ERIC E. GOFNUNG CHIROPRACTIC CORP.

QME OF THE STATE OF CALIFORNIA

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Boulevard, Suite 604 • Los Angeles, CA 90048 • Tel: (323) 933-2444 • Fax: (323) 933-2909

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am a resident of the County aforesaid: and I am over the age of eighteen years and not a party to the within action: my business address is 6221 Wilshire Boulevard, Suite 604 Los Angeles, CA 90048.

On 23 day of November 2022, I served the within concerning:

Patient's Name: Walls, Darlene

SIF Case: SIF13026215

On the interested parties in said action, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid in Los Angeles, California, to be hand delivered Via United States Mail.

[ ] MPN Request	[ ] QME Appointment Notification
[ ] Notice of Treating Physician	[ ] Designation Of Primary Treating Physician
[ ] Medical Report _____	[ ] Initial Comprehensive Report
[ ] Itemized – (Billing) / HFCA _____	[ ] Re-Evaluation Report / Progress Report (PR-2)
[ ] Doctor's First Report	[x] Subsequent Injury Benefits Trust Fund Medical Evaluator's ML 201 **08/08/2022**
[ ] RFA	[ ] Permanent & Stationary
[ ] Review of Records	[ ] Authorization Request for Evaluation/Treatment _____

List all parties to whom documents were mailed to:

cc: Workers Defenders Law Group
8018 E. Santa Ana Cyn., Ste. 100-215
Anaheim Hills, CA 92808
Attn: Natalia Foley, Esq.

Subsequent Injury Benefits Trust Fund
1750 Howe Avenue, Suite 370
Sacramento, CA 95825-3367

I declare under penalty and perjury under the laws of the State of California, that the foregoing is true and correct, and that this Declaration was executed at Los Angeles, California on 23 day of November 2022.

Ilse Ponce

ERIC E. GOFNUNG CHIROPRACTIC CORP.

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August 08, 2022

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Sacramento, CA 95825-3367

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8018 E. Santa Ana Cyn., Ste. 100-215
Anaheim Hills, CA 92808
Attn: Natalia Foley, Esq.

Re:	Patient:	Walls, Darlene
	SSN:	558-37-5679
	EMP:	Kaiser Foundation Hospital DBA Medical
	SIBTF:	SIF13026215
	INS:	Sedgwick Claims Management
	Claim #:	KAWC000144-001
	EAMS #:	ADJ13026215
	DOI (SIBTF INJURY):	CT: 01/03/2018 – 03/02/2020

SUBSEQUENT INJURY BENEFITS TRUST FUND
MEDICAL EVALUATOR'S ML-201 REPORT

Dear Gentlepersons:

The above-named patient was seen for a Subsequent Injury Benefits Trust Fund Medical Evaluation for determining eligibility, pursuant to California Labor Code 4751 on August 08, 2022, in my office located at 6221 Wilshire Boulevard, Suite 604, Los Angeles, CA 90048. The information contained in this report is derived from a review of the available medical records, as well as the oral history as presented by the patient.

The evaluation is not intended to ascertain the applicant's current function as it relates to the above captioned industrial injury, but rather determine whether pre-existing disability in combination with impairments arising from the subsequent industrial injury meet the requirements that would qualify the injured worker for SIBTF benefits. The Subsequent Injury Benefits Trust Fund (SIBTF) liability deals with pre-existing impairment and/or pre-existing disability. In other words, disability which was present prior to the industrial injury noted above. In essence, we are looking into the past in order to determine to what extent the injured worker

was disabled, at some time prior to the settled industrial injury noted above. In this report, we will discuss whether or not the injured worker had an industrial injury and whether or not there was an evidentiary basis to determine pre-existing permanent disability. Finally, we will determine whether or not the applicant preliminarily meets the initial criteria for SIBTF eligibility of 35% permanent disability, or 5% permanent disability to an opposite corresponding member, and whether or not he/she will likely incur a total disability in excess of 70%, subject to additional medical evaluations in various medical specialties.

A request was made by Workers Defenders Law Group for me to evaluate Ms. Walls, to determine her qualification for the Subsequent Injury Benefits Trust Fund. This evaluation is being performed to address the applicant's pre-existing disability to various body parts, as well as outline additional impairment and disability arising from the injury occurring on a cumulative trauma basis from January 03, 2018 through January 04, 2019 to her lower back, right shoulder, legs, right hand, and wrist, which are the subsequent industrial injuries. I have been authorized to evaluate the industrial injuries and any pre-existing problems. I have been advised to order further evaluations as necessary from other specialists.

This report is billed under ML-201 pursuant to California Code of Regulations 9793(h), and 9795(b)(c).

Explanation of Charges: (ML201)

The report is being billed as ML-201, a comprehensive medical legal evaluation. This is either the Initial evaluation or a re-evaluation by a physician which occurs after eighteen months of the date on which a prior comprehensive medical-legal evaluation was performed by the same physician. Additional billing is included as MLPRR record review. The following modifiers are also included:

- MLPRR record review was performed on the 1268 pages received. Declaration and attestation was received for the same number of pages. 200 pages were included in the fee for ML201, all pages beyond 200 were billed at $3/page as required by CR 9795.
- Billed as follows:
    - ML201 = $2015
    - 1068 Units of MLPRR X $3 $3204
    - Total = $5219

Upon meeting Ms. Walls, I introduced myself and discussed with her my role as an evaluator in this SIBTF matter. She expressed no objection to proceeding with the evaluation.

Initial SIBTF Summary:

1. Did the worker have industrial injury? Yes.

2. Did the industrial injury rate to 35% disability without modification for age and occupation? Yes.

3. Did the worker have a preexisting labor disabling permanent disability? As related to my specialty, no.

4. Did the preexisting disability affect an upper or lower extremity, or eye? Unable to determine as related to eyes. No as related to extremities.

5. Did the industrial permanent disability affect the opposite and corresponding body part? No.

6. Is the total disability equal to or greater than 70% after modification? Unable to determine.

7. Is the employee 100% disabled or unemployable from other preexisting disability and work duties together? Unable to determine.

8. Is the patient 100% disabled from the industrial injury? Unable to determine at this time. I recommend this patient undergo a Vocational Expert Consultation.

9. Additional records reviewed? Yes.

10. Evaluation or diagnostics needed? Yes. See page 19**.**

JOB DESCRIPTION (SUBSEQUENT INJURY) :

Ms. Walls was employed by Kaiser Permanente as a certified nurse assistant at the time of the injury. They began working for this employer on February 25, 2008. The patient worked full time.

Job activities included caring for up to 15 patients per day, taking vitals, cleaning and feeding patients, repositioning the patients, walking patients, transferring patients from beds to

wheelchairs and vice versa, changing sheets, making beds, changing diapers, changing foleys, assisting with oral hygiene, combing their hair and bathing as well as charting.

The physical requirements consisted of sitting, walking, standing, flexing, twisting, and side-bending and extending the neck, bending and twisting at the waist, squatting, climbing, and kneeling.

The patient is a left-hand dominant female, and they would use the bilateral upper extremities repetitively for simple grasping, power grasping, fine manipulation, keyboarding, writing, pushing, and pulling, reaching at shoulder level, reaching above shoulder level, and reaching below shoulder level.

The patient was required to lift and carry objects while at work. The patient was required to lift and carry objects weighing up to 100+ pounds.

The patient worked 8 hours per day and five days a week. Normal work hours were 7:15 a.m. to 3:45 p.m. Lunch break was 30 minutes. Rest break was 15 minutes. The job involved working 100% indoors.

The last day the patient worked for Kaiser Permanente was in February of 2020, at which time the patient was placed on temporary disability by a doctor.

There was no concurrent employment at the time of the injury.

The patient reports working for 3 days in October of 2021 for a Temp Employment agency at a job site at FedEx, but patient stopped working as she couldn't tolerate the pain associated with prolonged standing.

Prior Work History:

The patient worked for the above employer for 13 years.

HISTORY OF SUBSEQUENT INJURIES AND TREATMENT ACCORDING TO PATIENT:

CUMULATIVE TRAUMA: 01/03/2018-03/02/2020

The patient states that while working at her usual and customary occupation as a certified nurse assistant for Kaiser Permanente, they sustained a work-related injury to her right shoulder/arm, both wrist/hand/forearm, lower back, and right lower extremity, which the patient developed in the course of employment due to continuous trauma dated January 3, 2018, to March 2, 2020. The patient attributes the injuries due to the gripping, grasping, repetitive movements, bending forward, kneeling, stooping, squatting while repositioning patients, and using forceful pulling and pushing when pulling the patient up on their beds as well as transferring the patients from their beds to wheelchairs and vice vera repetitively throughout her workday. In 2014, the patient

developed gradual onset of pain and discomfort. She reported the injury to her employer and was referred to a physician with Kaiser (her employer) for evaluation and was treated through her health insurance. Treatment included prescription medication and physical therapy for her right shoulder, which did help to alleviate the pain. She was released to full duty, but continued to have problems with moving patients and with lifting. She remained under treatment for six weeks and was released from medical care.

In about 2012, she was walking down a hallway at work when she experienced dizziness. She experienced worsening of high blood pressure. She received treatment at Kaiser and was given medication. She also developed bronchitis and sinus infections while working for Kaiser and this would cause her to cough and affect her smell. She would have issues while working as this would slow her down as it would affect her breathing.

The patient reports she wears eye glasses that she was prescribed during the time she worked for Kaiser and she would use her glasses while working.

She worked with ongoing pain.

In 2015, due to persistent pain she returned to her physician at Kaiser and was on light duty for six weeks for her right shoulder and back. She had issues with lifting, pushing and pulling. Medication was prescribed.

From 2016-2018 the pain progressively worsened at her right shoulder/arm, left wrist/hand/forearm with numbness/tingling worse than right, and back. She developed radiation of pain from back to right leg and began to limp. She has been experiencing headaches.

In 2018, she retained an attorney and was referred to doctor for evaluation. X-rays and MRI scans were obtained of the back, right shoulder and left wrist. She was diagnosed with a torn rotator cuff of the right shoulder. Due to COVID, she did not have surgery. She completed several sessions of physical therapy, acupuncture and was treated with medication. She was released to light duty restricting her bending, stooping, lifting, pulling, pushing and other restrictions. Due to prolonged sitting at a desk looking at cameras as she monitored the patients, she experienced aggravated pain and discomfort at her back. She would work light duty as per her doctors, get better and be released to full duty, then get worse again and would be placed on light duty. This cycle went on for some time. She worked with ongoing pain until February of 2020, when the pain became unbearable and she could no longer continue working. She also has depression/anxiety due to her work-related stress and was treated by psychologist or psychiatrist as she is not certain which one.

In 2021, an injection was administered by Dr. Anderson at Kaiser for the left upper extremity as she recalls to the forearm/wrist area.

The patient reports due to persistent pain and difficulty with activities of daily living as related to right shoulder and back injury radiating to the right leg to foot, she has been favoring her

shoulder and right leg and has developed pain in the neck, left shoulder and left knee. On 1.24.19, she was repositioning a patient when she developed neck, right shoulder and back pain.

In May of 2022, she presented to her primary care physician in Las Vegas where she currently resides as she no longer has insurance covered. X-rays of the left shoulder, left knee, and lower back were obtained. An anti-inflammatory and muscle relaxer was prescribed. She last followed up with her PCP in June- July of 2022.

CURRENT COMPLAINTS:

Headaches:

Patient reports difficulty concentrating at times due to headaches.

Neck/Left Shoulder:

The pain radiates to the arm and hand. The pain is moderate, and the symptoms frequently. Patient experiences weakness and restricted range of motion in the shoulder. Numbness and tingling in the hands and fingers is present. The patient complains of stiffness and experiences increased pain with repetitive motion of the arms/shoulders. The pain is aggravated with overhead reaching, pushing, pulling, lifting, and carrying greater than 10 pounds and repetitive use of the right upper extremity. Pain level varies throughout the day depending on activities. The patient has difficulty falling asleep and awakens throughout the night due to the pain and discomfort.

Right Shoulder:

The pain radiates to the neck and right arm, and hand. The pain is moderate, and the symptoms frequently occur in the right shoulder. Patient experiences weakness and restricted range of motion in the shoulder. Numbness and tingling in the right hands and fingers is present. The patient complains of stiffness and experiences increased pain with repetitive motion of the arms/shoulders. The pain is aggravated with overhead reaching, pushing, pulling, lifting, and carrying greater than 5 pounds and repetitive use of the right upper extremity. Pain level varies throughout the day depending on activities. The patient cannot sleep on the right shoulder due to the pain. The patient has difficulty falling asleep and awakens throughout the night due to the pain and discomfort.

Bilateral Hand/Wrist (left worse than right):

The pain is moderate, and the symptoms occur frequently in the left wrist, hand, and fingers, and intermittently in the right. The pain is aggravated with gripping, grasping, torquing motions, flexion, and extension of the wrist/hand, pinching, fine finger manipulation, repetitive use of the left upper extremity, pushing, pulling, and lifting, and carrying greater than five pounds. The patient has weakness, and loss of grip strength in hand and wrist and has dropped objects, as a result. There is tingling in the hands and fingers. Patient has difficulty sleeping and awakens

with numbness, tingling and pain, and discomfort. Pain level varies throughout the day depending on activities.

Lower Back:

The pain radiates down the buttocks and back of the right thigh to right foot. There is numbness and tingling in her right leg. The pain is moderate to severe at times, and the symptoms occur frequently in the lower back, which increases becoming sharp and stabbing. The pain is worse at night. The pain increases with activities of prolonged standing as well as activities of kneeling, stooping, squatting, forward bending, ascending and descending stairs, forceful pushing and pulling, lifting and carrying greater than 5 pounds, going from a seated position to a standing position and twisting and turning at the torso. Patient complains of muscle spasms. Patient complains of pain and difficulty with intimate relations/sexual activity due to increased pain in the lower back. The patient denies experiencing bladder or bowel problems. Patient does awaken from sleep as a result of the low back pain. The patient self-restricts by limiting her activities. They walk with a limp due to low back symptoms.
Pain medication provides pain improvement, but they remain symptomatic

Left Knee:

The pain is moderate, and the symptoms occur frequentyly in the left knee. The pain increases with flexing, extending, prolonged standing and walking, going up and down stairs, bending, stooping, squatting, and walking on uneven surfaces or slanted surfaces. The patient has episodes of swelling in the knee. She reports buckling on occasions.

Psyche:

The patient has episodes of anxiety, stress, and depression due to chronic pain and disability status. The patient denies suicidal ideation.

The patient has difficulty sleeping, often obtaining a few hours of sleep at a time. The patient feels fatigued through the day and finds herself lacking concentration and memory at times. The patient worries about medical condition and the future.

Hypertension:

She reports developing hypertension during the time she worked for Kaiser and is currently medicated.

Bronchitis and Sinus Infections:

The patient developed respiratory issues and Sinus issues while working for Kaiser and they would affect her ability to work as she had issues with respiration.

Vision issues:

Patient wears eyeglasses for reading and driving.

PAST MEDICAL HISTORY:

Illnesses:

The patient reports a ten-year history of high blood pressure and is currently medicated. High blood pressure was labor disabling due to the symptoms of dizziness and discomfort.

She has bronchitis and sinus infections she developed while working for Kaiser over 10 years ago.

She is far sighted and developed need for reading glasses and driving glasses while working for Kaiser.

Injuries:

The patient denied any prior work-related injuries.

The patient reports injuring her back in about the late 1990's while a passenger in a car when it was rear ended. She recalls having about a few months of treatment and pain resolved. She did not have any surgery due to that accident.

The patient denied any new injuries.

Allergies:

The patient is allergic to Keflex and penicillin.

Medications:

1. Bisoprolol 10 mg, taken for high blood pressure since approximately 2020.
2. Ibuprofen 800 mg, taken for pain and inflammation since 2015.
3. Name unrecalled muscle relaxer for back muscles since 2020.
4. Tylenol #3 has been taken for pain since 2019.

Surgeries:

The patient denied any prior major surgeries.

Hospitalization:

The patient denied any hospitalizations.

REVIEW OF SYSTEMS:

GENERAL:	Denies fever, weight loss, malaise.
	The patient reports night sweats, which were not labor disabling.
HEENT:	Denies headache. Denies sore throat, ear pain or nasal congestion.
	The patient reports blurred vision, which was labor disabling due to not being able to see.
CARDIAC:	Patient denies chest pain, orthopnea, or palpitations.
	The patient reports hypertension, which was labor disabling due to a lack of alertness and having to lay down to get it under control.
PULMONARY:	Denies wheezing, hemoptysis, or productive cough.
	The patient suffered from bronchitis and sinus infections once a year from 2013 to 2021 while working. They were labor disabling and she have difficulty smelling.
GASTROINTESTINAL:	Denies hepatitis, ascites, abdominal pain, or jaundice.
NEUROLOGIC:	Denies migraine headaches, , cramping, dementia, cerebral palsy, Alzheimer's disease, epilepsy, stroke, paralysis, or TIA. The patient has numbness/tingling of right leg.
MUSCULOSKELETAL:	See Current complaints/past Medical history.
HEMATOLOGIC:	Denies easy bleeding or bruising.
ENDOCRINE:	Denies polyuria or polydipsia.
GENITOURINARY:	Denies hesitancy, urgency or frequency, nocturia, or bladder and/or bowel incontinence.
PSYCH:	**The patient reports depression and anxiety and lack of sleep and this was labor disabling as it would affect her ability to focus at work as she was sleepy.**

ACTIVITIES OF DAILY LIVING:

Self-Care - Personal Hygiene: As a result of the industrially-related injury, the patient states: Difficulty with bathing by self and dressing by self with a rating of 2-3/5.

Hand Activities: As a result of the industrially-related injury, the patient states: Difficulty with grasping or gripping, lifting, and manipulating small items with a rating of 3-4/5.

Travel: As a result of the industrially-related injury, the patient states: Difficulty with riding in a car, driving a car, traveling by plane, and a restful night sleep pattern, with a rating of 235

FAMILY HISTORY:

Mother is 72 years old and is epilepsy and high blood pressure.

Father is 75 years old and is in good health.

The patient has seven siblings. They are well and in good health.

There is no known history of colon cancer, breast cancer, or heart problems.

SOCIAL HISTORY:

The patient is single. She has four children.

The patient has completed one year of community college.

The patient consumes alcohol occasionally and smokes ½ pack of cigarettes daily.

The patient does not exercise.

The patient participates and does not participate in any sports activities.

The patient denies hobbies or social activities.

Physical Evaluation (August 08, 2022) – Positive Findings:

General Appearance:

The patient is a 55-year-old left-handed female who appeared reported age, well-developed, well-nourished, and well-proportioned, alert, cooperative and oriented x3. She is not pregnant.

Vital Signs:

Pulse:	59
Blood Pressure:	160/101
Height:	5’7’’
Weight:	181

Cervical Spine:

Tenderness was noted over the bilateral paravertebral musculature and upper trapezius musculature. Tenderness and hypomobility was noted over the cervical spine vertebral regions from C5 through C7, predominantly over the bilateral facet joints, greater at the left than right.

Bilateral shoulder depression tests were positive.

Cervical spine ranges of motion were decreased and painful. Please see attached formal ranges of motion study performed utilizing dual electronic inclinometers.

Shoulders & Upper Arms:

Tenderness was noted over bilateral shoulders over the supraspinatus, subacromial and subdeltoid bursa and acromioclavicular joints.

Right Apprehension test was positive, left was negative.

Bilateral Impingement sign tests were positive.

Ranges of motion of the bilateral shoulders were decreased and painful, as follows.

Shoulder Ranges Of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	180	**165**	**150**
Extension	50	**45**	**35**
Abduction	180	**165**	**110**
Adduction	50	**35**	**30**
Internal Rotation	90	**75**	**50**
External Rotation	90	**90**	**80**

Elbows & Forearms:

Hardened area of soft tissue was noted over the anterior aspect of the forearm mid shaft over the radius, which the patient reports has been there since she received the injection about a year ago, tenderness is present.

Tenderness is not present over the lateral epicondyle, medial epicondyle and cubital tunnel bilaterally. Tenderness is not present over the flexor muscle group and extensor muscle group of the forearm bilaterally.

Valgus and Varus Stress Tests are negative. Cozens' (resisted wrist extension) and Golfers' (resisted wrist flexion) tests are negative bilaterally.

Left Tinel's sign is negative. **Right Tinel's sign is positive.**

Ranges of motion for the bilateral elbows were normal:

Elbow Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	140	140	140
Extension	0	0	0
Supination	80	80	80
Pronation	80	80	80

Wrists & Hands:

Right Wrist & Hand:

Tenderness was noted over the volar crease.

Tinel's sign was positive at the tunnel of Guyon's, negative over the carpal tunnel. Finkelstein is negative.

Left Wrist:

Tenderness was noted over the volar crease over the carpal tunnel and carpals.

Tinel's is noted over the carpal tunnel. Finkelstein is negative.

Ranges of motion of the bilateral wrists were normal **with discomfort at the extremes.**

Wrist Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	60	60	60
Extension	60	60	60

Ulnar Deviation	30	30	30
Radial Deviation	20	20	20

Fingers:

Finger ranges of motion were performed without pain. Triggering of the digits and mechanical block is not present. Tenderness is not present at the digits. Thumb abduction is 90 degrees bilaterally. Thumb adduction reaches the head of the 5th metacarpal bilaterally.

Bilateral hand digit ranges of motion were grossly within normal limits.

Grip Strength Testing:

Grip strength testing was performed utilizing the Jamar Dynamometer at the third notch, measured in kilograms, on 3 attempts and produced the following results:

Left: 2/4/2
Right: 10/14/12

Motor Testing of the Cervical Spine and Upper Extremities:

Deltoid *(C5)*, Biceps *(C5)*, Triceps *(C7)*, Wrist Extensor *(C6)*, Wrist Flexor *(C7)*, Finger Flexor *(C8)* and Finger Abduction *(T1)* motor testing is normal and 5/5 bilaterally **except for bilateral shoulders 4/5, left finger flexion 4/5, all other myotomes 5/5.**

Deep Tendon Reflex Testing of the Cervical Spine and Upper Extremities:

Biceps *(C5, C6)*, Brachioradial *(C5, C6)* and Triceps *(C6, C7)* deep tendon reflexes are normal and 2/2 bilaterally.

Sensory Testing:

C5 *(deltoid)*, C6 *(lateral forearm, thumb & index finger)*, C7 *(middle finger)*, C8 *(little finger & medial forearm)*, and T1 *(medial arm)* dermatomes are intact bilaterally as tested with a Whartenberg's pinwheel **with the exception of dysesthesia in the left hand median and ulnar distribution and dysesthesia in the right hand ulnar nerve distribution.**

Upper Extremity Measurements in Centimeters		
Measurements	Left	Right
Biceps	**28**	**28.5**
Forearms	**23**	**23**

Thoracic Spine:

Tenderness was noted over the paravertebral musculature at the region of T10 to T12 with hypomobility.

Kemp's test was positive bilaterally with increased thoracolumbar pain.

Thoracic spine ranges of motion were decreased and painful. Please see attached formal ranges of motion study performed utilizing dual electronic inclinometers.

Lumbar Spine:

Tenderness was noted over the bilateral paravertebral musculature with myospasming and L1 to L5 tenderness and hypomobility.

Milgram's test was unable to be performed due to back pain.

Straight Leg Raising Test performed supine was positive bilaterally for back pain with radiation of pain on the right to lower extremity below the knee.

Right: 55 degrees
Left: 65 degrees

Lumbar spine ranges of motion were decreased and painful. Please see attached formal ranges of motion study performed utilizing dual electronic inclinometers.

Hips & Thighs:

Deformity, dislocation, edema, swelling, erythema, scars and lacerations are not present upon visual examination of the hips and thighs.

Tenderness and spasm is not present over the greater trochanteric region, hip bursa, hip abductor, hip adductor, quadriceps, biceps femoris musculature and femoroacetabular joint bilaterally.

Patrick Fabere test and Hibb's test are negative bilaterally.

Hip ranges of motion were performed without pain and spasm.

Hip Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	120	120	120
Extension	30	30	30
Abduction	45	45	45
Adduction	30	30	30
External rotation	45	45	45

Internal rotation	45	45	45

Knees & Lower Legs:

Visual examination of knees and lower legs does not identify deformity, dislocation, edema, swelling, erythema, scars and lacerations.

Right Knee:

Tenderness is not present over the quadriceps tendon, patella, infrapatellar tendon, tibial tuberosity, medial joint line, lateral joint line and popliteal fossa bilaterally. Palpation of the lower leg muscles/regions was unremarkable for tenderness at the gastrocnemius, tibialis anterior *(dorsiflexion & inversion)* and peroneal musculature *(lateral ankle-eversion)* bilaterally.

McMurray's test and drawer test are unremarkable.

Left Knee:

Tenderness was noted over the medial joint and popliteal fossa.

Left McMurray's test was positive.

Range of motion of the right knee was within normal limit. **Range of motion of the left knee was decreased and painful, measured as follows:**

Knee Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	135	**90**	135
Extension	0	0	0

Ankles & Feet:

Examination of ankles and feet did not demonstrate gross deformity, dislocation, amputation, edema, swelling, erythema, scars, lacerations, hallux valgus and hammertoes. The foot arch height is normal and without pes planus and pes cavus.

Tenderness is not present of digits 1 through 5, including metatarsals, cuneiforms, navicular, cuboid, talus and calcaneus. Tenderness is not present at the distal tibia, distal fibula, talonavicular joint, anterior talofibular ligament and deltoid ligament. There is no medial ankle instability or lateral ankle instability bilaterally. The Achilles tendon is intact. Tenderness is not present over the tarsal tunnel, sinus tarsi and tibialis posterior tendons *(medial ankle-plantarflexion & inversion*) bilaterally.

Anterior drawer test, posterior drawer test and Tinel's sign are negative bilaterally. The dorsalis pedis pulses are present and equal bilaterally.

Ankle ranges of motion were performed without pain, spasm, weakness, crepitus or instability bilaterally.

Ankle Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Metatarsophalangeal joint (MPJ) Extension	60	60	60
MPJ Flexion	20	20	20
Ankle Dorsiflexion	20	20	20
Ankle Plantar Flexion	50	50	50
Inversion (Subtalar joint)	35	35	35
Eversion (Subtalar joint)	15	15	15

Motor, Gait & Coordination Testing of The Lumbar Spine and Lower Extremities:

Ankle Dorsiflexion *(L4)*, Great Toe Extension *(L5)*, Ankle Plantar Flexion *(L5/S1)*, Knee Extension *(L3, L4)*, Knee Flexion, Hip Abductor and Hip Adductor motor testing was normal and 5/5 **with the exception of left knee flexion and extension 4/5, all other myotomes 5/5.**

Squatting was difficult to perform due to back and left knee pain.

Heel and toe walking was difficult to perform due to back and left knee pain.

The patient's gait was antalgic and broad-based while favoring the right lower extremity as well as the left knee.

Deep Tendon Reflex Testing of The Lumbar Spine and Lower Extremities:

Ankle *(Achilles-S1)* and Knee *(Patellar Reflex-L4)* deep tendon reflexes are normal and 2/2.

Sensory Testing:

L3 *(anterior thigh)*, L4 *(medial leg, inner foot)*, L5 *(lateral leg and midfoot)* and S1 *(posterior leg and outer foot)* dermatomes are intact bilaterally upon testing with a pinwheel **with the exception of hypoesthesia in the left L5-S1 dermatomal innervation.**

Girth & Leg Length (Anterior Superior Iliac Spine to Medial Malleoli) measurements were taken of the lower extremities, as follows in centimeters:

Lower Extremity Measurements Circumferentially & Leg Length in Centimeters		
Measurements (in cm)	Left	Right
Thigh - 10 cm above patella with knee extended	**58**	**58.5**

Calf - at the thickest point	**36**	**36.5**
Leg Length - Anterior Superior Iliac Spine To Medial Malleolus	**103**	**103**

REVIEW OF RECORDS:

See Addendum #1

Diagnostic Impressions:

1. Cephalgia, G44.099.

2. Cervical spine myofasciitis, M79.1.

3. Cervical spine facet-induced versus discogenic pain, M53.82.

4. Thoracic spine myofasciitis, M79.1

5. Lumbar spine myofasciitis, M79.1.

6. Lumbar facet-induced versus discogenic pain. Straightening of the lumbar spine seen. Disc desiccation was noted at L4-5 and L5-S1 levels. Restricted range of motion in flexion and extension positions. Prominent ovarian follicular cyst measuring 4.5 x 4.4 cm seen on right side, follow up with ultrasound. At L2-3: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral: 2.9 mm; Flexion: 2.9 mm; Extension: 2.9 mm. At L3-4: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral 2.7 mm; Flexion: 2.7 mm; Extension: 2.7 mm. At L4-5: Focal central disc protrusion with annular tear effacing the thecal sac. Spinal canal was compromised. Disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L4 exiting nerve roots. Disc measurements: Neutral: 6.2 mm; Flexion: 6.2 mm; Extension: 6.2 mm. At L5-S1: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral: 3.0 mm; Flexion: 3.0 mm; Extension: 3.0 mm, as per MRI dated 7/28/2019, M47.816.

7. Lumbar disc protrusions, M51.26.

8. Bilateral shoulder tenosynovitis/bursitis, M57.21.

9. Bilateral shoulder impingement syndrome, M75.41.

10. Right shoulder rotator cuff tear. Low-grade partial-thickness tear at the articular surface of the supraspinatus tendon insertion as per MRI dated 3/31/2019, M75.101.

11. Bilateral elbow ulnar neuritis as per NCV/EMG study dated 2/27/2020, clinically significant radicular upper back pain with radicular upper extremities symptoms (pain, tingling, numbness and signs. Patient's right hand is dominant. The temperature or the patient's arms was > 32C. Impression: Abnormal neurodiagnostic study of bilateral upper extremities is consistent with: Mild left carpal tunnel syndrome involving the sensory fibers only. Bilateral demyelinating ulnar motor neuropathy across the elbows, G56.22.

12. Right wrist tunnel of guyon syndrome.

13. Double crush syndrome of Ulnar nerve at the Right Elbow and Right Wrist.

14. Left carpal tunnel syndrome, as per NCV study of 2/27/2020, G56. 02.

15. Left wrist mass/cyst and dequerain's tenosynovitis, per record # 26-32

16. Left knee internal derangement, rule out, M23.92.

17. Left knee ligament and meniscus injury, S83.26

18. Hypertension, I10.

19. Bronchitis, J40.

20. Sinusitis, J01.90.

21. Decreased vision, H54.7.

22. Anxiety and depression, F41.9, F34.1.

SUMMARY, CONCLUSIONS & RECOMMENDATIONS:

This patient has had multiple medical issues, and injuries. She will need to see medical specialists to evaluate her specifically for the Subsequent Injury Benefits Trust Fund as indicated below. Due to continued work duties while working for Kaiser through early 2020, her condition progressed. Due to favoring her right shoulder and right leg due to her work injuries, she has developed injuries to the neck, left shoulder and left knee pain and difficulty with activities of daily living. Her low back condition progressed and radiculopathy that was previously predominantly right sided, began to radiate to both legs. He developed tendonitis of thumbs of both hands of both hands as well as a mass/cyst at the left wrist. She developed bilateral ulnar neuropathy at the elbows and at the right wrist.

Record #26 from January 27, 2021 documents an injury at Kaiser on 1.24.19 to the **neck**, right shoulder and back.

Record #27 documents further the 1.24.19 work injury to the neck, right shoulder, low back with **left sided radiculopathy** as well as **left wrist cyst.**

Record # 28 documents additionally cervical radiculopathy and left dequervain's tenosynovitis of the thumb.

Record #29 documents additionally left elbow cubital tunnel syndrome.

Record #30-32 continue to document the 1.24.19 injury at Kaiser with surgical recommendations to the right shoulder, left wrist and extensor compartment (thumb) and left elbow.

The patient's condition has progressed beyond these records to now clinically involves the thoracic spine, ulnar nerve at the right elbow/wrist as well as the left knee due to activities of daily living and favoring her injured body parts. There has not been any new employment that could have contributed to her current condition nor any new accidents.

Please also note that she has had numbness tingling of both hands/wrists due to her work injury and this is confirmed diagnostically with electrodiagnostic testing showing left carpal tunnel and ulnar neuropathy at both elbows. Diagnostic Studies recommended to further evaluate nature and extent of injury:

- **X-rays: Yes – Cervical spine, left shoulder, left knee.**
- **MRI: Cervical spine, left shoulder and left knee.**

Specialty Medical Evaluations recommended to further evaluate nature and extent of injury:

- **Neurologist –** For further evaluation of headaches, sleeping issues and radicular as well as nerve issues.
- **Psychiatrist vs Psychologist** – For evaluation of psych sleep complaints.
- **Opthamologist vs Optometrist** – For Further evaluation of eye complaints.
- **Internist** – For further evaluation of respiratory and sinus issues, and hypertension.

AMA Impairment , 5th Edition Analysis, Causation, Pre and Post Subsequent Injury Apportionment, Maximum Medical Improvement, Work Restrictions and Discussions:

A. **Causation (Subsequent Injury):** As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation of cervical spine, thoracic spine, lumbar spine, both shoulders, both elbows, both wrists and hands,

and left knee is secondary to the subsequent injury dated CT: 01/03/2018 – 03/02/2020 as discussed within this report and summarized in the "discussion section." I reserve the right to change my opinions should additional medical records come forward.

Permanent & Stationary Status:

A) **Preexisting the subsequent work injury:** It is within reasonable medical probability this patient's preexisting condition**(s) as related to lumbar spine due to an accident in the 1990's** reached maximum medical improvement/permanent and stationary status a significant time to her employment with Kaiser and prior to the time of the subsequent injury dated CT: 01/03/2018 – 03/02/2020. I have not seen any evidence of a pre-existing labor disabling condition.

B) **Following the subsequent Work Injury:** It is within a reasonable medical probability this patient has reached maximum medical improvement as related to cervical spine, thoracic spine, lumbar spine, both shoulders, both elbows, both wrists and hands, and left knee and is permanent and stationary following the subsequent injury dated CT: 01/03/2018 – 03/02/2020. If this patient at some point decides to proceed with surgeries as recommended for her upper extremities, her impairment will have to be reassessed. It is within reasonable medical probability that the patient's subsequent injury is compensable and labor disabling with a permanent partial disability.

AMA IMPAIRMENT & APPORTIONMENT ANALYSIS

1. Spine: Cervical, Thoracic, Lumbar
2. Upper Extremities**:** Right Shoulder, Left Shoulder, both Wrists
3. Lower Extremities**:** Left Knee

Spine:

A. Cervical Spine:

Cervical Spine: Patient qualifies for **DRE** category II, 8% whole person impairment by referencing Table 15-5 on page 392 due to asymmetric loss range of motion.
Subsequent Injury – I apportion 100% to subsequent injury.

B. Thoracic Spine: Patient is qualifying for category II, 5% whole person impairment by referring table 15-4 on page 389 due to asymmetric loss of range of motion.
Subsequent Injury – I apportion 100% to subsequent injury.

C. Lumbar spine: Patient qualifying for range of motion method due to disc protrusions/HNP at L3 through S1 at three levels as confirmed by MRI.

1. Lumbar spine range of motion, 13% whole person impairment by referencing Tables 15-8 and 15-9 on page 407 and 409.

2. Specific disorder, 9% whole person impairment by referencing table 15-7 on page 404 and patient qualifying for category IIC, 7% due to degenerative condition at one level plus category IIF, 2% due to three additional levels.

3. Lumbar spine total, 21% whole person impairment by combining range of motion with specific disorders impairment.
   Subsequent Injury – I apportion 100% to Subsequent Injury.

UPPER EXTREMITY:

A. **Right Shoulder Muscle Function Deficit Impairment, 11**% upper extremity impairment by referencing tables 16.35 due to grade 4 & 20% strength deficit of flexion, abduction, internal/external rotation. This converts to 7% whole person impairment by referencing table 16.3 on page 439.
Subsequent Injury – I apportion 100% to subsequent injury.

B. **Left Shoulder range of motion,** 5% upper extremity impairment by referencing figure 16-40, 16-43 and 16-46 on pages 476-477 and 479. This converts to 3% whole person impairment.
Subsequent Injury – I apportion 100% to subsequent injury.

C. **Left Wrist/Hand**: Major grip strength impairment is 30% upper extremity impairment by referring tables 16-32 and 16-34 on page 509 due to 88% SLI; Table 16.3 converts to 18% whole person impairment.
Subsequent Injury – I apportion 100% to Subsequent Injury.

D. **Right Wrist/Hand**: Minor grip strength impairment is 20% upper extremity impairment by referring tables 16-32 and 16-34 on page 509 due to 34% SLI, which converts to 12% whole person impairment using Table 16.3 converts.
Subsequent Injury – I apportion 100% to Subsequent Injury.

LOWER EXTREMITY:

A. **Left knee**: Muscle function impairment is 24% lower extremity impairment by referring table 17-7 and 17-8 due to grade 4 strength deficit of knee flexion/extension, which converts to 10% whole person impairment by referencing table 17-3 on page 527.
Subsequent Injury – I apportion 100% to Subsequent Injury.

- Total Whole Person Impairment = 59%

Permanent Work Restrictions Currently:

Cervical Spine: No very heavy lifting. No prolonged posturing with head/neck.

Thoracic and Lumbar Spine: No lifting over 15 pounds, forceful pushing and pulling, squatting, kneeling, climbing. No repeated bending or twisting. No prolonged weightbearing. Sit predominantly and stand as needed to stretch based on pain levels. Wear a lumbar brace.

Bilateral Shoulders: No overhead work with both arms. No forcefull pulling/pushing. No lifting over 10 pounds.

Bilateral Elbow/Wrists: No repeated or forceful pushing, pulling, torquing and grasping. No prolonged writing, keyboarding, fine manipulation.

Left Knee: No walking over uneven ground. No squatting, kneeling, or climbing. Sit predominantly. Use a left knee brace.

Subjective Factors of Disability:

Please see current complaints section of this report.

Objective Factors of Disability:

Please see positive findings on physical exam, diagnostic studies reviewed under "review of diagnostic studies" section of this report.

Vocational Rehabilitation Benefits:

In my opinion, the patient is a qualified injured worker.

CONCLUSIONS:

1. The permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or age of the employee, exceeds the 35% threshold for Labor Code 4751.

REASONS FOR OPINIONS:

1. The consistency of the mechanism of injury with the patient's complaints and the consistency of the patient's description of injuries in relation to the submitted medical records.

2. Review of available medical records.

3. Perceived credibility of Ms. Darlene and her internally consistent statements and physical action.

4. My experience in treating similar patients and injuries over the past 20 years.

LC 4751 Compensation for specified additions to permanent partial disabilities

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

DISCLOSURE STATEMENT

I derived the above opinions from the oral history as related by the patient, revealed by the available medical records, diagnostic testing, credibility of the patient, examination findings and my clinical experience. This evaluation was carried out at 6221 Wilshire Boulevard, Suite 604, Los Angeles, California 90048. I prepared this report, including any and all impressions and conclusions described in the discussion.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628 (b)): I declare that the history was taken by Irma Chavira and I personally reviewed the history with the patient (essentially the history was taken twice), I performed the physical examination, reviewed the document and reached a conclusion. The names and qualifications of each person who performed any services in connection with the report are Acu Trans Solution, LLC, whoo transcribed this report and I proofread and edited the final draft prior to signing the report in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628 (j)): "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 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 compliance with recent Workers' Compensation legislation (Labor Code Section 5703 under AB 1300): "I have not violated Labor Code Section 139.3 and the contents of this report are true and correct to the best of my knowledge. This statement is made under penalty of perjury and is consistent with WCAB Rule 10978."

The undersigned further declares that the charges for this patient are in excess of the RVS and the OMFS codes due to high office and staff costs incurred to treat this patient, that the charges are the same for all patients of this office, and that they are reasonable and necessary in the circumstances. Additionally, a medical practice providing treatment to injured workers experiences extraordinary expenses in the form of mandated paperwork and collection expenses, including the necessity of appearances before the Workers' Compensation Appeals Board. This office does not accept the Official Medical Fee Schedule as prima facie evidence to support the reasonableness of charges. I am a board-certified Doctor of Chiropractic, a state-appointed Qualified Medical Evaluator, a Certified Industrial Injury Evaluator and certified in manipulation under anesthesia. Based on the level of services provided and overhead expenses for services contained within my geographical area, I bill in accordance with the provisions set forth in Labor Code Section 5307.1.

NOTE: The carrier/employer is requested to immediately comply with 8 CCR Section 9784 by overnight delivery service to minimize duplication of testing/treatment. This office considers "all medical information relating to the claim" to include all information that either has, will, or could reasonably be provided to a medical practitioner for elicitation of medical or medical-legal opinion as to the extent and compensability of injury, including any issues regarding AOE/COE - to include, but not be limited to, all treating, evaluation, and testing reports, notes, documents, all sub rosa films, tapes, videos, reports; employer-level investigation documentation including statements of individuals; prior injury documentation; etc. This is a continuing and ongoing request to immediately comply with 8 CCR Section 9784 by overnight delivery service should such information become available at any time in the future. Obviously, time is of the essence in providing evaluation and treatment. Delay in providing information can only result in an unnecessary increase of treatment and testing costs to the employer. I will assume the accuracy of any self-report of the examinee's employment activities, until and unless a formal Job Analysis or Description is provided. Should there be any concern as to the accuracy of the said employment information, please provide a Job Analysis/Description as soon as possible.

I request to be added to the Address List for Service of all Notices of Conferences, Mandatory Settlement Conferences and Hearings before the Workers' Compensation Appeals Board. I am advising the Workers' Compensation Appeals Board that I may not appear at hearings or Mandatory settlement Conferences for the case in chief. Therefore, in accordance with Procedures set forth in Policy and Procedural Manuel Index No. 6.610, effective February 1, 1995, I request that defendants, with full authority to resolve my lien, telephone my office and ask to speak with me.

The above report is for medicolegal assessment and is not to be construed as a report on a complete physical examination for general health purposes. Only those symptoms which I believe have been involved in the injury, or might relate to the injury, have been assessed. Regarding the general health of the patient, the patient has been advised to continue under the care of and/or to get a physical examination for general purposes with a personal physician.

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

Sincerely,

Eric E. Gofnung, D.C.
Manipulation Under Anesthesia Certified
State Appointed Qualified Medical Evaluator
Certified Industrial Injury Evaluator

Signed this 21 day of November 2022, in Los Angeles, California.

ADDENDUM 1 - REVIEW OF RECORDS

Pursuant to Cal Code Regs., Title 8, § 9793(n) the parties attested to 1268 pages being provided for my review, which have been received and reviewed by myself in preparation of this report.

A - Review of Legal Records

1) June 23, 2022, Attestation from Applicant Attorney Natalia Foley, Esq. attesting to 1268 pages being sent to Dr. Gofnung for his upcoming appointment on August, 08, 2022.

2) Demographics: DOI: CT: 01/03/18-01/04/19. Description of Injury: Stress and strain due to repetitive movement over period of time; injured lower back, right shoulder, legs, right hand, wrist. Body Parts Claimed: Lower back, right shoulder, legs, right hand, and wrist.

3) June 31, 2022, Cover Letter for SIBTF Medical Evaluation, Natalia Foley, Esq (Workers Defenders Law Group): DOI: CT: 01/03/18-01/04/19. This office represents the above referenced applicant. You (Dr. Gofnung) have been selected to act in the capacity of Medical Evaluator in regard to the applicant's Subsequent Injury Benefit Trust Fund Claim in your medical specialty. You are specifically asked to provide a medical legal evaluation in your area of expertise.

   Please provide a medical legal evaluation and address the issue of causation of any injury within your area specialty.

   Please provide your opinion if any other referral is necessary.

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

   1) Pre-existing condition
   2) Subsequent injury
   3) Current condition (post-industrial)

   Please cover in your report the following topics:

   •Subjective complaints
   •Objective factors or findings
   •Current diagnosis and impairment rating
   •Occupational history
   •Past medical history

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

Please answer the following questions within the scope of your specialty:

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

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

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

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

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

6) **IF YES**, please answer the following questions:

(a) Was that preexisting condition partially labor disabling and could have been rated as permanent partial disability ("PPD") at the time worker suffered the subsequent industrial injury?

(b) Was that preexisting condition aggravated during the time of the subsequent employment?

(c) Did worker have a subsequent injury within the scope of your specialty?

(d) Did the subsequent industrial injury result in additional PPD?

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

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

9) Did the subsequent industrial injury rate to a 35% disability without modification for age and occupation:
(a) within the scope of your specialty?
(b) within the multidisciplinary combined rating (if known)?

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

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

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

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

Rating Determination: When you rate pre-existing condition, please remember, that the prior labor disabling disability is not rated separately in the SIBTF case. SIBTF liability is not determined by rating the prior disability alone. The percentage of permanent disability from the prior disability is not a relevant factor in determining SIBTF eligibility [Subsequent Injuries Fund v. Industrial Acc. Com. (Harris) (1955) 44 Cal. 2d 604, 608, 20 Cal. Comp. Cases 114, 283 P.2d 1039]. Rather, the factors of disability or WPI from the prior disability are rated together with those from the subsequent industrial injury to produce the combined disability rating required by Labor Code section 4751.

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

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

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

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

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

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

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

•Whether the degree of disability from prior disability and subsequent injury combined is greater than that from subsequent injury alone,
and

•Whether subsequent compensable industrial injury resulting in additional permanent disability

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

If you need any additional testing, please advise so.

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

4) June 20, 2022, Attestation Pursuant to Cal Code Regs., Title 8, § 9793(n), Natalia Foley, Esq: I declare that the total page count of the documents provide to the physician is 1268.

B - Review of Diagnostic Records

1) May 17, 2018, X-Ray of Right Hip, Tina Hardley, MD, Kaiser Permanente: Impression: No acute fracture is identified. The alignment is normal. No significant soft tissue abnormality is identified.

2) November 29, 2018, US Kidney, Christopher J. Starr, MD, Kaiser Permanente: Impression: Cyst visualized in the left kidney. Otherwise normal exam.

3) November 30, 2018, Bilateral Screening Mammogram, Elisa M. Chen, MD, Kaiser Permanente: Impression: Benign. There is mammographic evidence of malignancy. A routine screening mammogram is recommended within 2 years.

4) March 31, 2019, MRI of the Right Shoulder, **illegible print**: Impression: 1) Low-grade partial-thickness tear at the articular surface of the supraspinatus tendon insertion.

5) April 30, 2019, X-Ray of the Lumbar Spine, **illegible print**: Impression: 1) Reduced intervertebral disc height was noted at L5-S1 level. 2) No other significant abnormality noted.

6) July 28, 2019, MRI of the Lumbar Spine, Amjad Safvi, MD: 1) Straightening of the lumbar spine seen. 2) Disc desiccation was noted at L4-5 and L5-S1 levels. 3) Restricted range of motion in flexion and extension positions. 4) Prominent ovarian follicular cyst measuring 4.5 x 4.4 cm seen on right side, follow up with ultrasound. 5) L2-3: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral: 2.9 mm; Flexion: 2.9 mm; Extension: 2.9 mm. 6) L3-4: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral 2.7 mm; Flexion: 2.7 mm; Extension: 2.7 mm. 7) L4-5: Focal central disc protrusion with annular tear effacing the thecal sac. Spinal canal was compromised. Disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L4 exiting nerve roots. Disc measurements: Neutral: 6.2 mm; Flexion: 6.2 mm; Extension: 6.2 mm. 7) L5-S1: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral: 3.0 mm; Flexion: 3.0 mm; Extension: 3.0 mm.

7) February 27, 2020, EMG/NCV and Somatosensory Evoked Potentials (SSEP) Report Upper Extremities, Benjamin Gross, MD: Clinical Summary: Clinically significant radicular upper back pain with radicular upper extremities symptoms (pain, tingling, numbness and signs. Patient's right hand is dominant. The temperature or the patient's arms was > 32C. Impression: Abnormal neurodiagnostic study of bilateral upper extremities is consistent with: Mild left carpal tunnel syndrome involving the sensory fibers only. Bilateral demyelinating ulnar motor neuropathy across the elbows.

8) February 27, 2020, EMG/NCV and Somatosensory Evoked Potentials (SSEP) Report Lower Extremities, Benjamin Gross, MD: Clinical Summary: Clinically significant radicular lower back pain with radicular lower extremity symptoms (pain, tingling,

numbness and signs. The temperature or the patient's legs was > 31 C. Impression: Abnormal neurodiagnostic study of bilateral lower extremities is consistent with: Mild axonal post. Tibial motor neuropathy affecting the left lower extremity probably from left L5 radiculopathy. Monopolar needle examination of the lower extremities muscles reveals evidence of the left anterior tibialis muscle showed moderately increased polyphasic potentials. The left vastus lateralis muscle showed slightly increased polyphasic potentials. 2) Bilateral sup. Peroneal axonal sensory neuropathy.

C - Review of All Other Records

1) June 29, 2017, Office Visit - Internal Medicine, Jin Hong, MD, Kaiser Permanente: Reason for Visit: Shoulder pain. HPI: The patient is a KP CNA here for followup chronic right shoulder pain. Seen by ortho; probably impingement syndrome. She had cortisone shot x 2. She reports symptoms worse with consecutive working days if > 4 days. Overall symptoms controlled with cortisone shot, Naproxen (as needed), and intermittent leave for exacerbation of symptoms. She quit smoking few months ago, but relapsed under stress from family issues. States dizziness side effect from Nictotine patch, "too strong" per patient. Assessment/Plan: 1) Right shoulder joint pain: Naproxen 500 mg. FMLA extended. Same frequency as before - two times per month, one day per exacerbation episode. 2) Hypertension: Stable, controlled: Continue Hyzaar. 3) Smoking cessation counselling: Prescribed Bupropion 150 mg.

2) December 18, 2017, Telephonic Appointment Visit, Daniel Edward Gavino, MD, Kaiser Permanente: Reason for Visit: URI symptoms. Assessment: Upper respiratory infection symptoms. Plan: Use cough suppressant of choice as needed; push fluids; rest, appl heat to sinuses for pain and followup as needed.

3) January 11, 2018, Followup Office Visit - Internal Medicine, Jin Hong, MD, Kaiser Permanente: Reason for Visit: Shoulder pain.

4) May 17, 2018, Followup Office Visit - Internal Medicine, Jin Hong, MD, Kaiser Permanente: Reason for Visit: Right foot pain (with radiation up to hip); constipation. Interim History: The patient complains of right hip pain, right buttock pain over the past few weeks. She states the pain radiates to her pelvic area. Abdomen symptoms worse with walking, and only partially relieved with Naproxen. Also complains of constipation with abdomen bloating. Allergy: Penicillins class and Keflex (Cephalexin). Assessment: 1) Sciatica, right side. Plan: Trial of Motrin 800 mg, and Tylenol #3 300-30 mg; x-ray of right hip. 2) Hypertension: Stable, controlled. Labs were ordered. 3) Female pelvic pain: Referred to ob-gyn. 4) Constipation: Prescribed Enulose 10 gm/15 mL.

5) June 08, 2018, Office Visit, John Keary Moran, MD, Kaiser Permanente: Chief Complaints: Pelvic pain, vaginal discharge. HPI: The patient complains of left lower quadrant abdominal discomfort x 1 month, off and on only in the early mornings. Also complains of some vaginal irritation, usual after working and may be from the toilet

tissue used at work. She is asymptomatic and when at home and not working. She desires STD testing to be sure. Impression: Left lower quadrant pain only in AM and relieved by BM **C/W (consistent with)** GI origin, BV, desires STD screening. Plan: Labs were ordered. Prescribed Flagyl 500 mg. Advised to followup with primary care for left lower quadrant, rule out GI origin. IBS (irritable bowel syndrome) discussed and info given in After Visit Summary. Also discussed healthy life style and health diet.

6) October 15, 2018, Allied Health/Nurse Visit, Michele Marie Bateman, RN, Kaiser Permanente: Reason for Visit: Forms; flu shot; urinary tract infection symptoms. Plan: Referred to Lisa Kerestedjian, MD for UTI symptoms.

7) October 15, 2018, Progress Notes, Lisa Kerestedjian, MD, Kaiser Permanente: Chief Complaint: Urinary tract infection symptoms x 1 week. Assessment/Plan: 1) Urinary tract infection: Prescribed Nitrofurantoin Monohydrate 100 mg. 2) Nicotine dependence: Discussed, urged to quit: Prescribed Polacrilex 4 mg. 3) Smoking cessation counselling. 4) Screening for colon cancer: Labs were ordered. Referral to GI for CRC screening. 5) Hypertension: Stable, advised low salt diet and encouraged aerobic exercise 20 min x 3/week and weight management. Continue current medications. 6) Overweight: Weight loss; low fat/carb/salt diet, and regular exercises. 7) Prediabetes: Stable, advised weight control; ADA diet and regular exercises.

8) November 15, 2018, Progress Notes, Claudia Adelina, RN, Kaiser Permanente: Reason for Request: Dr. Hong, patient reports having dry mouth, constipation, aches in body and bones x 2 weeks. Per patient she believes it was due to the Losartan BP medication that she picked up in September and was change in Manufacture and now giving her this side effect. She is aware she has been taking same medication for years but she is sure the manufacture was changes and giving her problems. Requesting to be changed back to old manufacturer. Spoke to pharmacist and explained PCP will have to evaluate her to make sure it is the medication giving issues and gave PCP speak to pharmacist directly and see what manufacture patient has been using and place special note to give it back to patient.

9) November 16, 2018, Followup Office Visit – Internal Medicine, Jin Hong, MD, Kaiser Permanente: Reason for Visit: Muscle cramps; mouth problems; work slip. Interim History: The patient complains of dry mouth, nocturnal leg cramp over the past two months. She believes symptoms due to side effect from HCTZ in her BP medications. She wants to know why this provider "changed" her medications two months ago. HC records reviewed with the patient, she has been on Losartan/HCTZ since 2012. She states medication appears different, and requests switching back to original manufacture. Also requests to check electrolytes. Assessment/Plan: 1) Hypertension: Side effect from Losartan/HCTZ, but patient has been on the same medication over the past 8 years. Discussed with patient in length regarding disease and treatment option. Ok to hold Hyzaar for now. Labs were ordered. 2) Right shoulder joint pain: Refilled Naproxen 500 mg.

10) November 19, 2018, Telephonic Visit (Message sent to the Office of Jin Hong, MD), Steven Funez, LVN, Kaiser Permanente: Per patient she has stopped taking the Losartan-Hydrochlorothiazide (Hyzaar) 50-12.5 mg; states this was causing her dry mouth and feeling "dry." Declined a TAV or office visit with any provider. Will keep a followup with her PCP for 11/30/18. In the meantime asking for a prescription till then. Currently her BP readings are 158/105 and 157/87.

11) November 29, 2018, Telephonic Appointment Visit – Internal Medicine, Jin Hong, MD/Maricela Reivera Bonilla, MA, Kaiser Permanente: Reason for Visit: Test results; left message to call. Call Documentation: The patient came in to her appointment with Dr. Hong; informed patient of persistent mild blood in urine. Will refer her to have kidney ultrasound and urology for further evaluation. Both ordered. Ultrasound and urology appointment scheduled for patient.

12) November 30, 2018, Followup Office Visit – Internal Medicine, Jin Hong, MD, Kaiser Permanente: Chief Complaint: Hypertension. BP: 130/80. Plan: Stable, controlled. Labs reviewed with patient. Continue Losartan now.

13) December 13, 2018, Office Visit, William Guangyau Chu, MD, Kaiser Permanente: Reason for Visit: Blood in urine. Assessment: Microscopic hematuria. Plan: Followup UCx results. Will complete upper tract work-up with Renal US as ordered. Followup for cytoscopy for lower tract work-up.

14) December 17, 2018, Office Visit - Urology, Allen Chang, MD, Kaiser Permanente: Reason for Visit: Consultation – micro hematuria, persistent and asymptomatic. Assessment: Asymptomatic microscopic hematuria. Plan: Her workup includes: 1) Upper tract imaging – 12/13/18 renal ultrasound with left renal cyst but no renal mass. 2) Cytoscopy – to be scheduled. 3) Urine culture – submitted 12/17/18. 4) Urine cytology – not indicated.

15) January 24, 2019, Primary Treating Physician's Initial Comprehensive Report, Edward Komberg, DC: DOI: CT: 01/03/18-01/04/19. HPI: Remained unchanged. Diagnoses: 1) Cervical musculoligamentous injury. 2) Cervical muscle spasm. 3) Rule out cervical disc. 4) Rule out cervical radiculitis versus radiculopathy. 5) Lumbar musculoligamentous injury. 6) Lumbar muscle spasm. Plan: Chiropractic treatment 2-3 x per week for 5 weeks. Physiotherapy/kinetic activities 2-3 x per week for 6 weeks. Home exercise program was recommended. Referred to Functional Capacity Evaluation and pain management. X-rays of cervical spine, lumbar spine, right shoulder, left wrist and right wrist were ordered. Followup in 4-6 weeks.

16) March 13, 2019, Primary Treating Physician's Initial Evaluation and Report, Harold Iseke, MD: DOI: CT: 01/03/2018-01/04/2019. WCAB No: ADJ11859979; ADJ11864576. Body Parts Claimed: 1) CT: 01/03/2018-07/2018/12/31/2018: Lower back (with radiating pain to the right hip and down the right leg), and right shoulders (with pain radiating to the right hip and right hand). 2) CT: 07/2018-12/31/2018: She is

also complaining of symptoms of stress, depression and anxiety. Job History: She worked at Kaiser Permanente from 02/25/2008 to present as a nurse assistant. She worked more than 40 hours per week. Her job duties included: vital signs, clean patients, assistant wheel patients, feed patients, providing patient care. Her job requirements included: sitting, walking, standing, squatting, bending, twisting, flexing, side-bending, extending the neck, reaching, pushing, pulling, typing, writing, grasping, gripping, working overhead and lifting of approximately up to 200 pounds. She states that she was not exposed to any toxic chemicals including cleaning supplies. She states that chemical odors do not occur at work. Current Work Status: She is still employed by Kaiser Permanente. History of Injury: She states that while employed with Kaiser Permanente as a nurse assistant, she sustained injuries on a cumulative trauma basis from 01/03/2018-01/04/2019. Additionally, she also states she developed stress, depression and anxiety from 07/01/2018-12/31/2018. She has been employed for this company for a period of 11 years. Her date of hire was in 2008. From 01/03/2018-01/04/2019, she started to experience pain in her neck, lower back with radiating pain to the right hip and down the right leg), and right shoulders (with pain radiating to the right wrist and right hand), which she attributed to constant lifting, carrying, standing and walking.

From 07/01/2018-12/31/2018, she states she developed stress, depression and anxiety, which she attributes it to work-overload and to the stressful conditions she worked under. She reported these symptoms to her manager who referred to the company clinic. There she was evaluated and was prescribed pain medication. During her treatment with the company clinic, she states x-rays were taken of her right shoulder and low back. Due to her symptoms, she was referred to another location for physical therapy where she had completed 6 sessions. She was also referred to acupuncture therapy but because she felt acupuncture therapy worsened her symptoms, she opted not to continue with this treatment. During this time, she states she was sent back to work with restrictions but was later released back to perform her customary and daily duties. Currently, she states she is still scheduled to receive more physical therapy sessions. She is still employed by Kaiser Permanente as a nurse assistant. Past Medical History: She has a history of high blood pressure. Medication: She is currently taking medication for high blood pressure. Surgery: She underwent a uterus removal in 2005 due tumor. She states she made full recovery. Hospitalization/Fractures: She was hospitalized in 2005 when she underwent the uterus removal. She was also hospitalized in 1983, 1985, 1986, and 1988 due to child birth. Previous Automobile Accidents: She was in an automobile accident in 1999 where she sustained injuries to her lower back. She states she received the proper medical care including physical therapy. She made full recovery. Social History: She states she smokes cigarettes and occasionally drinks alcoholic beverages. Family History: Her mother has a history of high BP. ROS: History of anxiety and constant headaches. ADLs: ADLs were reviewed.

Subjective Complaints: 1) Head: The patient complains of occasional occipital dull, achy headache. Reports exacerbation with activity. 2) Lumbar spine: She complains of frequent mild 2-3/10 achy low back pain with occasional radiating pain into right posterior thigh aggravated (up to 4-5/10) with repetitive movement, sitting, standing,

driving, bending, twisting and squatting. 3) Right shoulder: She complains of intermittent mild achy right shoulder pain, aggravated (4-5/10) with repetitive movement, lifting 10 pounds, pushing, pulling repetitively and overhead reaching. 4) Right wrist: She complains of activity-dependent 3-4/10 achy right wrist pain with tingling sensation into right hand associated with repetitive movement, grabbing/grasping, gripping and squeezing. 5) Sleep: There is complaint of loss of sleep due to pain. 6) She states that due to prolonged stress, she feels like his condition will never improve, which is causing stress. PE: Ht: 5'8." Wt: 181 lbs. BP: 148/96. Lumbar spine: There is tenderness to palpation of the bilateral sacroiliac joints, L3-S1 spinous processes, lumbar paravertebral muscles and spinous processes. There is muscle spasm of the lumbar paravertebral muscles. Kemp's is positive bilaterally. Right shoulder: There is tenderness to palpation of the lateral shoulder, posterior shoulder and trapezius. There is muscle spasm of the posterior shoulder and trapezius. Impingement is positive. Supraspinatus Press is positive. There is tenderness to palpation of the dorsal wrist, lateral wrist, medial wrist, thenar and volar wrist. There is muscle spasm of the thenar.

Diagnoses: 1) Headache. 2) Low back pain. 3) Spinal enthesopathy, lumbar region. 4) Impingement syndrome of right shoulder. 5) Pain in right shoulder. 6) Pain in right wrist. 7) Sleep disorder, unspecified. 8) Reaction to severe stress, and adjustment disorders. 9) Myositis, unspecified. 10) Chronic pain due to trauma. **Incomplete report/missing pages.**

17) June 19, 2019, Extracorporeal Shockwave Procedure Report, Harold Iseke, DC: Procedure #: 1. Diagnosis: Rotator cuff syndrome, right shoulder.

18) August 12, 2019, Doctor's First Report of Occupational Injury or Illness, Julie Goalwin, MD: DOI: CT: 07/01/18-12/31/18. **Illegible handwriting**. Diagnoses: 1) Depressive disorder. 2) Insomnia.

19) May 27, 2020, Doctor's First Report of Occupational Injury or Illness, Nelson J. Flores, PhD, QME: DOI: 01/01/2015-01/20/2020; 07/01/2018-12/31/2018; 07/01/2018-01/29/2020. Description of Injury: The patient reports that, while working for Kaiser Foundation Hospitals DBA Medical Center, she was exposed to work stress, work pressure, work overload, and incidents of harassment by her coworkers. With time, she developed pain in her arms, wrists, shoulders, back, and which she related to the heavy and repetitive nature of her work. As a result of her work exposure and persisting pain, she developed symptoms of anxiety, depression, and insomnia. Subjective Complaints: She reports feeling sad, helpless, hopeless, lonely, afraid, terrified, scared, angry, and irritable. She tends to socially isolate and withdraw from others. She experiences conflicts with others due to her irritable mood. She has lost confidence in herself and interest in her appearance. She lacks motivation. She has lost interest in her usual activities, as she no longer enjoys these activities as she once did. She experiences crying episodes. At times, she feels like crying. She feels much more sensitive and emotional than she once was. She has an increased appetite and estimates that she has gained approximately ten pounds. She has difficulty controlling her impulses. She reports sleep

difficulties due to her excessive worries and pain. She awakens throughout the night and early in the morning.

She maintains a low energy level and feels easily tired and fatigued throughout the day. She experiences distressing dreams, flashbacks, and intrusive recollections. She reports angry outbursts. She feels nervous, restless, agitated, and tense. She has difficulty concentrating and remembering things. She is fearful without cause and worries excessively. She worries about the possibility of future surgery. She is bothered by episodes of dizziness, muscle tension, numbness, tingling sensations, and wobbliness in her legs. She feels unable to relax. She fears the worst happening and losing control. She feels pessimistic and self-critical. She has a decreased sexual desire. She reports gastrointestinal disturbances, headaches, and hypertension. Her headaches are exacerbated and/or triggered when she feels under stress and as her mood worsens. Objective Findings: She presented with an anxious and sad mood, depressed affect, and memory difficulties. Psychological testing revealed significant depressive and anxious symptoms. Diagnoses: Axis I: 1) Major depressive disorder, single episode, mild. 2) Anxiety disorder not otherwise specified. 3) Insomnia related to generalized anxiety disorder and chronic pain. 4) Stress-related physiological response affecting headaches. Barriers of Recovery: Chronic sleep disturbances, persisting pain, and physical impairments. Plan: Cognitive behavioral group psychotherapy 1/week for 8 weeks. Hypnotherapy/relaxation training 1/week for 8 weeks. Medical evaluation to consider the use of psychotropic medication. Follow up in 45 days.

20) May 28, 2020, Psychological Testing Report (Via Telemedicine Services), Nelson J. Flores, PhD, QME: Summary and Discussion: The patient was administered a comprehensive battery of psychological tests to help in the diagnosis of possible emotional and psychological disturbances. She completed the battery of psychological tests in a cooperative manner. During the pretest and the testing sessions with me, her mood was anxious and sad. She showed no impairment in her production of speech or her thought process. She denied any perceptual disorder. The results of the psychological tests suggest that the patient is reporting moderate clinical levels of anxiety and moderate levels of depression. She was alert and there is no indication that the patient may be experiencing neuropsychological disturbances. On the Epworth Sleepiness Scale, there is an indication that the patient is experiencing higher normal daytime sleepiness. On the Insomnia Severity Index, there is an indication that the patient is experiencing moderate clinical insomnia.

21) July 16, 2020, Videoconference Deposition of Darlene Walls: This is a 49 page deposition. The proceedings lasted for 1 hour and 27 minutes. **Page 6-21** – Examination by Greg Brown, Defense Attorney (Russell Legal Group): She reported that she had spent approximately one hour regarding this deposition. The Deponent testified that she had consumed a pain pill in the last 24 hours of this deposition. This was prescribed by her primary care physician Dr. Hong, at Kaiser with her Kaiser Health Plan. She took this for her lower back and left wrist pain. She was also on high BP medications. She also testified that she takes ‘Napryn’ for her lower back, wrist and shoulder pains. These

were also prescribed by Dr. Hong. In addition, she reported taking Motrin 800 on an as needed basis and Vitamin tablets. When asked, "What do you take the vitamins for?" She replied, "Just a daily Vitamin." She reported that she was born in Los Angeles, California, and added that she was living at the 8407 Crenshaw Boulevard address for one year. She was living with her daughter, son in law and grandson. It was a rented one and her daughter and son-in-law were the primary responsible persons for the rent. She testified that she was married twice and divorced twice. First one started in 1992 and ended in 1999 and second one started in 2005 and ended 2008. She reported that in the first one she divorced him and the reason was unrecalled. In the second one he divorced her because of unreconcilable differences. She elaborated in simple terms it was basically due to the disagreement over finance. When asked, "He wanted spend more, or he thought you were spending too much money?" She replied, "Me spending too much." She also testified that she had lived in Bellfower address prior to her current address on Crenshaw for eight years. She reported that basically she was staying alone there, and added, "My son visited. My mom stayed a little bit." She also testified that she had four children aged, 31, 32, 35, 36. She reported that her highest qualification was a certificate program in early education from Harbor College. When asked, "Okay. So we've got the workers' comp claims that we're here for today. We have both your allegation of an orthopedic injury, which is accepted, for your back and your left wrist. Then we also have the psych, the hostile work environment, stress claim. Besides those two, have you ever had any other prior workers' comp claims?" She responded, "No"

Furthermore, she reported that the largest debt she owed was $15,000, and it was for a car. She reported that the car was repossessed, and added that she had repossessed two cars in total. She also reported that currently she had outstanding debts for which debt collectors were attempting to collect payment. When asked, "To the best of your knowledge, what are those debts? How much are they, and what's your status on them?" She replied, "It's a recurring of a car that I paid. It was 15,000, and I paid 7,000 on it. I'm fighting that." She testified that she had enrolled in a debt consolidation or credit counselling services, and the most recent was in December 2019. She added that it was related to a credit card debt of about $7,000. She was required to pay $89 every month for the credit card debt. Her current credit score was six eighty. In addition, she recalled that she was involved in a motor vehicle accident and testified, "Passenger on the freeway, and someone hit the side rear, left side rear." She was not able to recall exactly when it was happened but estimated that it was around ten years ago, prior to her employment with Kaiser. She reported sustaining low back injury and receiving physical therapy treatment. **Page 22-35**: When asked, "Now, I want to talk about your orthopedic injuries. Those are your stress, psych issues. So I understand that you've got pain in your lower back; is that correct?" and she replied yes added that she also got left wrist pain, right shoulder pain, and right leg pain. When asked, "And I'm asking you just in your own personal opinion. I'm not asking for a medical opinion. When you say 'right leg pain,' do you get pain that shoots into your leg from your lower back, or is it a different type of pain?" She replied, "From my right leg up to my back." Again when asked for clarification, "Because I'm just trying to figure out if the pain in your right leg

is because your leg hurts or it's because that's just a symptom of the lower back pain and it's just a shooting pain into your leg." She replied, "Lower back pain."

She reported experiencing pain bilaterally, right side worse than the left side. When asked, "So oftentimes with back injuries people feel more pain or more symptoms with increased activity. So you have a busy day going to the grocery store, you're on your feet a lot. Does doing those sort of things increase the symptoms you have with the back pain, or is it essentially constant no matter what's going on?" She relied, "Yes. I said it increased. Increases with activity." She specifically stated that her pain was much more aggravated with bending down, sitting too long, or walking too long. When asked, "So -- and please let me know if this is correct because I don't want to put words in your mouth because I'm trying to figure out the extent of the issue. So do you feel like you can do everything you could do before, but it's the, you know, I could bend down one time to pick up a shoe, but if I have to do it again, you know, it's that second time or third time that makes increased symptoms?" She replied, "No. It's -- no." She was not feeling like she could do everything she could before. She testified that she was not able to do mopping, dancing, carrying her grandbaby, and picking her up. When asked, "And in the last ten years, have you received medical treatment for your low back or left wrist or right shoulder anywhere but at Kaiser or in connection with this workers' compensation case?" She replied, "No." When asked, "Okay. I want to talk about your right shoulder. It looks like you've been having issues with the right shoulder since -- just a second -- 2015. Do you recall going and seeing somebody for problems with your right shoulder in 2015?" She replied yes and added that she had received right shoulder injection in the past as well as an MRI, which showed a small tear in her right shoulder. She also testified that she was taken off of work because of the right shoulder. When asked, "Is that some sort of modified duty?" She replied, "Yes. Like, I was granted two days a month to rest my shoulder, and I've never ever been off completely." She testified that she got the right shoulder injections in 2016. When asked, "And in 2016, do you recall, did the doctor tell you the cause of your right shoulder issues? Did he say it was related to work, it was related to something else?"

She replied, "Work, repetitive use." She testified that she had seen Dr. Flores in connection with her workers' compensation case, and had received psyche treatment including some testing. When asked, "When was the first time in your life you ever saw somebody for mental health treatment or mental health issues?" She replied that it was probably in 2008 and it was with a provider though Kaiser. She added that at that time she received therapy related to her marital issues. She denied seeking psychiatric care though anyone else prior to that. In addition, she reported that she had also received treatment for her job stress issues through Kaiser in 2016. When asked, "So I see a note from 2011. And it looks like you went to an urgent care. And some of the notes - - and again, I'm not saying that this is accurate. I'm just bringing this up to see if this refreshes your recollection. Has pending court case as a witness in armed assault; poor sleep; toss and turning; feels job stress; finance issues. Has been ongoing for two months, blood pressure up. Recently under stress. Do you recall going to see urgent care about that issue in 2011?" She replied, "Oh, yes. That was – yes." She recalled being a witness to

some sort of armed assault where she had to testify. When asked, "Just so – I'm looking at the records too. I also see a visit in October of 2012 about a week before Halloween. Complains of stress at work. Excessive workload. Given days off. Has been followed by psych. Has returned to full duty. Do you recall that?" She replied yes and added that she was not working currently and the last time that she worked was on February 13th of this year. She added that she was taken off work by her lawyer's doctor, Dr. Iseke. She reported that she was currently receiving benefits from the EDD. She was receiving a check of $1598 every two weeks. She reported that she was working as a CNA nurse attendant in the Med-surg tele department of Kaiser. She had been working for them for 14 years and her position was the CNA nurse attendant in her entire career.

When asked, "Have you been a CNA in the same department, or have you bounced around different departments?" She replied, "I've bounced around." She reported that she was in the Med-surg department for seven years. She reported receiving corrective actions during that 7-years period and testified that the most recent one was in 2017 (it was a level 1 corrective action for attendance). When asked, "Just so we're on the same page, the correction action notice is a write-up by Kaiser, and there's levels of severity from a 1, you know, do better, but it's probably not that big of a deal, to a 5, which is a termination. So level 1 is the lowest level on the corrective action notice scale; is that correct?" She replied, "Prior to 2000 -- I think it was '9 or '10, it was a higher level." She confirmed that in the last ten years, the highest level she had been on was a level 1, and it was just related to attendance issues. When asked, "So in your department, did you have any interpersonal problems with anybody that -- you know, if I was to go interview people in the department, ask about you or you've got some sort of personal belief that somebody would make stuff up about you or lie about you because of a personal problem?" She responded that she has had problem with two of her coworkers, Michelle Lamberg and Siony (last name unrecalled). When asked, "Okay. So what was the issue between Michelle and you? **Page 36-49**: She replied, "Just harassment. Talking to me in a way, professional way as being my lead, like, 'You chew gum like a cow.' Just harassing me all the time. 'I expect you to be on the floor at 7:15,' but I hold the elevator for her to come in. Just there was a lot of back and forth." Again when asked to describe the issue with Siony, the Deponent testified, "Yeah. She would, like, demand me or holler at me, call me stupid on different occasions." When asked, "Darlene, so what happened in February that made your orthopedic injuries come to a head such that you were taken off work? Did the pain start getting worse? Did the job duties change? Why February? I'm just trying to understand."

She replied that the pain started getting worse and added that she felt like she wasn't getting appropriate treatment with Kaiser On the Job. When asked why she felt that the treatment was not appropriate, she replied, "It was just a short therapy, light duty for three 4 weeks. And then it's, like, release you back to work." When asked, "So I saw something in Dr. Flores's report that talked about an increased workload. Did your -- you know, the workload change at all in January and February of 2020?" She replied, "Yes. Because we have more stroke patients, and there are heavy patients." She was also asked, "So in your own mind -- and I'm just asking for you. I'm not trying to get a

medical opinion -- was it more the orthopedic that made you go off work, or was it the stress that made you go off work in February of this year?" She replied "Both," and added that "One more than the other, the ortho." She confirmed that the increased physical demands of work and the pain that increased at that time was what caused her stress. When asked, "So here's the part where I usually ask you about, like, what sort of stuff do you go out and do for fun, but with Covid nobody's going out and having any fun. Before Covid what sort of - - you know, outside of work, what sort of physical activities would you do?" She reported that she go dancing, shoot pool, and gatherings with her family. When asked, "I was having employees, managers, watching every move I make. When I took a break, they had the employees write the time down. They watched me go down the hallway, watch me come back. Saying to me, because I was on light duty, just keep your eye on the monitor, because I was doing -- monitoring the cameras." In addition, reported that she has had a surgical history of partial hysterectomy. She also testified that her son was convicted due to gang banding and was currently in prison. When asked, "And when you say 'gang banging,' is that an armed assault? murder? armed robbery? What sort of - -" She replied, "Assault, I guess." She added that his prison term was 14 years and he would be out in 14 years. She reported that she has had abortion more than once but denied any current psyche issues related to that.

22) September 16, 2020, Panel QME in the Specialty of Orthopedic Surgery, Narendra G. Gurbani, MD: DOI: CT: 01/03/2018-01/04/2019; CT: 07/01/2018-12/31/2018. Identifying Data: The patient is evaluated today pursuant to a continuous trauma injury to the right shoulder, left wrist and lower back from January 03, 2018 through January 04, 2019 during the course of her employment as a CNA for Kaiser Foundation Hospitals. Employment History: At the time of injury, the patient was employed as a certified nurse assistance at Kaiser Foundation Hospital, Downey from 2008 to the present time. Her typical work schedule was from 7 a.m. to 3: 45 p.m., 5 days per week. Overtime was frequent and approximately 12 hours/week. Her usual duties included caring for stroke patients, taking vital signs, performing EKGs, assisting patients with toileting, and frequent repositioning patients in their beds. Her job duties included prolonged standing and walking, frequent bending, stooping, kneeling, squatting, twisting, turning, lifting, carrying, pushing, pulling, transferring patients from bed to wheelchair with assistance, and continuous fine and firm maneuvering of her hands and fingers, forceful gripping and grasping, and reaching to all levels. She was required to lift and carry items weighing up to approximately 100 pounds. She was not exposed to chemicals, noise, fumes, smoke, mold, or dust. History and Treatment of Continuous Trauma: Examinee stated that during the course of her employment with Kaiser Foundation Hospitals, she gradually developed pain in her right shoulder, low back and left wrist due to continuous and repetitive physical activities associated with her job duties as a CNA. Examinee first experienced symptoms in 2016, at which time she began to experience pain in her right shoulder. She attributed her right shoulder pain to repetitively repositioning patients in bed and assisting patients to the bathroom. She reported her symptoms to her supervisor, Michelle Limbert, and was referred for medical care.

The patient began care under Dr. Jin Hong, her Primary Care Physician. She was evaluated, referred for a course of physical therapy, and referred to Kaiser Occupational Medicine (name of the doctor not recalled). She saw an orthopaedic doctor through Occupational Medicine who administered two cortisone injections in the right shoulder, which provided approximately 2 months of relief. She stated that she was provided with work restrictions which allowed her to miss 2 days of work per month for her right shoulder injury. She remained symptomatic with ongoing pain in her right shoulder. She was then discharged and allowed full duty. In 2017, she began to experience pain in her lower back. She attributed her low back symptoms to repetitive heavy lifting, repositioning patients in bed, and assisting patients to the bathroom. She reported her symptoms to her supervisor, Danny Jameny, and was sent back to Dr. Hong for medical treatment. She was referred for a course of physical therapy but saw no significant improvement in her condition. She received no further treatment or care for the low back at Kaiser. She continued working her usual and customary duties after 2 weeks of light duty. In July of 2019, imaging studies of the right shoulder were obtained and allegedly demonstrated a rotator cuff tear. Dr. Hong referred her for an additional 12 sessions of physical therapy for the right shoulder, which provided no significant benefits. In 2019, she began to experience pain in her left wrist, which gradually worsened. She attributed her pain to repetitive heavy lifting, repositioning patients in bed, and assisting patients to the bathroom. She reported the injury to her employer and began treating with Dr. Hong. Dr. Hong referred her to an orthopaedic specialist (name unrecalled). X-rays of the left wrist allegedly demonstrated abnormalities. The orthopaedic specialist provided her with a left wrist brace. She received no further care or treatment for the left wrist at Kaiser. In approximately mid-2019, she began treating with Dr. Isaac at Well Health Clinic for the low back, left wrist, and right shoulder.

There, she was provided with electric shock therapy, acupuncture, chiropractic treatment, and additional physical therapy. She saw significant improvement in her right shoulder pain; however, she continued to have low back and left wrist pain. In early 2020, she began traction therapy for her lower back; however, due to Covid-19 precautions, she was unable to continue her therapy. On June 08, 2020, imaging studies were obtained of the left wrist, right shoulder, and lower back. She stated that the imaging studies demonstrated abnormalities. She has since continued conservative treatment, including acupuncture for the left wrist. She was mostly recently referred to an orthopaedic specialist and is currently awaiting approval. She felt 70% improvement in her right shoulder with the above treatment. She had 0% improvement in her lower back with the above treatment. Her left wrist has worsened despite treatment. History of Current Treatment per the Patient: She is currently being treated by Dr. Isaac at Well Health Clinic. She is awaiting approval to be evaluated by an orthopaedic specialist. Current Medications: Losartan 25 mg; Tylenol with codeine; multivitamin; Motrin 800 mg; Naprosyn 500 mg. Allergies/Reactions: Keflex. History of Disability Status: She has been off work completely from February 14, 2020 up to the present time. She was placed on modified duty from 2016 through February 2020. Current Complaints: 1) Right shoulder: She complains of intermittent pain in her right shoulder, with pain radiating to

her right arm. Her shoulder pain is present 50% of the time. She has numbness and tingling in her forearm and hand. She rates her pain 2-5/10. Her pain increases with reaching and lifting her upper extremity above shoulder level. Her pain level becomes worse at night. Ice or medications help to alleviate the pain. 2) Left wrist/hand: She complains of continuous left wrist/hand pain, with pain radiating to her hand. Her wrist/hand pain was present 100% of the time.

She has numbness and tingling in her wrist, hand and fingers. She has cramping and weakness in her left hands and has dropped several objects. She rates her pain at 4-5/10. Her pain increases with gripping, grasping, repetitive hand and finger movements. Her pain level becomes worse at the night. Medications help to alleviate the pain. 3) Lumbar spine: She complains of intermittent pain in the lower back, with pain radiating to her right leg. Her low back pain is present 50% of the time. She has numbness and tingling in her right leg to the calf. She rates her pain at 2-5/10. She states coughing aggravates her lower back. Her pain increases with prolonged standing, walking, and sitting activities. She is unable to sit for more than 3 hours or stand for more than 4-5 hours before her pain symptoms increase. She has difficulty driving for a prolonged period of time. She also has difficulty sleeping and awakens with pain and discomfort. Her pain level becomes worse in the morning. Medications help to alleviate the pain. 4) Other Problems: She has claimed development of depression and insomnia as a result of this injury. She has not received treatment. It has to be noted that these problems are out of the scope of this examiner's orthopedic practice and need to be managed by the patient's Primary Treating Physician if applicable. Activities of Daily Living: Activities of Daily Living were reviewed. Prior Employment History: In the past 10 years, the patient has been employed in the following jobs prior to the job where the current injury occurred. She was employed as a CNA at Mediscan agency in Woodland Hills from 2006 to 2008. Her typical work schedule was part-time, 32 hours per week at different hospitals. She cared for patients, took vital signs, performed testing, assisted with toileting, and repositioned patients in bed. She was required to walk and stand for the majority of her shift.

The heaviest object the examinee was required to lift was up to 100 lbs Her job duties included prolonged standing and walking, frequent bending, stooping, kneeling, squatting, twisting, turning, lifting, carrying, pushing, pulling, continuous fine and firm maneuvering of her hands and fingers, forceful gripping and grasping, and reaching to all levels. Prior to working for Mediscan, the examinee was employed as a maintenance worker for Carson City Hall for approximately 2 years. Her typical work schedule was part-time, 32 hours per week. She cleaned restrooms, mopped floors, scrubbed counters, refilled supplies, and took out the trash. Her job duties included prolonged standing and walking, frequent bending, stooping, kneeling, squatting, twisting, turning, lifting, carrying, pushing, pulling, continuous fine and firm maneuvering of her hands and fingers, forceful gripping and grasping, and reaching to all levels. Heaviest object examinee was required to lift was up to 50 lbs. Prior Non-Work Related Injuries: More than 5 years ago, she sustained a sprained left ankle after tripping while wearing high heels. She received conservative treatment and was placed in a brace for several weeks.

Subsequently, she made full recovery. More than 20 years prior, she was involved in a motor vehicle accident. She stated that the vehicle was side-swiped on the left side; she was the passenger in the vehicle. She experienced minor low back pain following the accident and underwent a course of physical therapy. Subsequently, she made a full recovery and denied any continued symptoms. Past Medical History: She provided a positive past history of depression and high blood pressure. History of Medical Illnesses in Past Six Months: She has experienced frequent constipation and swelling in the wrist joint. PSH: She underwent a partial hysterectomy approximately 16 years ago.

Social History: She is single and has 4 children. She smokes 3 packs of cigarettes per week. She drinks alcoholic beverages 4 times per week. Before injury, she bowled and danced. She exercised 4 days per week. Family History: There is a positive history of diabetes in her paternal aunt. There is a positive history of high blood pressure in her paternal uncle. Vitals: Ht: 5 ft, 7 inches. Wt: 173 lbs. Review of Records: Dr. Gurbani reviewed the patient's medical/nonmedical records dated from 01/24/19 to 08/10/20. Diagnostic Studies: 1) MRI of the right shoulder dated revealed March 31, 2019: a) Low-grade partial-thickness tear at the articular surface of the supraspinatus tendon insertion. 2) X-Ray of the lumbar spine dated April 30, 2019 revealed: a) Reduced intervertebral disc height was noted at L5-S1 level. b) No other significant abnormality noted. 3) MRI of the lumbar spine dated July 28, 2019 revealed: a) Straightening of the lumbar spine seen. b) Disc desiccation was noted at L4-5 and L5-S1 levels. c) Restricted range of motion in flexion and extension positions. d) Prominent ovarian follicular cyst measuring 4.5 x 4.4 cm seen on right side, follow up with ultrasound. e) L2-3: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral: 2.9 mm; Flexion: 2.9 mm; Extension: 2.9 mm. f) L3-4: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral 2.7 mm; Flexion: 2.7 mm; Extension: 2.7 mm. g) L4-5: Focal central disc protrusion with annular tear effacing the thecal sac. Spinal canal was compromised. Disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L4 exiting nerve roots. Disc measurements: Neutral: 6.2 mm; Flexion: 6.2 mm; Extension: 6.2 mm.

h) L5-S1: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral: 3.0 mm; Flexion: 3.0 mm; Extension: 3.0 mm. 4) Electromyogram and Nerve Conduction Velocity Report February 27, 2020 revealed: Abnormal neurodiagnostic study of bilateral upper extremities was consistent with: a) Mild left carpal tunnel syndrome involving the sensory fibers only. b) Bilateral demyelinating ulnar motor neuropathy across the elbows. Diagnoses: 1) Partial-thickness tear supraspinatus tendon insertion of the right shoulder. 2) Mild Left carpal tunnel syndrome. 3) Degenerative arthritis of the lumbar spine with L4-L5 disc protrusion with annular tear, spinal canal compromise and foraminal narrowing. Summary of Issues and Discussion: The patient is certified nurse assistant who while working at Kaiser Foundation Hospital in Downey has claimed a cumulative trauma injury to her right shoulder, left wrist and lower back from January 23, 2018 to January

04, 2019. The patient has been employed as a certified nurse assistant at Kaiser Foundation Hospital in Downey for 12 years, from 2008 to 2020. Her work involved moderate physical activities. She had the gradual onset of symptoms without any specific injury in 2016 to 2019 for various body parts as described above. She did report these symptoms to her primary care physician, who eventually referred her to the occupational medicine department at Kaiser and she obtained orthopaedic consultations. She has been appropriately treated with non-surgical management as well as diagnostic tests. Prior to working for Kaiser, she was employed as a CNA at Mediscan agency in Woodland Hills from 2006 to 2008. Her typical work schedule was part time, for 32 hours per week at different hospitals. Her job duties were similar as current employment at Kaiser. Prior to working for Mediscan, she was employed as a maintenance worker for Carson City Hall for approximately 2 years. Her typical work schedule was part-time, 32 hours per week. She cleaned restrooms, mopped floors, scrubbed counters, refilled supplies, and took out the trash.

Her job duties included prolonged standing and walking, frequent bending, stooping, kneeling, squatting, twisting, turning, lifting, carrying, pushing, pulling, continuous fine and firm maneuvering of her hands and fingers, forceful gripping and grasping, and reaching to all levels. This examiner opined that, both prior employments have contributed to cumulative trauma to right shoulder, left wrist, and lumbar spine. He also opined that the patient has preexisting degenerative condition of the lumbar spine as described in radiological findings, which has contributed to her lower back symptoms. When she was not satisfied with the management by Kaiser physicians, including the occupational medicine department, she sought an attorney consultation who referred her to a chiropractor, Dr. Harold Iseke, D.C. in February of 2018. Dr. Iseke has been treating her without any surgical intervention. He had also been sending her back to full-time duty; however, due to her continuation of symptoms of the left wrist, he took her completely off work since February 14, 2020. So far, she has been managed by chiropractic treatment only and has not been evaluated by any orthopedic surgeon for her musculoskeletal injuries. According to the patient, she has exhausted all physical therapy sessions for the lower back, left wrist and right shoulder. She has also received acupuncture treatment for the left wrist without resolution of symptoms. As per Dr. Iseke, she has a pending left wrist appointment for an orthopaedic evaluation. She has persistent symptoms and positive radiographical findings in right shoulder and lower back as described above in Diagnostic Studies section. In this examiner's opinion, the patient will benefit from consultations by orthopedic surgeons specialized in shoulder and lower back to relieve the effects of cumulative trauma from her industrial injuries.

Causation: With regard to the right shoulder, left wrist, and lumbar spine, the patient provides a plausible mechanism of injury that is further corroborated by the limited chiropractic medical reports available for review and is commensurate with the diagnoses listed above. Corresponding symptoms are documented in the medical records with appropriate progression and response to the treatment rendered to date. There is no evidence of concurrent employment or engagement in recreational activities that may be implicated in the above injuries. However, there is radiographical MRI evidence of

preexisting degenerative condition of lumbar spine. Therefore, with regard to right shoulder and left wrist, based on the history of injury provided by the examinee, physical examination conducted by me, the review of available medical records, review of reports of radiological imaging studies and given the preponderance of the evidence, it is fair to state with reasonable medical probability that the cumulative injury to the right shoulder, and left wrist sustained by the patient, which resulted in disability and a need for medical treatment arose out of employment and during the course of employment at Kaiser Permanente Medical Center Downey, Mediscan Agency Woodland Hills, and Carson City Hall. With regard to lumbar spine, it is fair to state with reasonable medical probability that the cumulative injury to the lumbar spine sustained by the examinee, which resulted in disability and a need for medical treatment was an aggravation of preexisting condition and this aggravation arose out of employment and during the course of employment at Kaiser Permanente Medical Center Downey, Mediscan Agency Woodland Hills, and Carson City Hall.

Permanent and Stationary Status: With regard to right shoulder, left wrist, and lumbar spine, it is this examiner's opinion that all periods of temporary partial and/or total disability noted in the medical records were appropriate for and commensurate with the examinee's injuries. She has received appropriate diagnostic tests and medical management so far since the injury; however, she has not reached permanent and stationary status because maximum medical improvement has not been achieved. Symptoms have not reached a plateau and the examinee will benefit from consultations from appropriate specialty orthopaedic surgeons and further medical and or possible surgical treatment to cure or relieve the effects of the industrial injury. Permanent Impairment and Apportionment: Permanent Impairment and apportionment will be appropriate when the patient has achieved maximum medical improvement and reached permanent and stationary status. Current work status is deferred to primary treating physician. Further Medical Care: With regard to the left wrist, she should wear a wrist brace and utilize over the counter anti-inflammatory medications. Surgical intervention is not warranted in near future. With regard to right shoulder and lower back, the patient should continue to engage in a home exercise program including range of motion, strengthening, and use of heating packs to alleviate muscle spasm. Over the counter medication may be utilized for pain. The patient should be evaluated by orthopedic surgeons specialized in shoulder and lower back and consultation reports be provided to this evaluator.

23) September 23, 2020, Primary Treating Physician's Permanent and Stationary Report, Harold Iseke, DC: DOI: CT: 01/03/18-01/04/19. HPI: Remained unchanged. Interim History: The patient was referred to Dr. Iseke's office for evaluation and treatment. She has had 19 chiropractic visits to date and 4 acupuncture sessions to date. Total number of treatments included 23. Having completed the regimen of treatment, she has reached maximum medical improvement and is ready for permanent and stationary considerations. Current Status: She has reached maximal medical improvement and is released from care. Present Complaints: 1) Head: She complains of frequent dull left-sided headache radiating to the low back and right leg. Reports exacerbation with stress.

2) Lumbar spine (4/10): She complains of frequent moderate sharp low back pain and stiffness radiating to right leg, associated with lifting 10 pounds, standing, bending, kneeling, twisting and squatting. 3) Right shoulder (4/10): She complains of frequent moderate sharp right shoulder pain and stiffness radiating to right arm with tingling, associated with lifting 10 pounds, grabbing/grasping, gripping, pushing, pulling repetitively and overhead reaching. 4) Right wrist (2-3/10): She complains of intermittent mild achy right wrist pain, stiffness, with occasional numbness and tingling into right hand associated with lifting 10 pounds, grabbing/ grasping, gripping, squeezing, pushing and pulling repetitively. 5) Left wrist: She complains of constant moderate achy left wrist pain, stiffness, numbness and tingling becoming sharp severe pain with lifting 10 pounds, reaching, grabbing/grasping, gripping, squeezing, pushing, pulling repetitively and turning.

6) Sleep: The patient complains of loss of sleep due to pain. 7) Psychological: She states that due to pain, she is experiencing anxiety and stress. ADLs: ADLs were reviewed. PE: Wt: 177 lbs. BP: 149/100. Lumbar spine: There is tenderness to palpation of the bilateral sacroiliac joints, L3-S1 spinous processes, lumbar paravertebral muscles and spinous processes. There is muscle spasm of the lumbar paravertebral muscles. Right shoulder: Noted mildly restricted and painful ROM. There is tenderness to palpation of the lateral shoulder, posterior shoulder and trapezius. There is muscle spasm of the posterior shoulder and trapezius. Right wrist: Noted full ROM but with pain. There is tenderness to palpation of the dorsal wrist, lateral wrist, medial wrist, thenar and volar wrist. There is muscle spasm of the thenar. Left wrist: There is tenderness to palpation of the dorsal wrist, lateral wrist, medial wrist and volar wrist. There is muscle spasm of the forearm, hypothenar and thenar. Neurological Examination/Gait: Functional Testing: Standing on heels: Increased low back pain. Standing on toes: Increased low back pain. Standing on the right foot: Increased low back pain. Standing on the left foot: Increased low back pain. Kneeling: Increased low back pain. Squatting: Increased low back pain. Diagnoses: 1) Headache. 2) Low back pain. 3) Spinal enthesopathy, lumbar region. 4) Impingement syndrome of right shoulder. 5) Pain in right shoulder. 6) Incomplete rotator-cuff tear/rupture of shoulder, not trauma. 7) Pain in right wrist. 8) Lesion of ulnar nerve, right upper limb. 9) Unspecified mononeuropathy of left upper limb. 10) Pain in left wrist. 11) Ganglion, left wrist. 12) Lesion of ulnar nerve, left upper limb. 13) Sleep disorder, unspecified. 14) Major depressive disorder, single episode, unspecified. 15) Anxiety disorder. 16) Reaction to severe stress, and adjustment disorders. 17) Myositis, unspecified. 18) Chronic pain due to trauma.

Discussion: The patient claims work-related injury that she sustained from 01/03/2018-01/04/2019 while performing her usual and customary job duties at Kaiser Permanente as a nurse assistant. She stated that while performing her usual and customary work duties on the above noted date she injured her lumbar spine, right shoulder, right wrist and left wrist. Impairment Rating: Lumbar spine: 13% WPI. Right shoulder: 1% WPI. Left wrist (carpal tunnel syndrome): 2% WPI. Causation: The patient's current symptomatology is a result of the work-related injury that occurred from 01/03/2018-01/04/2019, during the course of her employment for Kaiser Permanente.

Apportionment: Wight regards to the right shoulder and left carpal tunnel, 100% of the disability is apportioned to the continuous trauma injury from 01/03/2018-01/04/2019, during the course of her employment for Kaiser Permanente. With regards to the lumbar spine, I would apportion 10% of the disability to pre-existing degenerative changes and 90% to the continuous trauma 01/03/2018-01/04/2019. Work Restrictions: She is precluded from lifting over 15 pounds. No repetitive bending and stooping. No repetitive or forceful pushing and pulling and no overhead work or overhead reaching with the right arm. Future Medical Care: She should have access to chiropractic and acupuncture treatment during the periods of exacerbation as well as access to pain management for possible epidural steroid injections to the lumbar spine and corticosteroid injection the right shoulder and left carpal tunnel. If no better, then she should have access to orthopedist for possible surgical considerations. She should also have access to psych for anxiety and depression.

24) September 23, 2020, Chiropractic/Acupuncture Treatment Summary, Harold Iseke, DC: DOI: CT: 01/03/2018-01/04/2019. The patient attended 19 chiropractic and 4 acupuncture sessions from 03/13/19 to 09/23/20.

25) October 08, 2020, PQME in Psychology Specialty, Christopher Simonet, PhD: DOI: CT: 07/01/18-12/31/18 (psyche); CT: 01/03/19-01/04/19 (ortho). Review of Records: Dr. Simonet reviewed the patient's medical/nonmedical records dated from 04/23/08 to 02/12/20.

Conclusions:

1) Detailed description of the reasonable medical evidence that exists to support the opinions expressed in these conclusions is predominantly covered in the "Discussion" section of this evaluation.

2) The patient is diagnosed with the following DSM-IV-TR psychiatric disorders:

Adjustment disorder with mixed anxiety and depressed mood, chronic

3) The patient is assigned a GAF of 67, which translates to a WPI of 5.

4) Based upon the reasonable medical evidence, with respect to causation, this examiner has determined that 60% of the cause of the condition noted above, at the time of onset, is related to supervisor interactions regarding workload conflicts and work expectations. This examiner considers this portion personnel action, as this was in relation to a direct supervisor, Michelle Lambert, who ultimately filed multiple disciplinary citations in the patient's personnel record. An additional 20% causation is attributable to generalized work stress stemming from a perceived hostile work environment. Lastly, 20% of the causation at onset was related to financial distress, which was pre-existing and nonindustrial to the work-related complaint. Although this examiner did not find clear evidence that orthopedic complaints contributed to the onset of her psychological

condition, he notes these are currently a central factor maintaining this same continued psychological condition.

Therefore, he has determined the patient's injury was both substantially (i.e. 40% or more) and predominantly (>50%) the result of personnel actions, specifically her conflicts with her immediate supervisor, Michelle Lambert. Therefore, Labor Code section 3208.3(h) should be considered.

Since he has determined that the patient's psychiatric condition is predominantly caused by personnel actions, the significant determinations, in this case, hinge upon the Trier-of-Fact's legal determinations regarding the "good-faith personnel actions defense" analysis or the typical Rolda Analysis.

a. If the Trier-of-Fact determines only good faith personnel actions were conducted, causation would not be met for an industrial psychiatric injury, and the psychiatric condition as described would not be compensable (not AOE/COE).

b. If the Trier-of-Fact determines that personnel actions were not performed in good faith, then industrial causes would be predominant (AOE/COE) as to all other causes combined to have produced the psychiatric injuries.

5) Reasonable medical evidence provided leads me to the conclusion that the patient has never been discretely temporarily totally disabled or temporarily partially disabled on a psychiatric basis. She was never precluded from her usual and customary position on a psychiatric basis.

6) With regards to the patient's psychiatric maximum medical improvement status:

a. If the personnel action is deemed compensable by the Trier-of-Fact, the patient has not yet reached maximum medical improvement on a psychiatric basis, and psychiatric treatment (as outlined below) should be provided on an industrial basis prior to psychiatric re-evaluation.

b. If the personnel action is deemed non-compensable by the Trier-of-Fact, then maximum medical improvement status on a psychiatric basis is moot in the absence of predominant industrial causation being met for the psychiatric condition. The treatment outlined below could be completed on a nonindustrial basis.

7) It is this examiner's recommendation that the patient complete her current course of psychological treatment under Dr. Flores as scheduled. Given that she currently attributes her psychological distress primarily to her orthopedic complaints, an additional, brief focus on coping with chronic pain may be helpful. She indicated to this examiner that she has no interest in taking psychotropic medications at this point. Therefore, he is not recommending an evaluation for psychopharmacological treatment by a board-

certified psychiatrist. Whether her current treatment is continued on an industrial basis is dependent upon the determination of the Trier-of-Fact with regard to the Rolda analysis:

a. If the Trier-of-Fact determines that personnel actions were not performed in good faith, then the treatment should be provided on an industrial basis.

b. If the Trier-of-Fact determines that personnel actions were performed in good faith, then any treatment should be pursued on a nonindustrial basis.

8) If the personnel action is deemed compensable by the Trier-of-Fact, permanent disability rating is deferred as the patient is not yet at maximum medical improvement due to pending determination by the current orthopedic QME regarding the industrial relatedness of her orthopedic complaints. Should these orthopedic conditions be found industrial in nature, permanent disability will be deferred until she reaches maximum medical improvement on an orthopedic basis, as such a finding will be a prerequisite to a finding of maximum medical improvement on a psychiatric basis. She should complete the psychological treatment outlined above prior to a permanent stationary rating on a psychiatric basis.

9) If the personnel action is deemed compensable by the Trier-of-Fact, factors of permanent disability are deferred as the patient is not yet permanent and stationary on a psychiatric basis.

10) Regarding work restrictions, it is too early to specify psychiatric work restrictions or psychiatric work modifications in this case. However, this examiner does not believe the patient is currently precluded from her usual and customary duties on a psychiatric basis based upon current reasonable medical evidence, and he believes future work restrictions on a psychiatric basis are very unlikely.

11) If the claim is deemed compensable, apportionment (and any Benson apportionment, if applicable) will be addressed if and when the patient has been deemed permanent and stationary on a psychiatric basis, which in turn cannot be established at this time without the qualified medical evaluation in the field of orthopedics, the results of which are currently pending.

12) After a careful review of the records and psychiatric evaluation this injury is not a direct result of exposure to significant violent acts, therefore, section 3208.3(b)(2) does not apply.

13) This examiner did consider 3208.3(d); the patient was employed more than six months on a full-time basis with the subject employer.

14) As her psychological injury occurred prior to January 1st of 2013, labor code LC4660.l (c) (l) does not apply. He is aware that the case involves a claim filed for psychological CT from 2018-2019 that is derivative to orthopedic injuries, but he does

not believe those injuries, if present, caused any new psychological injury. Rather, they helped maintain the existing psychological injury, which he believes was present beginning 08/31/11.

15) LC3208.3 (3) post-termination concerns not apply, as she remains employed by the subject employer.

16) After a careful review of the records and a comprehensive evaluation, this examiner is not recommending evaluations by any additional panel or agreed medical examiners beyond the QME evaluation(s) of the current orthopedic QME specialist.

17) There is evidence of missing records, which this examiner would like to review to substantiate his opinions related to this evaluation. He requested for those records if available:

- Orthopedic QME report (physician's name/location unknown), conducted approximately two weeks prior to this examiner's evaluation by teleconference.

- Deposition of the patient taken in August 2020 via Zoom.

- Nelson Flores, Ph.D. (psychology) approximately three visits from August 2020 via Zoom.

- Harold Iseke, DC (chiropractic), Long Beach, CA, approximately 15 additional visits between March 2019 and Dr. Simonet's interview.

- Any records of psychiatric treatment with mental health providers in or around August 2011 at Kaiser (as referenced in the note of Dr. Brian Keller at Kaiser on 08/31/11).

18) If this examiner is provided an orthopedic maximum medical improvement report within the next 9 to 12 months, he may be able to furnish his finalize conclusions without reevaluation. If greater than 9 to 12 months passes prior to the patient being found at maximum medical improvement on an orthopedic basis, it is likely that a psychological reevaluation would be necessary to re-examine the patient's mental condition and provide accurate opinions regarding his substantial questions at hand. In either case, he requested to forward the missing records and any other relevant intervening records 60 days prior to any need for a supplemental report or reevaluation.

Diagnostic Impression:

Axis I (Primary Psychiatric Diagnosis)

Adjustment disorder with mixed anxiety and depressed mood, chronic

Axis II (Personality or Developmental Disorders)

Diagnosis deferred

Axis III (General Medical Conditions)

Orthopedic conditions deferred to orthopedic QME (e.g., shoulder, back, arm/wrist)

Hypertension

Prediabetes

Status post total abdominal hysterectomy

History of pelvic pain

Axis IV (Psychosocial Stressors)

Occupational problems

Economic problems

Axis V Global Assessment of Functioning Scale (GAF)

67, which translates to a WPI score of 5% (GAF 61-70 – some mild symptoms)

26) January 27, 2021, Primary Treating Physician's Progress Report (PR-2), Paul Simic, MD/Alexander Kaye, PA-C, UCLA SCOI Van Nuys: DOI: 01/24/19. Chief Complaints: Right shoulder, neck, and lower back pain. Identifying Data: The patient was seen for hand and upper extremity consultation, at the request of insurance carrier (Sedgwick), for evaluation of her industrial injury. HPI: Remained unchanged. Impression: 1) Right shoulder impingement syndrome; partial rotator cuff tendon tear. 2) Cervical spine strain; radiculopathy. Plan: Due to the nature of the injury/condition, and with unsuccessful non-operative treatment, recommended proceeding with surgical intervention, to include right shoulder arthroscopic cuff repair, subacromial decompression with partial acromioplasty, extensive debridement.

27) January 28, 2021, Orthopedic Evaluation Report, Babak Barcohana, MD, UCLA SCOI Van Nuys: DOI: 01/24/19. HPI: The patient is employed by Kaiser Permanente/Hospitals as a CNA. During the course of employment on 01/24/19, she reports that while performing her usual and customary duties she was repositioning a client when she developed pain in her lower back, right shoulder, and neck. The injury was reported to her employer. She was referred by the employer to the industrial doctor. Radiographs were obtained. She received approximately 1-2 weeks of physical therapy to the right shoulder and lower back. MRIs were obtained of the right shoulder, neck and

back. She was administered cortisone injections into both shoulders a few years ago. She underwent Qualified Medical Examination with Dr. Narendra Gurbani. She requested her medical records be reviewed since she has poor recollection of treatments and doctors. She has an examination with Dr. Barcohana on January 29, 2020 for her neck and back. Present Complaints/Review of Systems: Musculoskeletal: The right shoulder pain comes and goes. Pain is dull. She rates her pain at 3/10. She has difficulty with reaching overhead. There is no clicking and popping. She has a left wrist cyst that is growing in size. The neck pain comes and goes. Pain is dull and aching depending on movement. She rates her pain at 4/10. She has difficulty with turning the left. There is numbness and tingling in the left wrist.

The lower back pain comes and goes and is sharp. She rates her pain at 3/10. She has difficulty with prolonged walking. There is radiating sharp pain in the right leg to the foot. Diagnoses: 1) Chronic left-sided neck pain. 2) Chronic low back pain. 3) Left lumbar radiculopathy. 4) Asymmetric disc space narrowing on the left at L4-5. Comments and Conclusions: She is employed by Kaiser Permanente/Hospitals as a CNA. She was injured during the course employment on 01/24/2019. She underwent Qualified Medical Examination with Dr. Narendra Gurbani and was recommended that she see Dr. Barcohana for her neck and low back. The radiographs of the cervical spine showed straightening of the cervical lordosis but this examiner does not have a cervical MRI. The lumbar x-ray showed asymmetric disc space narrowing at L4-5 on the left. There is an MRI report of the lumbar spine. She has not yet had any spinal injections and Dr. Barcohana would suggest she see a pain specialist to undergo injections prior to considering any type of surgery for her neck or her lower back. He added that if she fails conservative measures and wishes to undergo surgery then he would be happy to see her again. At that point he will order updated MRI studies. At this time he has not arranged followup.

28) <u>February 24, 2021, Primary Treating Physician's Progress Report (PR-2), Paul Simic, MD/Alexander Kaye, PA-C, UCLA SCOI Van Nuys:</u> DOI: 01/24/19. Chief Complaints: Right shoulder, neck, and lower back pain. Interim History: The patient underwent QME with Dr. Gurbani. She requested her medical records be reviewed since she has poor recollection of treatments and doctors. She has examination with Dr. Barcohana on January 29, 2020 for her neck and back. **C&T** for the left wrist has been authorized. She states that the symptoms have been present from initial onset. She also complains of numbness and tingling, worse in the thumb. She denies history of a nerve study. She states she had a brace but it broke from overuse. She reports numbness and tingling worse at night. Right shoulder surgery has been authorized. Impression: 1) Right shoulder impingement syndrome; partial rotator cuff tendon tear. 2) Cervical spine strain; radiculopathy. 3) Left wrist sprain/strain; carpal tunnel syndrome; Dequervain's tenosynovitis. Plan: Right shoulder surgery has been authorized. Continue followup with Dr. Barcohana regarding her neck and lower back pain. Submit RFA for nerve study. Submit RFA for new wrist brace; wear at night and with activities. Also submit RFA for left wrist carpal tunnel and left wrist first extensor compartment US guided

corticosteroid injection. US guidance required to ensure proper needle placement, required per Dr. Simic protocol. She will followup for preop evaluation.

29) March 24, 2021, Primary Treating Physician's Progress Report (PR-2), Paul Simic, MD/Alexander Kaye, PA-C, UCLA SCOI Van Nuys: DOI: 01/24/19. Chief Complaints: Right shoulder, neck, and lower back pain. Interim History: The patient has received a wrist brace, wearing at night and with activities as needed. Injections for the wrist have not been authorized. She had nerve study performed, would like to discuss results. She has questions regarding the authorized right shoulder surgery. Impression: 1) Right shoulder impingement syndrome; partial rotator cuff tendon tear. 2) Cervical spine strain; radiculopathy. 3) Left wrist sprain/strain; carpal tunnel syndrome; Dequervain's tenosynovitis. 4) Left elbow cubital tunnel syndrome. Plan: Need MRI images prior to surgery. Submit RFA for C&T for the left elbow. Advised on use of towel technique at night for cubital tunnel symptoms. Continue followup with Dr. Barcohana regarding her neck and lower back pain. Advised on use of wrist brace at night and with activities. Re-submit RFA for left wrist carpal tunnel and left wrist first extensor compartment US guided corticosteroid injection. US guidance required to ensure proper needle placement, required per Dr. Simic protocol.

30) April 14, 2021, Primary Treating Physician's Progress Report (PR-2), Paul Simic, MD/Alexander Kaye, PA-C, UCLA SCOI Van Nuys: DOI: 01/24/19. Chief Complaints: Right shoulder, neck, and lower back pain. Interim History: Today, the patient reports that the shoulder pain has improved while at rest since she has been off work. She still reports persistent left wrist pain, mass, and numbness radiating from the elbow. She still plans to return to work but is hesitant to return to work just yet out concern for aggravating her symptoms. Impression: 1) Right shoulder impingement syndrome; partial rotator cuff tendon tear; improved. 2) Cervical spine strain; radiculopathy. 3) Left wrist sprain/strain; 1st extensor tenosynovitis. 4) Left elbow severe cubital tunnel syndrome. 5) Left wrist carpal tunnel syndrome. 6) Left wrist mass. Plan: Submit RFA for C&T for the left elbow. Advised on use of towel technique at night for cubital tunnel symptoms. Continue followup with Dr. Barcohana regarding her neck and lower back pain. Advised on use of wrist brace at night and with activities. Re-submit RFA for left wrist carpal tunnel and left wrist first extensor compartment US guided corticosteroid injection. US guidance required to ensure proper needle placement, required per Dr. Simic protocol.

31) May 19, 2021, Primary Treating Physician's Progress Report (PR-2), Paul Simic, MD/Alexander Kaye, PA-C, UCLA SCOI Van Nuys: DOI: 01/24/19. Chief Complaints: Right shoulder, neck, and lower back pain. Interim History: Received a wrist brace, wearing at night and with activities intermittently. Injection for the left wrist and the surgery for the left wrist and elbow have not been authorized. Today, the patient reports continued pain, numbness and tingling in the left wrist/hand. Impression: 1) Right shoulder impingement syndrome; partial rotator cuff tendon tear; improved. 2) Cervical spine strain; radiculopathy. 3) Left wrist sprain/strain; 1st extensor tenosynovitis. 4) Left elbow severe cubital tunnel syndrome. 5) Left wrist carpal tunnel

syndrome. 6) Left wrist mass. Plan: Submit RFA for C&T with a pain management specialist, such as Dr. Wahba, SCOI, Van Nuys, CA. Re-submit RFA for C&T for the left elbow. Advised on use of towel technique at night for cubital tunnel symptoms. Continue followup with Dr. Barcohana regarding her neck and lower back pain. Advised on use of wrist brace at night and with activities. Re-submit RFA for left wrist carpal tunnel and left wrist first extensor compartment US guided corticosteroid injection. US guidance required to ensure proper needle placement, required per Dr. Simic protocol. Re-submit RFA for left wrist and elbow surgery. Due to the nature of the injury/condition, and with unsuccessful non-operative treatment, recommend proceeding with surgical intervention, to include left wrist carpal tunnel release; left wrist deep tenosynovectomy, first extensor compartment release; left elbow cubital tunnel release pending authorization for C&T left elbow.

32) June 18, 2021, Primary Treating Physician's Progress Report (PR-2), Paul Simic, MD/Alexander Kaye, PA-C, UCLA SCOI Van Nuys: DOI: 01/24/19. Chief Complaints: Right shoulder, neck, and lower back pain. Interim History: US guided injection for the left wrist have not been authorized. C&T for the left elbow has not been authorized. Surgery for the left wrist and elbow have not been authorized as well. Currently, the patient reports no change in symptoms since the previous visit. Impression: 1) Right shoulder impingement syndrome; partial rotator cuff tendon tear; improved. 2) Cervical spine strain; radiculopathy. 3) Left wrist sprain/strain; 1st extensor tenosynovitis. 4) Left elbow severe cubital tunnel syndrome. 5) Left wrist carpal tunnel syndrome. 6) Left wrist mass. Plan: Continue followup with Dr. Barcohana regarding her neck and lower back pain. Re-submit RFA for C&T with a pain management specialist, such as Dr. Wahba, SCOI, Van Nuys, CA. Re-submit RFA for C&T for the left elbow. Advised on use of towel technique at night for cubital tunnel symptoms. Advised on use of wrist brace at night and with activities. Re-submit RFA for left wrist carpal tunnel and left wrist first extensor compartment US guided corticosteroid injection. US guidance required to ensure proper needle placement, required per Dr. Simic protocol. Re-submit RFA for left wrist and elbow surgery. Due to the nature of the injury/condition, and with unsuccessful non-operative treatment, recommend proceeding with surgical intervention, to include left wrist carpal tunnel release; left wrist deep tenosynovectomy, first extensor compartment release; left elbow cubital tunnel release pending authorization for C&T left elbow. Followup in 4 weeks.

33) August 15, 2021, Compromise & Release: Employer: Kaiser Permanente Downey Medical Center. Occupation: Nursing assistant. DOI: a) CT: 01/01/15-01/20/20. Injured Body Parts: Arms, wrist, back, shoulder, lower extremity, legs, neck, hips. WCAB No: ADJ11859979. b) CT: 07/01/18-12/31/18. Injured Body Parts: Head, stress, psyche. WCAB No: ADJ11864576. The parties agreed to settle the above claim on account of the injury by the payment of $100,000.