and a 3 mm joint space in the patellofemoral joint. Dx: 1) S/p L knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy, and chondroplasty. 2) Early DJD, L knee. 3) L/S myoligamentous sprain/strain. 4) Lumbar DDD. Discussion: The L/S injury is a compensable consequence, due to altered gait mechanics as a result of the L knee injury. He did have another injury involving the R leg, unrelated to the industrial injury. Apportionment, in regards to the L/S, is therefore an issue, although there is evidence of a compensable consequence of the L/S to the L knee. No authorization for treatment has been provided. He can be considered P&S and has reached MMI. Causation: Industrial injury of 01/26/08 for L knee and L/S. Subjective Factors of Disability: Frequent slight to moderate pain in the L knee, increasing to moderate with more vigorous activities. Frequent slight to moderate pain in the L/S, increasing to moderate with more vigorous activities. Objective Factors of Disability: L knee: Arthroscopic incisions. Findings at the time of surgery. 1+ anterior drawer and Lachman test. X-ray findings. L/S: Paravertebral tenderness. Restricted ROM. X-ray findings. Apportionment to Causation: In regards to the L knee, 100% to the industrial injury of 01/26/08. In regards to the L/S, apportioned one-third to the natural progression of DDD; one-third as a compensable consequence of the industrial injury of 01/26/08 and one-third of the non-industrial injury involving the RLE. Work Restrictions: Recommend a restriction 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 Rehab: If the recommended work restrictions cannot be accommodated, then pt would be considered a QIW. Permanent Impairment: The total WPI for the L knee is 14%. In regards to the L/S, 8% WPI. Final Comments: This examiner 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 this examiner's area of expertise. Recommended an internal medicine consultation. Future Medical Care: Evaluation and treatment by a physician, analgesic, anti-inflammatory, and muscle relaxant medications, on an as-needed basis, corticosteroid injection for the L knee, in addition to Hyaluronic Visco supplemental injections. An additional surgery in regards to the L/S. Short courses of physical or chiropractic therapy. Additional diagnostic testing, and additional treatment based on reexamination and diagnostic studies, a medically supervised weight-loss program.

10/05/14 - Medication Orders, All Other Orders and Results, Discharge Instructions, Flow Sheets, After Visit Summary at Providence St. Joseph Medical Center.

10/05/14 - X-ray of R Tibia and Fibula Interpreted by Nhan Tran, MD at Providence St. Joseph Medical Center.
Impression: No evidence of acute fracture. Old tibia and fibula fractures. Plantar calcaneal spur.

10/06/14 - ED Note by Carolina Benavides-Baron, PA. Pt presents to the ED for evaluation of acute RLE pain. Today, while exercising at the beach, he was riding his bike and then decided to go for a walk in the beach. While going in the water, he felt pain on his R calf. Since then has had a difficult time ambulating due to pain. PMH: HTN and asthma. Social History: He has never smoked, does not have any smokeless tobacco history and does not drink alcohol. ED Course: Pt had pain at the site of the L gastrocnemius muscle. Due to the mechanism of the injury, pain could be related to a small muscle tear or a muscle cramp that has not improved. He was treated 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 and told to f/u with his PCP. Dx: Muscle cramp. Rx: Flexeril 10 mg and Norco 5-325 mg. Disposition: Good. Pt is discharged.

10/09/14 - PR-2 by Philip H. Conwisar, MD. He has persistent pain, more severe. Dx remains unchanged. Plan: Instructed on HEP. Advised to take the medications prescribed in the ER.

01/13/15 - ED Note by Philip S. Schwarzman, MD. Pt yesterday developed intermittent L upper chest and shoulder pain. Pt continues to have discomfort, dull 3/10 and has some N/T in his hands. He was evaluated for similar problem in November. He had a treadmill at that time. Social Hx: He never smoked. He does not have any smokeless tobacco. He does not drink alcohol. PE: Eyes: PERRL. EOMI. ED Course: Pt's chest pain is atypical. Hemovac had a negative treadmill several months ago. Labs and EKG were performed. Dx: Atypical chest pain. Plan: Advised to f/u with his doctor. Disposition: Discharged.

01/13/15 - ECG Rpt interpreted by Philip S. Schwarzman, MD at Providence St. Joseph Medical Center.
Impression: Normal sinus rhythm. Possible L atrial enlargement. Borderline ECG.

01/13/15 - Laboratory Rpt at Providence St. Joseph Medical Center. Glucose (H) 109.

01/13/15 - X-ray of Chest Interpreted by Edward J. Jahnke, III, MD.
Impression: Stable chest with normal heart size. No evidence of acute process.

01/13/15 - All Cardiac Orders and Results, Flow Sheets, After Visit Summary at Providence St. Joseph Medical Center.

01/14/15 - ECG Rpt at Providence St. Joseph Medical Center.
Interpretation: No acute MI seen.

01/23/15 - Orthopedic Treating Physician's Supplemental Rpt by Philip H. Conwisar, MD. DOI: 01/26/08; CT: 04/28/11-04/11/12. Medical records were reviewed. Discussion: The records from the document pertain to a non-industrial injury when he was struck by a car on 02/28/08, sustaining fx to the R tibia and the L ankle. There are additional medical records from Cedars-Sinai pertaining to non-orthopedic related treatment. This examiner has also re-reviewed the QME reports from Dr. Fell. After a review of the records from Cedars-Sinai, there are no changes to his prior opinions other than in regards to apportionment. Examiner has re-reviewed the QME reports of Dr. Fell and

disagrees with Dr. Fell that weight gain was not related to the industrial injury and was related to both the industrial injury of 01/26/08, for which pt underwent L knee arthroscopic surgery and to the non-industrial MVA when he sustained a fx to the R tibia and the L ankle and required prolonged rehab. He believes that both of these injuries contributed to the subsequent weight gain for which he now requires treatment. This pt 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 L knee injury of 01/26/08 and the need for L knee surgery did contribute to immobility of pt and contributed to weight gain. Additionally, examiner changed his opinion in regards to the WPI of the L/S. The ROM method is more appropriate, as there was no specific injury and there are multiple levels of involvement. After reviewing these records, the following are his amended opinions: Apportionment to Causation: In regards to the L knee, it remains 100% to the industrial injury of 01/26/08. In regards to the L/S, 50% to the natural progression of DDD; 20% as a compensable consequence of the industrial injury of 01/26/08; 20% to the non-industrial injury involving the R and LLE fractures; and 10% to the CT injury of 04/11/12. Permanent Impairment: Total WPI for the L/S is 22%.

09/29/15 - Laboratory Rpt at Providence St. Joseph Medical Center. Glucose (H) 102.

09/29/15 - ED Nursing Notes at Providence St. Joseph Medical Center.

09/29/15 - After Visit Summary, All Other Orders and Results, Discharge Instructions, Flow Sheets at Providence St. Joseph Medical Center.

09/30/15 - ED Note by Celina M Barba-Simic, MD at Providence St. Joseph Medical Center. Visit for flank pain, RUQ pain.

09/30/15 - Ultrasound of Abdomen Interpreted by Sumit Dua, MD at Providence St Joseph Medical Center.

11/04/15 - Dr's 1st Rpt by Gabriel V. Rubanenko, MD/Orthopedic Surgery. DOI: 01/26/08. Pt 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 garage 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 towing that he needed to have surgery on his L knee, which was performed several days later. He states that he also has since developed headaches. Currently c/o headaches, back pain and L knee pain. Dx: 1) H/o headaches. 2) Lumbosacral musculoligamentous s/s with radiculitis. 3) Lumbosacral spine multiple disc protrusions per QME Dr. Fell. 4) H/o L knee ligamentous tear per medical records and s/p L knee partial meniscectomy in 2008 with residual impaired gait and atrophy. Rx: Ultram, Flurbi (NAP) Cream-LA, Theramine. Plan: Ordered lumbosacral brace, L knee sleeve and a TENS unit, urine toxicology. Requested MRI of L knee, L knee injection (steroid and then Synvisc per PQME Dr. Fell's recommendations) and physical performance FCE. Recommended PT for L/S

and L knee. TTD until 12/16/15. Causation: Pt's diagnoses are a direct result of the industrial injuries the pt sustained on a cumulative trauma basis from 04/28/11 to 04/11/12 working for The Roberts Co.

11/04/15 – RFA Form by Gabriel V. Rubanenko, MD. Medication prescribed: Ultram, Flurbi (NAP) cream-LA (Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%), Theramine. Requested lumbosacral brace, L knee sleeve (TENS unit), urine toxicology, physical performance – FCE, PT for L/S and L knee, x-ray of L knee, MRI of L knee, L knee injection (steroid, then Synvisc per PQME, Dr. Fell's recommendation), consult with weight loss specialist for a formal weight loss program, consult with internist to r/o industrial causation of DM, hypertension and asthma.

11/04/15 – Urine Drug Screen at Pacific Toxicology Laboratories. Result: Negative.

11/04/15 – Laboratory Rpt from Pacific Toxicology Laboratories. Urine Drug Screening Test. Ethyl Glucuronide (ETG) and Ethyl Sulfate: Detected.

11/12/15-12/03/15 (4 visits) PT Notes at Majzel Chiropractic Clinic. Pt underwent 4 sessions of PT for L/S and L knee.

11/23/15 – RFA by Gabriel Rubanenko, MD. Requested for MRI of L knee.

11/25/15 - MRI of L Knee interpreted by William Feske, MD at Peralta Hills-Mission Valley. Impression: 1) Fibrotic strands in the superior aspect of Hoffa's fat pad are seen extending to the intercondylar notch, indicative of 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 L 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 L 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.

12/21/15 - Dr's 1st Rpt by John A Donahue, MD/Orthopedics. DOI: 01/26/08. Pt 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 L 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, meds were prescribed, and he was told that he needed to have surgery on his L knee, which was performed several days later. He remained off work and eventually started a course of post-op therapy. He continued to attend f/u visits and states that approximately one week after his surgery, he was run over by a car and sustained injuries to his R leg (thigh) and L ankle. Subsequently, all treatments to his L knee were 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 also has since developed headaches. Dx: 1) H/o headaches. 2) Lumbosacral spine s/s with radiculitis. 3) L/S multiple disc protrusions per PQME, Dr. Fell. 4) History of L knee ligamentous tear per medical records. 5) S/p L knee partial meniscectomy in 2008 with residual impaired gait and atrophy. Causation: Industrial. Plan: Ordered lumbosacral brace, L knee sleeve, and TENS unit. Requested L knee steroid injection and then Synvisc per PQME, Dr. Fell's recommendation, MRI of L knee and physical performance-FCE. Also requested PT for the L/S and L knee and consultations with a weight loss specialist. TTD until 02/01/16.

12/24/15 - ED Note by John S. Rankin, MD/Emergency Medicine at Providence St Joseph Medical Center. Pt c/o dull, sore sensation LBP 8/10, 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 it as a sharp and tingling sensation. He has had similar pain to this off and on for the past 2 years since he was in a car accident and he is gained a significant amount of weight since that time. This pain feels similar to his previous back pain but has been worse over the last 2 days. PE: Eyes: PERRL. EOMI. ED Course: Administered Hydromorphone injection 1 mg and Ketorolac injection 60 mg. Feels much better at this time. X-ray of L/S was performed. On re-evaluation, pt feels much better with pain down to 2/10. He can ambulate steadily. Dx: Acute lumbar radiculopathy. Rx: Meloxicam 15 mg and Oxycodone-Acetaminophen 5-325 mg. Plan: He will f/u with his orthopedic surgeon and with his primary doctor. Discharged in good condition.

02/25/16 –PR-2 by John A Donahue, MD. C/o increased LBP at 8-9/10 and L knee pain at 4-5/10. He is currently symptomatic regarding his headaches, which have improved from 2/10. Dx: 1) Weight gain (approximately 150 lbs) secondary to immobility. 2) DM, industrial causation deferred. 3) HTN, industrial causation deferred. 4) Asthma, industrial causation deferred. Plan: Continue PT. Referred for a surgical consult. TTD.

03/04/16 - ED Note by Tina C. Wang, MD/Emergency Medicine at Providence St Joseph Medical Center. Visit for abdominal pain.

03/04/16 - Laboratory Rpt at Providence St Joseph Medical Center.

04/05/16 - Clinical Peer Review Referral by John A. Donahue, MD at Bunch CareSolutions. Requested for PT and surgical consult for L knee TKR.

04/07/16 - Clinical Peer Review by Marappa Gopinath, MD at Bunch CareSolutions. Requested for PT for L knee are non-certified.

04/08/16 – Utilization Review Determination at Maximus Federal Services. Request for 12 sessions of PT for L knee was denied.

04/21/16 - PR-2 by John A. Donahue, MD. C/o LBP 8/10 and L knee pain rated 6-7/10. Dx remains unchanged. Rx: Flurbiprofen, Lidocaine, Amitriptyline, Hyaluronic Cream. Plan: Requested referral to consult for medical weight loss program. TTD.

04/28/16 – Scrip by John A. Donahue, MD. Prescribed Flurbiprofen 10%/Lidocaine HCl 5%/Amitriptyline 5%/Hyaluronic 0.2% cream.

05/19/16 - PR-2 by Rene Nevarez, DC. C/o LBP radiates in the pattern of bilateral L4 and L5 dermatomes as well as pain in the L knee. Lower back and L knee pain rated 7-8/10. Dx remains unchanged. Plan: PT is on hold. TTD until 06/02/16.

06/02/16 – PTP's P&S Rpt by John Donahue, MD/Orthopedic Surgeon. DOI: CT 04/28/11-04/11/12; 01/26/08. Pt 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 the wet surface from the rain. He fell to the ground landing on the left side of his body, hitting his knee and the floor, and the garage door dosed down on him. Pt felt immediate sharp pain in his L knee and back. Pt states that from 04/28/12 to 04/11/12 while performing his usual and customary duties as a property manager for The Roberta Co., he gradually developed aggravating headaches, and back and L knee pain. He has gained approximately 150 lbs due to not being able to exercise because of his persistent pain and has since developed HTN, asthma and borderline diabetes. On numerous occasions, pt reported his symptoms to the employer who failed to offer any medical care. He continued performing his regular work activities, due to his financial necessity, until 04/20/12, at which time he was fired. At present, pt remains off work and states that his symptoms persist and have not improved. States that he has since gained approximately 150 lbs, and developed asthma, borderline diabetes and HTN all diagnosed by his private physician, due to the weight gain. C/o generalized headache rated 4/10. Pain is increased to 5/10 with repetitive overhead looking, repetitive flexion of the head neck, a repetitive extension of the head/neck, repetitive overhead work and loud sounds. It takes varying amounts of time for the pain to return to the pre-activity level following these activities. LBP occurs in the middle of the back at the waist, and the middle and B/L sides of the sacroiliac region and lumbar region with radiation to the B/L buttocks, thighs, knees, lower legs, calves, ankles, feet, and big toe. Pain rated 8/10 which increases to 9/10. L knee pain associated with limited ROM. Pain rated 7/10 and increased to 8/10. Difficulty with ADLs. Symptom's pt reported that during the week previous to this examination, he experienced swelling in his knee sometimes. He sometimes felt grinding and 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. Stiffness: Reported that during the week previous to this examination, he experienced moderate knee joint stiffness after his first awakening in the morning, and moderate knee stiffness after sitting, lying, or resting later in the day. Pain: The knee is painful weekly and during the week previous to this examination. C/o weight gain, diabetes mellitus, HTN and asthma. Other Accidents: Sustained MVA on 02/22/08 to his R leg and L ankle. Dx: 1) Headaches, industrial causation deferred. 2) Lumbosacral strain/sprain

with radiculitis. 3) L/S disc protrusion per medical records. 4) L knee strain/sprain, chronic. 5) S/p L knee surgery on 02/18/08. 6) H/o anterior cruciate ligament and meniscus tears. 7) Recurrent ligament and meniscus tears per MRI dated 11/25/15. 8) DM, HTN, asthma and weight gain, industrial causation deferred. Causation: Pt's current diagnoses are the direct result of the injuries this patient sustained on a cumulative trauma period from 04/28/11 to 04/11/12 and 01/26/08 while working for The Roberts Companies. Causation is deferred by headaches, weight gain, asthma, DM and HTN. Disability Status: Pt reached MMI and is considered P&S. Subjective Factors of Disability: LBP and L knee pain. The objective of Disability: L/S: Decreased/limited ROM. Spasm on palpation of the lumbar paravertebral muscles. L Knee: Surgical scars. Decreased limited ROM as demonstrated on PE. Decreased motor strength. Impairment Rating: 6% WPI for L/S, 9% WPI for L knee, 20% WPI for gait derangement and 28% total WPI. Apportionment: 5% of the current level of impairment of the L knee to the prior nonindustrial factors and 95% of the current level of impairment to the direct result of pt's industrial injury, which occurred on a cumulative trauma period from 04/28/11 to 04/11/12 and 01/26/08 in the course of his employment with The Roberts Companies. For remaining body parts, apportioning 0% of the current level of impairment, to the presence of prior industrial or non-Industrial factors and 100% of the current level of Impairment to the direct result of pt's 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. Future Work restrictions: L/S: 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 can 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. Lifting/carrying 20 lbs frequently up to 3-6 hours and occasionally up to 25 lbs of less than 3 hours. Standing/walking less than 4 hours, sitting less than 8 hours, no pushing/pulling over 30 lbs, occasional climbing, stooping, kneeling, crouching, crawling and twisting. Future Medical Care: Pt should maintain an active exercise program that he has been taught in their facility. This is designed to maintain and/or increase ROM for 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 the affected parts. Pt 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 an increase of the permanent level of disability. Therefore, he should be awarded an opportunity to be evaluated by a qualified medical orthopedic practitioner in case of such exacerbations. If Rx is determined to be warranted, a short course of chiropractic and/or PT, access to OTC, prescription medications and weight reduction, trigger point and/or epidural injections or other necessary modalities such as acupuncture should be made available in a timely basis. Pt is a surgical candidate for L knee arthroscopic surgery.

08/22/16 - RFA by John A. Donahue, MD. Requested for consultation with Dr. Gendelman for L knee surgery.

08/25/16 – STP's Interim Internal Medicine Eval by Maria Ruby Leynes, MD/Internal Medicine. Pt presently has had no activities, except walking no more than 10 minutes because of the L knee pain. He continues to gain weight. PE: The pupils are equal, round and reactive to light and accommodation. The optic fundi are benign. The disks are flat. Dx remains unchanged. Plan: No change from previous comments. Pt is not yet P&S. Recommended that the obesity be further treated with gastric bypass surgery on an industrial basis and that he receive psych tx and other workup for the other conditions just mentioned.

08/26/16 - Progress Note by Maria Ruby Leynes, MD. Pt was last seen on 09/05/12 with diagnosis of obesity and weight gain. Pt has increased L knee pain, knee problems with RLE. He continued to gain weight up to 295 lbs. Also developed LBP. At about 2012, started with sleep apnea. Pt continues to c/o of depression and increased stress, "feels so upset, can't work." In 2013, had arthritis. In 2010, BP increased. In 2015 BP increased. In 2016 had upper abdominal pain. Presently not active except walking more not than 10 minutes, due to left knee pain. Social History: Quit smoking in 2008. PE: HEENT: Negative. Dx remains unchanged. Plan: Recommended Psych treatment. Pt should have gastric bypass, industrial. Recommended sleep index. Requested treatment for HTN, DM on industrial basis.

09/16/16 – Ortho QME Supplemental Rpt by Thomas Fell, MD. DOI: 01/26/08; CT 04/28/11-11/04/12. Medical records were reviewed. Comments: These records do confirm that the ACL and meniscal tears did exist prior to the MVA. At the time of the arthroscopy, the ACL tear were confirmed, as well as the meniscal tears. The operative report also confirms that no repair or reconstruction of the ACL was done. The medical records from Cedars-Sinai do not indicate any additional injury to L knee. It makes comments only to the fact that he had recent arthroscopic surgery. In regards to L/S, when examined pt in 2009, he had a definite antalgic gait. When examiner saw him four years later, there was only a questionable limp on the L side. This indicates that the gait actually improved during that 4-year period of time. During the time his gait improved, his LBP came on. In July 2012, it was the first time Dr. Kornberg mentioned any back pain. This is 3-1/2 years after the incident in question at a time when the pt's gait actually improved. Therefore, examiner would have difficulty attributing the LBP 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 a time when the limp was much more significant, that is in 2008 and 2009. In fact the 2008 and 2009 period of time would have been when the pt was most unstable, as he 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. Examiner respectively disagrees with Dr. Conwisar's apportionment in regard to the L/S impairment. In regard to the L knee, the MRI scan of Dr. Feske suggested possible complex tears of the medial and lateral menisci; however, examiner has 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 TKR, 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 TKR. After review of these additional records, it is still examiner's opinion that the pt's L/S is unrelated to an antalgic gait, since the gait improved in the four years between

examiner's examinations to a very minimal barely visible limp. The back pain did not occur until 3-1/2 years after the injury to the knee. The pt's weight gain is not due to immobility as the pt is being seen riding his motorcycle and he is able to walk, but he told the weight gain came on after he stopped smoking. This is not an uncommon occurrence. Examiner 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 his examination of July of 2013, as well as Dr. Conwisar's records just prior to Dr. Donahue seeing him, examiner does not feel at this point that he is a candidate for TKR. Impairment Rating: Examiner has changed his rating. 20% LE impairment for arthritis. 10% LE impairment for the partial medial and lateral meniscectomies and 17% impairment for the moderate instability of the ACL. 19% total WPI.

01/15/17 - ED Provider Note by Christian Herrera, MD at Providence St. Joseph Medical Center. Pt c/o of gradually worsening pain to the top of the R foot over the past 3 days. He has a history of blood clots in the past after a trauma. He reports having rods in his BLE from the accident. Pt is diabetic. Social History: Quit smoking. Does not have any smokeless tobacco history. Drinks alcohol. ED Course: X-ray of R foot performed. Dx: R foot pain. Plan: Pt will be given a walker and Naprosyn. He was advised mandatory f/u with his primary care doctor tomorrow for further evaluation and treatment and possible referral to an ortho specialist. Disposition: Pt is discharged to home.

01/15/17 - Laboratory Rpt at Providence St. Joseph Medical Center.

01/15/17 - X-ray of R Foot interpreted by De Mauricio, MD at Providence St. Joseph Medical Center.
Impression: 1) No radiographic evidence for fracture. 2) Soft tissue swelling. 3) Partially visualized ORIF hardware of the tibia.

05/03/17 – X-ray of Chest Interpreted by Richard Allan, MD at Cedars-Sinai Med Ctr.
Impression: No radiographic evidence of cardiopulmonary disease. Stable exam.

05/03/17 - ECG Rpt Interpreted by Xunzhang Wang, MD at Cedars-Sinai Med Ctr.
Impression: Normal sinus rhythm. Normal ECG.

05/03/17 - Progress Note by Michael G. Wetter, PsyD at Cedars-Sinai Medical Center. Pt presents for psychological f/u. Pt made a comment months ago regarding suicidal ideation and that was the specific focus of today's assessment. Pt 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. Pt feels "lost" due to his inability to be physically active and become healthy as a result of his weight. Pt 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. No need for additional psychological f/u.

05/03/17 – Office Visit by Alexander Gershman, MD/Urology at Institute for Advanced Urology. Visit for urinary stream problems.

05/03/17 - Radiology Images.

05/03/17 - Uroflow at Medical Measurement Systems.

05/04/17 - Pre-Operative (Pre-Procedure) Orders at Cedars-Sinai Medical Center.

05/11/17 - Surgical Pathology Rpt Interpreted by Stacey Kim, MD at Cedars-Sinai Med Ctr. Specimen: A) Stomach, antrum, biopsy. B) Stomach, antrum, additional, biopsy. C) GE junction biopsy. Dx: A) Stomach, antrum, biopsy: Oxyntic mucosa with mild chronic gastritis. No significant active inflammation identified. No Helicobacter pylori identified. No intestinal metaplasia or dysplasia identified. B) Stomach, antrum, additional, biopsy: Antral and oxyntic mucosa with mild chronic gastritis. No significant active inflammation identified. No Helicobacter pylori identified. No intestinal metaplasia or dysplasia identified. C) GE junction, biopsy: Squamous mucosa with no significant histopathologic changes. No columnar mucosa identified.

05/11/17 - Operative Rpt by Wayne Shin-Way Lee, MD at Cedars-Sinai Medical Center. Pre-op/Post-op Dx: Morbid obesity. Operation Performed: Flexible EGD with biopsy. No complications.

05/11/17 - Admission Form/All Orders/Medications/Care Plan/Flow Sheets/Surgery Report/Anesthesia Encounter at Cedars-Sinai Medical Center.

05/11/17 - Intra-op Airway Management at Cedars-Sinai Medical Center.

05/11/17 - EKG Strip at Cedars-Sinai Medical Center.

05/18/17 - Bariatric Surgery Multidisciplinary Conference Note by Scott Cunneen, MD/Miguel Burch, MD/Daniel Shouhed, MD at Cedars-Sinai Medical Center. Pt scheduled for bariatric surgery with another physician.

07/05/17 - Cardiac Imaging Questionnaire at Cedars-Sinai Medical Center.

07/11/17 - NUC Card PET Rubidium Pharmacologic Stress at Cedars-Sinai Medical Center.

08/09/17 – Initial Consult Notes by Sergey Lyass, MD/Bariatric Surgeon. Pt was here for morbid obesity. Pt has previous weight loss attempts and achieved 10-30 lbs weight loss. Reports h/o back problem, GERD, HTN, diabetes, depression and sleep apnea. ROS: Denied eye pain, recent injury or vision loss. Dx: 1) Morbid (severe) obesity due to excess calories. 2) BMI 45.0-49.9, adult. 3) Adjustment disorder with depressed mood. 4) Essential (primary) HTN. 5) GERD without esophagitis. 6) Mild intermittent asthma, uncomplicated. 7) OSA. 8) Type 2 DM without complications. 9) Polyosteoarthritis, unspecified. Plan: Recommended laparoscopic gastric sleeve.

08/10/17 – Operative Rpt Interpreted by Sergey Lyass, MD at Cedars-Sinai Med Ctr. Pre/Post op Dx: Morbid obesity. Procedure Performed: 1) Robotic-assisted laparoscopic sleeve gastrectomy. 2) B/L TAP block.

08/10/17 - ECG Rpt Interpreted by Xunzhang Wang, MD at Cedars-Sinai Med Ctr. Impression: Atrial fibrillation. Abnormal ECG.

08/10/17 - Laboratory Rpt at Cedars-Sinai Med Ctr. Glucose (H) 117.

08/10/17 – Surgical Pathology Rpt Interpreted by Stacey Kim, MD at Cedars-Sinai Med Ctr. Specimen: Stomach, sleeve gastrectomy. Dx: 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.

08/10/17 - Cardiology Consult by Jane Y. Kauffman, MD/Cardiology at Cedars-Sinai Medical Center. Examiner received a call this morning from the surgeon anesthesia saying that this pt is in atrial fibrillation, which is new, and he was totally asymptomatic. Examiner saw him in the office for cardiac clearance recently, and at that time, he was in sinus rhythm. PE: PERRLA. EOMI. Dx: Episode of paroxysmal atrial fibrillation in the morning, asymptomatic. Plan: Pt is not a candidate for anticoagulation. Planning to follow and probably apply a ZIO patch or some other kind of monitor to ensure that he does not have paroxysmal AFib frequently.

08/10/17 - Post-Operative/Post-Procedure Note by Mohan Krishna Mallipeddi, MD at Cedars-Sinai Medical Center. Pre-Dx/Post-Dx: Morbid obesity. Procedure Performed: Robotic sleeve gastrectomy.

08/10/17 - Post-Op Check by Melissa Chen, MD. Pt is doing well with no complaints. Pain control improving but discomfort still present. Dx: S/p robotic-assisted laparoscopic sleeve gastrectomy, POD #0, overall doing well. Plan: OOB. Added higher dose of Lortab for increased pain control. Recommended IVF and incentive Spirometry.

08/10/17 - Pre-Anesthesia Assessment Note by Mirjana Lovrincevic, MD at Cedars-Sinai Medical Center. Pre-op Dx: Morbid (severe) obesity due to excess calories. Proposed Procedure: 1) Gastrectomy sleeve laparoscopic robotic – robotic laparoscopic sleeve gastrectomy. 2) Robotic procedure XI. 3) Hiatal hernia repair robotic assisted. 4) Hiatal hernia repair open.

08/10/17 - Post-Anesthesia Assessment Note by Mirjana Lovrincevic, MD.

08/10/17 - Pre-Operative Orders at Cedars-Sinai Medical Center.

08/10/17 - Alarm Review Rpt at Cedars-Sinai Medical Center.

08/10/17 – EKG Strip at Cedars-Sinai Medical Center.

08/10/17 - Admission Form/Post-Op Note/Care Plan/Nursing Notes/All Orders/Medications/Surgery Rpt/Anesthesia Encounter/Flow Sheets at Cedars-Sinai Medical Center. Date ranges from 08/10/17-08/12/17.

08/11/17 – Laboratory Rpt at Cedars-Sinai Med Ctr. Glucose (H) 150.

08/11/17 - Progress Note by Jane Y. Kauffman, MD. Pt is resting comfortably. Did not sleep at night. Pain in incision site is better. Plan: Will monitor for AFib as outpatient.

08/11/17 - Medical Nutrition Therapy Response at Cedars-Sinai Medical Center. Pt expressed good understanding. Anticipate good compliance once home. Diet will advance per protocol. Pt was encouraged to f/u with outpatient RD once discharged.

08/11/17 - Alarm Review Rpt at Cedars-Sinai Medical Center.

08/12/17 – Discharge Summary by Melissa Chen, MD at Cedars-Sinai Med Ctr. Hospital Course: Pt underwent a robotic-assisted laparoscopic sleeve gastrectomy on 08/10/17. There was a question of AFib preoperatively but he did not experience any hemodynamic instability intraoperatively. Pt tolerated the procedure well and was transferred from the PACU to the floor with no complications. The post-op course was uneventful and without complication. 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 meds and was able to ambulate without difficulty. He did not have any further a fib witnessed during his hospitalization. Rx: Amlodipine, Fluticasone-Salmeterol, Norco, Invokana, Lisinopril-HCTZ, Metformin, Metoprolol and Pantoprazole. Plan: Encouraged to ambulate. Avoid heavy lifting, strenuous exercise and straining during bowel movements for 6 weeks. Discharged home in stable condition.

08/12/17 – ECG Rpt Interpreted by Michael Shehata, MD at Cedars-Sinai Med Ctr.
Impression: Normal sinus rhythm. Normal ECG.

08/12/17 - Care Plan at Cedars-Sinai Medical Center.

08/12/17 - Progress Note by Jane Y. Kauffman, MD. Pt is doing better and slept better. Tolerate diet. (Partial Document).

08/12/17 - Bariatric Surgery Progress Note by Melissa Chen, MD/Daniel Shouhed, MD. There are no acute events. Tolerating clears without nausea or vomiting. Has been ambulating and voiding. PE: NAD. Dx: S/p robotic-assisted lap sleeve gastrectomy, POD #2, doing well. Plan: Advance to full liquids including protein shakes. Encourage incentive spirometer. Anticipate DC to home today.

08/12/17 - Healthloop Full Export at Cedars-Sinai Medical Center.

08/23/17 – Progress Notes by Sergey Lyass, MD. Pt's pre-op weight was 407 lbs. Total weight loss 376 lbs. Excess weight loss 15%. ROS: Denied eye pain, recent injury, unusual sensations, vision loss. Dx: Bariatric surgery status. Plan: Continue PPIs, protein shakes and multivitamins.

09/12/17 - Correspondence at EIG Services, Inc.

10/20/17 – Correspondence from CMS.

11/15/17 – 11/17/17 (2 visits) PT Notes. Completed 2 sessions of PT for the low back.

11/15/17-11/17/17 (2 visits) Physical Therapy Note by Yelena Vaynerov, MD. Completed 2 PT sessions for low back.

11/20/17 - Laboratory Rpt at CSJ Providence St. Joseph Medical Center. CMP: Glucose (H) 108.

11/21/17 – Correspondence. Hold Invokana till hematuria is cleared and f/u with urologist.

11/22/17 - Bariatric Progress Note by Sergey Lyass, MD. Pt had R flank pain and microhematuria. Meds: Valium, Metformin, Invokana, Atorvastatin, Toprol XL, Diovan HCT, Benicar HCT, Lisinopril. ROS: Denied eye pain, recent injury, unusual sensations, vision loss. Dx remains unchanged.

12/07/17 – MRI of L/S w/o Contrast Interpreted by Dianna Chooljian, MD at Providence St. Joseph Ctr.
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 contributing to congenital spinal canal stenosis with moderate central canal stenosis at L2-L3 through L4-5 levels. 3) Multilevel neural foraminal stenosis at the L3-L4 and L4-L5 levels. 4) 2 mm L subarticular recess disc protrusion at T12-L1. 5) 2 mm central disc protrusion at L2-L3. 6) 3 mm central disc protrusion and annular tear at L4-L5. 7) Multilevel facet and ligamentum flavum osteoarthropathy.

12/11/17 - Adult Progress Note. Pt feels somewhat better with conservative treatment at home. MRI revealed DJD and moderate spinal stenosis. Did not take his Toprol today. Dx: 1) LBP (acute). 2) DJD of the spine, thyroid nodule. Plan: Recommended ortho consult. Ordered labs.

12/11/17 - US of Thyroid interpreted by George Mednik, MD at Olympic Imaging Services.
Impression: 1) Thyroid gland is mildly enlarged. 2) Hypoechoic lesion in the upper pole of the R loge of the thyroid.

03/05/18 – PQME Rpt by Michael D. Smith, MD/Orthopedics. DOE: 02/22/18. DOI: 01/26/08; CT 04/28/11 to 04/11/12. On 01/26/08, pt fell down. He sustained cumulative work trauma due to repetitive work activities. Injured back, L knee and L ankle and foot. His employer was notified. Pt was seen at UCLA ER where x-rays were taken and meds were prescribed. Has since received

treatment with PT. CC: Lumbar and lumbosacral pain frequently radiates down B/L legs with N/T. Has L knee pain. Also c/o L ankle and foot pain. ADLs: Because of the symptoms, there is difficulty with personal hygiene and dressing, as well as home care activities. PMH: History of high BP, diabetes, asthma, arthritis and heart disease. Has had several gastric and orthopedic surgeries. Dx: 1) L/S injury. 2) L knee injury. 3) L ankle and foot injury. Causation: Back, knee and L ankle and foot symptoms, impairment and associated disability are the result of the 01/26/08 work accident. No evidence of any cumulative work trauma both in the medical records nor in pt's history. Findings are consistent with the injuries claimed by pt. Disability Status: The conditions are P&S for the purpose of a disability rating. Factors of Disability from work-related claimed injury of current concern: Objective factors: Thoracic region-normal. Lumbar region-restricted torso motion. Abnormal straight leg tests suggesting sciatic nerve irritation. Restricted squatting. L Knee: Multiple parapatellar scars. Anterior and lateral joint tenderness. Impaired knee motion. Restricted squatting and kneeling. L Ankle/Foot: 3-inch medial ankle scar. Ankle tenderness. Work Status: Because of back condition, work capacity is limited to no heavy work with no lifting greater than 20 lbs and no repeated bending or stooping. Because of L knee and L 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. Impairment Rating: Low back: 13% WPI, L knee: 10% WPI, L ankle/foot: 6% WPI. Pt's combined conditions have resulted in total WPI of 27%. Vocational Rehab: Because of pt's injuries, pt cannot work the regular, unmodified job. However, a return to the preinjury place of employment is appropriate if reasonable accommodations can be made to coincide with the work restrictions. Apportionment: 100% of pt's current causation of back, L knee, and L 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 pt's symptoms or disability. Need for Medical Care: Medications per MTUS. Lumbar disc surgery and/or L knee surgery may be needed in future. Recommend Urology QME for evaluation of impotence and Internal Medicine QME due to weight gain. Summary: The examiner's findings are consistent with the injury claimed by pt. There is disability present now. Pt is P&S for rating purposes on 02/22/18.

04/05/18 – Adult Progress Note. Pt c/o mild dizziness. Lost and gained some weight. Dx: 1) Morbid obesity. 2) DM. 3) History of atrial fibrillation. Plan: Requested Carotid ultrasound Duplex and fasting labs.

04/09/18 – PQME Rpt by Jan H. Merman, MD/Neurology. DOI: 01/26/08; CT 04/28/11 and 04/11/12. Pt had an injury from 1997 to 1998 where he fractured his L middle finger. It was a Workers' Compensation injury and he does not remember the details. On 01/26/08, pt was attempting to fix a gate. It was raining and he fell hitting his L knee against the ground. Had L knee pain and swelling. The next day, he went to UCLA Hospital. Had x-rays which revealed torn ligaments. However, no surgery was done at that time. On 02/28/08, pt was hit by a car while crossing street. He was unconscious for about two days. Does not remember the details of the accident. Had a fx of his R lower leg and L ankle. He was admitted to the hospital for 8 days and had surgery on both legs with nails and rods. Had laceration of his head and his memory was "erased." Pt had some headaches after this injury lasting about three to four weeks. After this

injury, he noted numbness in his arms and legs. Reported this injury, but workers' compensation refused any treatment. Had rehabilitation for his R leg, but no immediate treatment for his L knee. He stopped working after 02/22/08 injury. Stopped working after the 02/22/08 injury and went back on modified duty in 2011. He worked as an actor. 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. Notes that his weight gain started significantly in 2011 through 2012 and 2013. He got up to 417 lbs in August 2017. It is now down to between 329 lbs after a sleeve was placed in August 2017. Also developed HTN and asthma and he had weight gain and he got treated for it. Was given BP pills, but he cannot remember the names of the BP medicine. Beginning in 2015, he began to get headaches lasting about 30 minutes. Headaches were not specifically treated. Started to have sleep apnea when he weighed 315 lbs and started on CPAP in 2017. CC: Reports headaches 3-5/10, two to three days a week in the middle of frontal areas. C/o 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, diplopia, blurred vision for distance. He has hearing loss in his L ear because of "swimmer ears." C/o gait disorder because of his increasing weight, but there are no recent falls. Pt 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 to 245 lbs. It was "costly." The patient was on a physical program from 2008 to 2009. He rarely gained about 5-10 lbs. C/o SOB with his weight gain and was diagnosed with "asthma." Also had discomfort and arrhythmia in August 2017. He saw a cardiologist. She placed him on metoprolol and possibly "blood thinners" although he does not know the names of his medicines. C/o some chest pain for two to three times a month, intermittently without exertion and may last as long as 7 hours. PMH: Asthma; organic heart disease, possibly AFib; peptic ulcer disease; duodenal ulcer at the age of 20 years; hepatitis at age 7 days in the hospital; gallstones surgery in 2006; AODM type II. He is on medication. He does not know the names. He discovered in around 2011; Kidney disease, type unknown possibly cyst; Obesity; Sleep apnea, diagnosed in 2017. PSH: He had gastric sleeve; gallbladder surgery; orthopedic surgeries for his R leg, L ankle; L knee surgery with arthroscopy, date unknown. PE: HEENT: Normal. Dx: 1) Cerebral concussion with 10-cm laceration slightly superior to L ear, nonindustrial. 2) Tibia-fibula fracture of the RLE, nonindustrial. 3) L foot fx of ankle, nonindustrial, s/p ORIF with multiple surgeries. 4) Pulmonary embolus, non-industrial. 5) HTN, nonindustrial. 6) Tension headaches, nonindustrial. 7) Obesity, nonindustrial. 8) COPD, nonindustrial. 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: After review of pt's information and reviewing submitted medical records, it was determined pt probably has tension headache disorder and the probable cause is the combination of stress related to his two injuries. His medical illnesses are basically dependent on several causations: Increasing age, history of smoking, and possibly the most significant one would be obesity. Causation: Causation is probably a combination of his two injuries which caused him to have increased stress. Trying to separate out the two is difficult. It may seem obvious that the second injury was much worse than

the first and would cause him the more stress, although this examiner does not have an evaluation by his psychiatrist. The patient is not P&S for his headache disorder and should be treated. Would use Topamax or Zonegran since they can cause weight loss. This examiner would defer his disability, apportionment, vocational rehabilitation and work restrictions until he gets three to six months of headache treatment. He should be treated by a neurologist who can use either Topamax, Zonegran, beta-blockers, calcium channel blockers. Can 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. Pt has to diet which will help him overall.

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

04/11/18 – Progress Note by Sergey Lyass, MD. Pt presents for f/u of bariatric surgery. ROS: Denied eye pain, recent injury, unusual sensations or vision loss. Dx remains unchanged. Plan: Continue PPIs. Continue protein shakes and multivitamins.

06/06/18 – Lab Rpt at LabCorp.

08/10/18 – Supplemental Ortho QME Rpt by Michael D. Smith, MD. DOI: 01/26/08; CT 04/28/11 to 04/11/12. Discussion: In receipt of 08/07/18 correspondence and this examiner's review of his report with regard to the nonindustrial car accident, apportions 100% of his L ankle and foot disability as the result of the 02/22/08 car accident. With regard to L knee disability, apportions 25% to the nonindustrial car accident of 02/22/08 and 50% to the 01/26/08 work accident and 25% to obesity.

09/07/18 – Visit Note by Alexander Gershman, MD. Pt c/o constant dull ache in the saddle area for months. Reported 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. Rx: Cipro 500 mg. Plan: Urinalysis obtained and reviewed. Ultrasound of pelvis, renal, and abdominal back wall were done with no abnormalities.

09/27/18 - Supplemental Neurology PQME Rpt by Jan H. Merman, MD. Discussion: After this examiner's deposition yesterday and review of further medical records from Dr. Smith, he discusses the following: One of the parties was overly aggressive in the questioning. They would not let the examiner and frequently interrupted when he had to say. The examiner thought this was unfair and the party was obviously angry about his 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. Dr. Smith's report from 03/05/18 notes that pt 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 he can tell, he does not make any connection in the evaluation of pt's injuries to his obesity. He notes that pt was a "normally developed and nourished male" on his PE. Pt was significantly obese. He does not make any connection between the second injury and his first knee injury. The examiner thinks this is a problem, for instance how did the second injury affect the first injury since without the second injury, pt's prognosis and healing might have been significantly different. If he does not think so, he could obviously state and/or give his reasons for it. During the deposition, they did not go over Dr. Gart's May 2007 progress note for pt's epidural of his L/S. The date of service was 05/03/07. In his post-procedure diagnosis, he noted that pt had a "lumbar disc herniation" and lumbar facet syndrome and lumbar radiculitis. He gave LESI at L4-5 and L5-S1 and again L4-5. In other words, pt patient 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 from Cedars-Sinai Medical Center, the examiner could not find preexisting MRI scan. Therefore, pt 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 08/10/18 added that he apportioned 25% in the nonindustrial car accident. He apportioned L knee disability 25% of the nonindustrial car accident and 25% to obesity and 50% to the 01/26/08 industrial injury. As far as in his first report of 03/05/08, he concluded that 100% of pt's current causation of his back, L knee and L ankle and foot disability were the result of the 01/26/08 work accident. This is obviously different from his second report. As far as the discussion of pt's obesity is concerned, in the examiner's opinion, pt's 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 the examiner's fault since it was obvious that most people now take in too many calories and it will be the major cause of obesity and that was the reason why there is a diet. In Ms. Carolina Castillo's report on 07/19/16, dietitian report, she lists that pt had been hit by a car and was not physically active for 9 months and has not been able to exercise since the accident. However, this is not exactly true. If we look at his physical activity, he actually does aqua aerobics 4-6 times per week. Therefore, pt was actually exercising at that time. She even states that under the nutrition, diagnosis was 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. He tries to avoid but he did drink one to two glasses of wine when he saw Ms. Castillo. If we 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, the examiner would state at this time after the deposition, exercise does help to lose weight. However, with overeating, this would blunt the effect of exercise and make it much less effective in helping to lose weight. However as noted above, pt was exercising, but the question is how much exercise. By the way, exercise does not always lead to weight loss. The second minor point is the pt told he is 6'4" tall, however, on medical records from Cedars-Sinai, they list his height as 6'3" tall, but it will actually make his BMI greater. Pt states to Ms. Castillo that his maximum adult weight was 175 lbs. The examiner thinks at that time pt was a 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.

10/29/18 – Nursing Documentation at Cedars-Sinai Medical Center.

01/04/19 - Adult Progress Note by Yelena Vaynerov, MD. Pt presents with R foot pain, low back pai, L knee pain, and lost 50 lbs after bariatric surgery. Dx: 1) Chronic lumbar radiculopathy. 2) Morbid obesity. 3) Plantar fasciitis. 4) DJD of knee. Plan: Recommended weight loss and PT.

01/17/19 - Patient Order Summary at Providence Health & Services.

02/27/19 - Lab Rpt at Diagnostic Laboratory Science. Result: Glucose (H) 106.

02/27/19 - Progress Note by Sergey Lyass, MD. Pt presents for f/u of bariatric surgery. ROS: Denied eye pain, recent injury, unusual sensations or vision loss. Dx remains unchanged. Plan: Continue PPI's. Continue multivitamins, calorie counting and exercising.

03/06/19 - Adult Progress Note by Yelena Vaynerov, MD. Pt gained weight again. Pt has pain in L foot, lower back and B/L knees. Dx: 1) Obesity. 2) Chronic LBP. 3) DJD of the knees. Plan: Recommended diet and exercises.

04/01/19 - IHSS Program Health Care Certification Form at Yelena Vaynerov, MD. Pt is unable to independently perform one or more ADLs. In this examiner's opinion, one or more IHSS service recommended in order to prevent the need for out-of-home care. Morbid obesity, chronic lumbar radiculitis pain, chronic knee pain, weakness, plantar fasciitis, foot pain, unable to walk, bend, lift or squat. Pt's condition is expected to last at least 12 consecutive months. This examiner has provided medical treatment for this pt since 2014 at a frequency of every 2 to 3 months. Last seen and treated this patient on 04/01/19.

05/17/19 – Lab Rpt. Result: GLU (H) 108.

05/17/19 - ED Provider Note by Telly Dane Arispe, PA-C at CSJ Providence St. Joseph Med Ctr. Pt presents with constant R upper quadrant abdominal pain for the past week, which worsened today. 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 has had significant weight loss since. PMH: Asthma, depression, DM borderline, gastritis, HTN. PSH: Appendectomy, cholecystectomy, gastric sleeve 2017, orthopedic surgery, tonsillectomy. PE: Eyes: EOMI. ED Course: Pt 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. Do not suspect choledocholithiasis or cholangitis. Pt is afebrile and well-appearing and will be discharged home without any new medications. Dx: 1) RUQ pain, acute. 2) Hx of cholecystectomy, acute. 3) Steatosis of liver, acute. Plan: F/u with surgeon at Cedar Sinai for further evaluation. Disposition: Discharge to home.

05/17/19 – X-Ray of Abdomen Supine and Upright with 1 View Chest Abdominal series by Karen Fu, MD.

05/17/19 - Summary of Care at Providence Health & Services.

05/18/19 - US Abdomen limited Right Upper Quadrant interpreted by John Swift, MD.

05/21/19 – Prescription by Yelena Vaynerov, MD. Prescribed PT for low back.

05/21/19 - Progress Note by Val Shulman, MD. Pt c/o R-side LBP, dull, constant and RUQ pain. PE: WD, NAD. Dx: 1) LBP. 2) Abdominal pain questionable radiculitis. Plan: Recommended PT to low back.

07/20/19 - PQME by Anthony G. Rodas, MD/Internal Medicine/Occupational Medicine. DOI: 01/26/08. Pt has alleged two injuries. The first is dated 01/26/08 where he has alleged injuries to the back, knee and head. In addition, he filed a CT claim 04/28/11 through 04/12/12. He has alleged CT injury to the same orthopedic body parts. C/o constant pain in L knee, low back radiating down to L leg and B/L hips. Pt has 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 for which he uses a CPAP mask for. Has numbness down L leg, tingling in R leg and both hands, and also down L knee. Grinding and locking of the joints in L knee. He can sit comfortably for 30 min, stand for 5 min and walk for 5-10 min. Currently, he is using several assistive devices including a cane. Also uses a soft brace on L knee in addition to a CAM walker for L ankle. C/o depression and suicidal thoughts. Pt is unable to do anything that he was able to do before. Pt is unable to work at the present time. Cannot perform any physical activities that he was doing. Could lift between 5 and 20 lbs. Prior, he could lift up to 140 lbs. PMH: Cholelithiasis, s/p cholecystectomy in July 2005. History of lumbar facet syndrome, lumbar disc herniation, and lumbar radiculitis. S/p MVA 02/22/08 with head laceration, closed head injury, R tibia/fibula closed fx s/p intramedullary rod pinning, s/p L ankle bimalleolar fx s/p ORIF, s/p hardware removal. Industrial injury 01/26/08, torn ACL, meniscal tears medially and laterally, s/p arthroscopy 02/18/08. History of HTN. Morbid obesity. AODM. Sleep apnea. Atrial fibrillation. S/p pulmonary emboli related to hospitalization for the MVA, 03/22/08. Asthma. Prior Injuries: In 1997, suffered a fx of his finger. He worked for Roberts Property Management for 10 years and this was his only work-related injury. Prior surgeries: Cholecystectomy and multiple orthopedic surgeries. SH: Nonsmoker, quit a few months after his L knee surgery. FH: Father is alive, but unknown health. Mother has a history of diabetes. ROS: Denies diplopia. PE: EOMs intact. Dx: 1) S/p work-related injury 01/26/08 specific; CT 04/28/11- 04/11/12. 2) Torn medial and lateral meniscus of L knee; torn ACL of L knees/p arthroscopic surgery for injury date 01/26/08. 3) Recurrent tear of the posterior horn of medial meniscus per MRI arthrogram 06/14/2012. 4) Morbid obesity. 5) Asthma. 6) AODM. 7) Sleep apnea. 8) Atrial fibrillation. 9) S/p MVA 02/22/08 with fx of R tib/fib s/p intramedullary rods; L ankle bimalleolar fx s/p ORIF. 10) Pulmonary embolism, DVT L 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. Discussion: It is clear that pt has suffered from obesity and probably pre-hypertension prior to his

injury of 01/26/08. He states that he was never given medicine for his BP until a few years ago after he gained a large amount of weight. Examiner concludes 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, 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, 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 this pt's ability to exercise. Weight gain can occur as a result of chronic pain also. Chronic pain is one of the major reasons that obese patients list for their weight gain. In fact, pt continues to have multiple orthopedic complaints and his medical records are replete with complaints referable to his low back as well as his L 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 patients appear to be more functionally impaired, have greater comorbid problems, and have more radicular symptoms than their non-obese counterparts. In summary, it is believed the obesity in this pt is multifactorial and includes: His history of chronic obesity, probable effect of smoking cessation (only for his early weight gain), appetite increase related to chronic pain, an element of orthopedic causation from his non-industrially related MVA as well as his industrial injury to L knee and recently added L/S injury. In summary, this examiner believes enough substantive evidence exists to opine that his obesity has some basis in industrial contribution. Obesity itself is not a ratable impairment. Before opining on his comorbidities of hypertension, sleep apnea, atrial fibrillation, diabetes, and asthma, this examiner needs 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. He would also like to see his medical records from the Lindora Weight Loss Clinic if available. Pt's recollections 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 he can review the above medical records. Conclusion: At this time, pt can be considered P&S from the effects of his industrially caused obesity. He became P&S on 08/10/17, the date of his gastric sleeve. Current diagnoses are limited at this time to morbid obesity. Subjective complaints are supported by the objective findings. This examiner did not find any evidence of dysfunctional behavior. The injuries and aggravation or contribution to a pre-existing problem. The patient has a known history of obesity; however, body mass index at the time of L knee surgery and auto accident in 2008 was approximately 30.Regarding temporary disability, based on review of his obesity alone, he was not temporary partially or TTD, except for a period of 1-2 weeks following the gastric sleeve procedure, which would have been a reasonable time for recovery. Pt would have been capable of performing his full active duties on an internal medicine basis alone and on an obesity basis alone. Spinal impairment and LE injuries are deferred to the orthopedist. AMA impairment rating has been deferred. Based on obesity alone, work restrictions and loss of preinjury capacity would not be applicable. This examiner has deferred issues of apportionment, permanent disability, issues of future/further medical treatment until he can review medical records from his private physician.

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.

08/28/19 - Physician Order by Yelena Vaynerov, MD. Ordered Duplex scan of abdominal aorta and US of prostate/bladder.

08/28/19 - Prostatic Ultrasound interpreted by George Mednik, MD at West Coast Medical Diagnostic Service, Inc.

08/28/19 - Progress Note by Yelena Vaynerov, MD. Pt has gained weight again. Has depression and c/o joint pain. C/o dizziness especially with changing body position and nocturia. Dx: 1) Dizziness. 2) Morbid obesity. 3) Depression. 4) Enlarged thyroid. 5) Hepatomegaly. 6) BPH. 7) CVA. Plan: Ordered abdomen and renal, prostate and thyroid ultrasound.

08/29/19 – Lab Rpt at Physicians Diagnostic Reference Laboratory. Result: Glucose (H) 112.

08/29/19 - Ultrasound of Abdomen interpreted by George Mednik, MD at Olympic Imaging Services.

08/29/19 - Medicare Well Patient Physical. Pt does have HTN, morbid obesity, gastric bypass. Assessment of Cognitive Impairment: Morbidly obesity and being depressed. Depression Screening: Over the past 2 weeks, pt expresses little interest or pleasure in doing things. Over the past 2 weeks, has not felt down, depressed, or hopeless. Functional Ability: Pt is not self-reliant. Does handle his own money. Does express both hearing and vision difficulties. Distance and reading eye charts were not used. Does have advance directive. His most recent glaucoma screening was in 2017 and is scheduled in 2019.

09/16/19 - Correspondence by Yelena Vaynerov, MD. Pt has been under this examiner's care since 11/25/14 and examiner confirms that pt 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, pt has certain limitations regarding his mobility. Recommend pt to request the HRC and the Department of Disability to verify that ADA is in compliance and keep informed about progress on these matters. Also, advised to avoid driving a vehicle that is not suitable for use by people with disabilities.

11/21/19 – Prescription by Yelena Vaynerov, MD. Prescribed Invokana and Metformin.

11/24/19-12/03/19 (3 visits) – PT Note at Majzel Chiropractic Clinic. Completed 3 sessions of PT to L knee.

01/30/20 – Lab Rpt. Result: GLU (H) 132.

01/31/20 - Lab Rpt.

03/05/20 - SOAP Note by Yelena Vaynerov, MD. Pt still has weakness, dizziness, weight gain, pain in unspecified lower extremity. She c/o pain with walking. Dx: 1) Morbid obesity. 2) Fatigue. 3) Dizziness. 4) Pre-diabetes. Plan: Requested labs. Repeat thyroid ultrasound and carotid and LE US.

03/05/20 - Ultrasound of Thyroid interpreted by George Mednik, MD at Olympic Imaging Services.

03/05/20 – Lab Rpt at PDRL. Result: Glucose (H) 113. Hemoglobin A1C (H) 6.2%.

03/06/20 - Physician Order by Yelena Vaynerov, MD. Ordered cerebrovascular profile and peripheral vascular profile.

03/06/20 -Carotid Duplex Scan interpreted by George Mednik, MD at West Coast Medical Diagnostic Service, Inc.
Impression: Spectral broadening of the B/L internal carotid arteries consistent with a 15-49% stenosis.

03/09/20 – Correspondence regarding receipt of pt's medical records.

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

03/12/20 – Prescription by Yelena Vaynerov, MD. Prescribed Lisinopril 10 mg.

07/23/20 - Physician Order by Yelena Vaynerov, MD. Ordered echocardiography.

07/23/20 - Echocardiogram Report by George Mednik, MD at West Coast Medical Diagnostic Service, Inc.
Impression: 1) Normal LV function and wall motion with normal LV EF at 56%. 2) There is no pericardial effusion, thrombus, or vegetation. 3) Mildly enlarged LV and L atrium. 4) Mild hypertrophy of the interventricular septum and posterior wall of the LV. 5) Atrial fibrillation. 6) Cardiac arrhythmia. 7) No valvular regurgitation or stenosis.

08/26/20 – Lab Rpt at DLS.

08/26/20 - Progress Note by Sergey Lyass, MD. Pt presents for f/u of morbid obesity, failure of previous weight loss surgery, failed gastric sleeve, and weight gain after weight loss surgery. ROS: Positive for weight gain, HBP, palpitations, hx of heart attack, arthritis, and diabetes. Denied eye pain, recent injury or vision loss. Dx: 1) Morbid (severe) obesity due to excess calories. 2)

Abnormal weight gain. 3) Essential HTN. 4) Type 2 DM without complications. 5) Abnormal coagulation profile. Plan: Recommended laparoscopic BilioPancreatic diversion with Duodenal Switch. Pt needs psychological evaluation and nutritional evaluation for clearance. Requested upper endoscopy, chest x-ray, EKG, CBC and CMP.

08/26/20 - Progress Note by Alexander Gershman, MD. Pt presents with BPH and LBP. Reported slow or weak urinary stream. Associated signs and symptoms include incomplete emptying. 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. Plan: Ultrasound of pelvis performed, which shows L kidney is larger. Ordered urinalysis and urine culture.

09/09/20 – Correspondence regarding pt's additional records for review.

09/16/20 - Correspondence regarding C&R.

09/23/20 - Supplemental QME Report by Anthony G. Rodas, MD. DOI: 01/26/18. Analysis: Submitted medical records were reviewed and analyzed as follows: Obesity: Pt does have a contribution to his obesity from his orthopedic injuries. In summary, although most of his obesity is related to genetic and dietary factors, there is enough substantive evidence to conclude that industrial causation in the form of injuries to his low back, L knee and ankle have contributed to its worsening. Examiner continues to find AOE/COE for his obesity. Future Medical Care: Office visit with PMD, continue weight loss program, Provision of anorectic drugs; review with a bariatric surgeon as he may benefit from a Roux-en-Y bypass as opposed to the gastric sleeve. All medications required to aid in the control of nutritional deficiencies caused by his bariatric surgery. Work Preclusions: As directly related to his obesity, none. Apportionment: 5% of his obesity to industrial causation and 95% to pre-existing causation. AMA Impairment Rating: Obesity is not ratable in and of itself by The Guides. Most of the effects of obesity are related to its affect on other organ systems. In this case, adult onset diabetes mellitus, HTN with LV hypertrophy, and atrial fibrillation. Turning to each of these issues: AODM: Pt is at MMI. Became MMI on 03/05/20. Future Medical Care: Office visit with PMD; provision of a glucose monitor Accuchek and chem strep for blood sugar determination. Endocrine consult for diabetes and progression to insulin therapy. All anti-diabetic drugs. Lab work every three months. Ophthalmologic consultations on a yearly basis. Podiatric consultations on an every six month basis. Apportionment: 5% to industrial causation and 95% to pre-existing obesity. BENSON: Because his obesity worsening is related to his orthopedic injuries and the QME in Ortho had rendered an opinion that there is no CT contribution to his condition, 100% of his AODM aggravation is to the specific injury, and 0% to the CT. Work Preclusions: None related to his AODM.AMA Impairment Rating: 6% WPI. HTN: In summary, there is clear aggravation of his HTN, part of which is due to industrially aggravated obesity, as a result of loss of physical capability for exercise which is also a modality used for BP control .The industrial component of his obesity has aggravated his hypertensive state. He is at MMI. He became MMI on the date of the QME. Future Medical Care: All BP medications, ECGs, cardiac consults, catheterization, stress echo and 2D echocardiograms. Office visits with primary treater. Work Preclusions: None related to his HTN. Apportionment: 95% to pre-existing causation and 5% to industrial causation. BENSON Analysis: 100% to the

specific injury; 0% to the CT. AMA Impairment Rating: Hypertensive heart disease with LV hypertrophy, he falls into a Class III 30% WPI. Atrial fibrillation: 20% impairment. He falls into a Class I 1% impairment of the whole person. He has signs of hemorrhagic disorder, e.g. use of anti-clotting medication, and needs no or infrequent treatment, and he performs all of his activities of daily living. Asthma: Given the fact that he has had persistently normal pulmonary function tests which do not objectively demonstrate his asthma, and the fact that there have been no documented asthma attacks since 2016, it appears at most that his obesity contributed to an exacerbation of his non-industrial asthma, which has firm causative factors in viral and smoking etiologies. His pulmonary status has returned to its pre-asthma attack status. Therefore, further medical-legal analysis is moot since there is no documented aggravation of his underlying pulmonary disease. Sleep Apnea: He is at MMI. He became MMI on 04/17/17, the date of his CPAP titration study. Future Medical Care: Office visit with PMD; repeat sleep study as needed to assess adequacy of CPAP. Pulmonary and sleep consultations as needed. Work Preclusions: No work preclusions as long as he uses his CPAP mask. Apportionment: 95% to pre-existing industrial obesity, 5% due to contribution from industrial worsening of his obesity. BENSON Analysis: 100% to the specific injury and 0% to the CT. AMA Impairment Rating: Based on Table 13-4 on page 317, he falls into a Class I 5% impairment of the whole person. Combined AMA impairment rating is 51 %. Sleep apnea 5%. Anticoagulant use 1%. Hypertensive heart disease with LV hypertrophy 30%. Atrial fibrillation 20%. Adult-onset diabetes mellitus 6%.

10/05/20 – Correspondence regarding supplemental rpt from PQME.

10/23/20 - Correspondence regarding updated medical reports.

11/03/20 – Correspondence regarding supplemental report from PQME.

11/03/20 – Correspondence requesting supplemental report.

12/18/20 - Supplemental Report by Anthony G. Rodas, MD. Discussion: Additional medical records were reviewed. Therefore, this examiner has changed his AMA impairment rating related to LV 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 this examiner's prior opinions offered in his most recent supplemental report. Therefore, sleep apnea is 5%. Anticoagulant use is 1%. Hypertensive heart disease with LV hypertrophy and left atrial enlargement is 35%. Atrial fibrillation is 20%. Adult-onset diabetes mellitus is 6%.

01/12/21 – Correspondence regarding supplemental report from PQME.

01/29/21 – Correspondence regarding agreeing to additional PQME panel in Psychiatry.

02/02/21 - Correspondence regarding authorization for medical services.

02/03/21 - Correspondence regarding updated medical records.

02/12/21 - Supplemental Report by Anthony G. Rodas, MD. Discussion: After reviewing the additional medical records spanning the timeframe from 01/17/13 through 01/31/20, this examiner has not changed his opinions originally expressed in his medical-legal reports of 07/20/19, 09/23/20, and 12/18/20.

04/25/21 - MRI of L Knee interpreted by Sean Johnston, MD at California Imaging Network. 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, as described above.

Deposition of Jan Merman, MD, Volume I, on 09/26/18 (25 Pages):

Pages 5, 6 - Doctor mentioned that he is a neurologist and had 3 years of training in internal medicine. He evaluated the pt and issued one report dated 04/09/18. He evaluated this pt for neurological and internal medicine issues, as well as headaches. According to the doctor, he had a lot of medical issues. Pages 7-10 - Doctor indicated that pt's fractures made it difficult for him to walk. According to page 10 of the doctor's report, he discovered that the majority of the evidence pointed to overeating as the cause of his weight gain. Doctor testified that the vehicle accident paralyzed him and also admitted that the pt had dropped weight and was now weighing 230 pounds. According to the medical history on page 9, doctor confirmed that his left meniscus tore again, as did his back problems, and that his radicular discomfort in his lower limbs from his back injury flared up. Pages 11, 12 - Doctor indicated that the pt's weight loss and gain are variable. Doctor discovered that there are causes for him to overeat, some of which may be depression or anxiety, but that his weight gain and loss is most likely due to overeating. Within the realms of medical possibility, the doctor believed that exercise would aid in weight loss. Pages 16-19 - Doctor stated that his weight loss was attributed to his diet. Doctor thought his fractures were more serious than his knee injuries. Page 8 of the doctor's report stated that pt saw Dr. Fell again on July 30th for a QME evaluation. Pt had been going to the gym every day since his last exam, walking 45 minutes and performing bike workouts. He used the Lindora Program, and reduced weight from 294 pounds to 235 pounds in 2012, but he had gained 100 pounds since then. Page 20 - According to the doctor, the majority of the pt's weight gain is most likely related to overeating. Page 23, 24 - Doctor observed that the pt was moving around and that he did not have much back tenderness. Because of his injuries, the doctor predicted that pt would be despondent and frustrated.

(End of Record Review)

BOUDRINE, Dmitri 621467 BKZ SIBTF 77080

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

Case Name Dmitri Boudrine v THE ROBERTS COMPANIES

Claim No. SIF8345007 **EAMS or WCAB Case No. (if any):** ADJ8345007

I, Edith Alejandre declare:

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

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

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

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

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

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

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

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

Means of Service *(For each addressee, Enter A - E as appropriate)*	*Date*	*Addressee and Address*
A	11-01-2022	Subsequent Injuries Benefit Trust Fund 1750 Howe Avenue Suite 370 Sacramento, CA 95825
A	11-01-2022	Natalia Foley Law Offices of Natalia Foley 751 South Weir Canyon Road, Suite 157-455, Anaheim, California 92808

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

Signature of Declarant

Edith Alejandre

Print Name
Edith Alejandre