ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

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

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am a citizen of the United States. I am over the age of 18 years and not a party of the above-entitled action; my business address is 6221 Wilshire Blvd, Suite 604 Los Angeles, CA 90048. I am familiar with a Company's practice where the mail, after being placed in a designated area, is given the appropriate postage and is deposited in a U. S. mailbox in the City of Los Angeles, after the close of the day's business. On **November 8, 2021**, I served the within following letter / forms on all parties in this action by placing a true copy thereof enclosed in a sealed envelope in the designated area for out-going mail addressed as set forth above or electronically on the specified parties with email addresses as identified. I declare under the penalty of perjury that the foregoing is true and correct under the laws of the State of California and that this declaration was executed at 6221 Wilshire Blvd, Suite 604 Los Angeles, CA 90048.

On **8** day of November 2021, I served the within concerning:

Patient's Name: DISNEY, EVAN
Claim Number: SIF11231848

- ☐ MPN Notice
- ☐ Designation of Primary Treating Physician & Authorization for Release of Medical Records
- ☐ Financial Disclosure
- ☐ Request for Authorization –
- ☐ Itemized – (Billing) / HFCA –
- ☐ QME Appointment Notification
- ☐ Primary Treating Physician's Referral
- ☐ Initial Consultation Report –
- ☐ Re-Evaluation Report / Progress Report (PR-2)
- ☐ Permanent & Stationary Evaluation Report – _____
- ☐ Post P&S Follow Up - _____
- ☐ Review of Records - _____
- ☒ Subsequent Injury Benefits Trust Fund Medical Evaluator's ML-201 Report
- ☐ Computerized Dynamic Range of Motion (Rom) And Functional Evaluation Report - _____

List all parties to whom documents were mailed to:

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

Subsequent Injury Benefits Trust Fund
1750 Howe Avenue, Suite 370
Sacramento, CA 95852-3367
Att: Jeff Souza, WC Consultant

Od Legal
355 S. Grand Avenue Suite 1400
Los Angeles, CA 90071

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 **8** day of **November**, 2021.

ILSE PONCE

ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Boulevard, Suite 604 / Los Angeles, California 90048 / Tel. (323) 933-2444 / Fax (323) 933-2909

September 27, 2021

Subsequent Injury Benefits Trust Fund
160 Promenade Circle, Suite 350
Sacramento, CA 95834
Attn: Jeff Souza, WC Consultant

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

Re:	Patient:	DISNEY, Evan
	SSN:	517-13-7948
	EMP:	Advanced Real Estate Management Company, Inc.
	INS:	Subsequent Injury Benefits Trust Fund
	SIBTF#0	SIF11231848
	WCAB #:	ADJ11231848; ADJ11231935
	DOI:	CT: 06/05/15-03/12/18; 02/14/18

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 September 27, 2021, 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 Mr. Disney Evan to determine his 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 June 5, 2015 through March 12, 2018 to his Neck, Bilateral Shoulders, Bilateral Elbows, Bilateral Hands/Wrists, Thoracic Spine & Lower Back, 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 2144 pages received. Declaration and attestation was received for the same number of pages. 200 pages were included in the fee for ML201, 1944 pages were billed at $3/page as required by CR 9795, for a total of $5832
- Billed as follows:
    - ML201 = $2015
    - 1944 Units of MLPRR X $3 $5832
    - Total = $7847

Upon meeting Mr. Disney Evan, I introduced myself and discussed with him my role as an evaluator in this SIBTF matter. He 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?
Yes.

4. Did the preexisting disability affect an upper or lower extremity, or eye?
Yes, lower extremity.

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?
Yes.

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

8. Is the patient 100% disabled from the industrial injury?
Yes, when considered with pre-existing issues.

9. Additional records reviewed?

10. Evaluation or diagnostics needed?
Yes. MRI of thoracic spine. NCV/EMG studies of upper and lower extremities.

JOB DESCRIPTION (SUBSEQUENT INJURY) :

Mr. Evan Disney was employed by Advanced Real Estate Services, Incorporated as a leasing consultant at the time of the injury. He began working for this employer in June of 2015. He worked full time.

Job activities included taking potential residents on tours, handling contracts, running ads and marketing, working at a desk, computer, right-handed-mouse, filing, working with UPS, and managing mail for 400 people.

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

The patient is a right-hand dominant male, and he 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 30-70 pounds.

The patient worked 8 hours per day and five days a week. Normal work hours were 9 a.m. to 6 p.m. Lunch break was 60 minutes. Rest break was 15 minutes. The job involved working, 50% indoors, and 50% outdoors.

The last day the patient worked for Advanced Real Estate Services, Incorporated was on December 12, 2018, at which time he suffered a work-related. He was placed on temporary total disability. On March 12, 2019, the case was settled with compensation, and he did not return to work.

There was no concurrent employment at the time of the injury. The patient denies working for any new employer.

Prior Work History:

Regarding prior employment, the patient worked for Cal Town Inc. in Montana as a floor runner for approximately four to five months.

Prior, the patient was employed by Opportunity Resources as an in-home health care person for approximately 18 months.

Prior, the patient was employed by Direct Television as a billing supervisor at the call center for approximately three years.

HISTORY OF SUBSEQUENT INJURIES AND TREATMENT ACCORDING TO PATIENT:

CUMULATIVE TRAUMA: 06/05/2015-03/12/2018

The patient states that while working at his usual and customary occupation as a leasing consultant for Advanced Real Estate Services, Incorporated, he sustained a work-related injury to his neck, shoulders, upper back, lower back, both elbows, wrists, hands, and fingers, which he developed in the course of his employment due to continuous trauma dated June 5, 2015, to March 12, 2018. He attributes the injuries to prolonged sitting, repetitive movements, excessive keyboarding, poor ergonomics while performing his job duties. In April 2016, the patient developed gradual onset of pain in both elbows and lowered back. He was always hunched over the screen and trying to support himself with his arms and elbows on a low chair. He worked a lot of overtime. He could not rest on his elbows, and after the fifth or sixth signature, he could not do it anymore. He had to sign and date documents with up to 90 signatures per day.

He reported the injury to his employer and requested an ergonomic chair from his assistant manager. He was told that a new chair would be provided within eight weeks, but that was never done. He continued working with progressive pain.

In November of 2016, he developed pain in both wrists and numbness in his hands and fingers. He developed frequent headaches and neck pain due to extensive time in front of the screen with prolonged posturing and cradling phone between shoulder and ear. He explains his monitor was offset to side, He issued notices to tenants twice a month. He was climbing up and down up to 90 flights of stairs throughout the property repetitively throughout his work shift. In December of 2016, he was walking from his office to home when he experienced tightness in his chest and experiencing anxiety. He presented to Anaheim Hospital emergency room for evaluation. He was told he was having an anxiety attack.

In February of 2017, the patient experienced pins and needles in both arms, hands, and fingers and aggravated pain in his neck and back due to the repetitive movements and excessive workload. He met with his community director, who told him to wait, and she would help get him the chair.

Back Injury:

In early April of 2017, while giving a tour, he was walking backward, talking to the residents he was giving a tour to when he lost his balance, twisted his back, and fell. He landed in a push-up position with his legs twisted and finally on his chest. He relates that he did not report the injury when it was hinted by his employer that if he avoided reporting the injury, there would be a bonus for his co-workers and himself. He reports back pain was present prior to this incident, but pain significantly worsened following this incident.

On May 2, 2017, the pain became intolerable, and the patient sought medical care on his own. He presented to Kaiser Anaheim for evaluation. An MRI scan of his lower back was performed. He was diagnosed with bulging disks. He was placed on TTD. He was off work from May 2, 2017 through sometime in July of 2017. He was treated with prescription medications.

In July of 2017, he returned to work and continued working with increased pain. He relates that he did not complain about his injuries or pain as he was looking to get promoted and make more money. He noted he is a single dad. He explains back pain.

He began to experience progressive pain, weakness, numbness, and tingling in his left leg.

He was working with increasing pain in his neck, back, bilateral shoulders, arms, elbows, hands, and fingers. He was also experienced frequent headaches and acid reflux.

SPECIFIC INJURY: 02/14/2018 (Neck and back)

The patient states that while working at his usual and customary occupation as a leasing consultant for Advanced Real Estate Services, Incorporated, he sustained a work-related injury to

his neck and back. The patient explains that he was taking classes at the corporate office in Irvine, and his property was in Costa Mesa. On his drive back to Costa Mesa, he exited the freeway and came to a stop when he was rear-ended by another car. Upon impact and his neck and upper back were jolted, and he experienced whiplash with his chin hitting his chest. A police report was not made. The patient presented to Kaiser Permanente in Costa Mesa for evaluation. X-rays were taken. He was diagnosed with whiplash. Ice and heat were advised. He was off work for two days. He relates he had one follow-up appointment, and a return appointment was not made. On February 18, 2018, when he returned, his employer spoke with Mr. Disney. He was falsely accused of drinking while driving. His promotion was taken away, and he was demoted. The harassment at work increased. Subsequently, he was moved to another property.

On March 4, 2018, the patient retained an attorney.

In mid-March of 2018, his attorney referred him to Dr. Iseke at the Wellness Studio in Long Beach. He was evaluated. X-rays and MRI scans were performed. He relates he underwent six months of physical therapy three times per week.

In October-November of 2018, the patient was referred for a QME evaluation.

Information regarding Medical Provider Networks and their rights if they are injured was not posted in their place of work on the walls in a common area. Upon being hired, they were not provided information relating to Medical Provider Networks and their rights if injured at work.

SPECIFIC INJURY: 12/12/2018 (Back and Left Hip / Leg)

The patient states that on December 12, 2018, while working at his usual and customary occupation as a leasing consultant for Advanced Real Estate Services, Incorporated, he sustained a work-related injury to his back, left hip and left leg. The patient explains that while doing his daily routine, he was walking down a flight of stairs when his left leg gave out on him due to his back injuries. He lost his balance and slipped down 11 concrete stairs. He experienced increased pain in his lower back, left hip and left leg and pins and needles feeling following this incident. He called his employer, but she did not answer. He drove himself to Kaiser Permanente emergency room. X-rays and MRI scans were performed. The MRI scan revealed a bulging disc in his back. He was taken off work. On March 12, 2019, he had a workers' compensation hearing where he received 30,000.00 and did not return to work.

In September of 2019, he came under the care of a physician at the VA. He completed 30 sessions of physical therapy for his lower back.

In January of 2020, he was accepted by the VA and came under the care of the physicians there. In early September of 2021, the patient was evaluated. On September 22, 2021, he was told his MRI would be sent to a neurosurgeon for a second opinion. He was diagnosed with protrusion at his L-2 and L-3. From April 2020 through September 2020, he underwent six months of physical therapy (home exercise instruction) by telemedicine.

The patient initially reported his injury to the employer on December 12, 2018. After reporting the injury to the employer, the patient was not provided with an Employee Workers' Compensation Claim Form. He was provided with medical attention. Information regarding Medical Provider Networks and their rights if they are injured was not posted in their place of work on the walls in a common area. Upon being hired, they were not provided information relating to Medical Provider Networks and their rights if injured at work. Upon reporting their injury, they were not provided information relating to Medical Provider Networks and their rights if injured at work.

CUMULATIVE TRAUMA: 03/12/2017-03/12/2018

The patient states that while working at his usual and customary occupation as a leasing consultant for Advanced Real Estate Services, Incorporated, he sustained an injury to his psyche. He relates that his employer was taking hours from him, and he was accused of drinking on the property. He relates he was singled out, resulting in stress.

In November of 2016, he developed frequent headaches due to extensive time in front of the screen. He issued notices to tenants twice a month. He was climbing up and down up to 90 flights of stairs throughout the property repetitively throughout his work shift. The workload was excessive, resulting in anxiety and stress. In December of 2016, he was walking from his office to home when he experienced tightness in his chest and anxiety. He presented to Anaheim Hospital emergency room for evaluation. He was told he was having an anxiety attack.

In January of 2020, he began counseling through the VA. He continued counseling through the present time.

Information regarding Medical Provider Networks and their rights if they are injured was not posted in their place of work on the walls in a common area. Upon being hired, they were not provided information relating to Medical Provider Networks and their rights if injured at work.

The patient presents to this office for further evaluation.

CURRENT COMPLAINTS:

Neck:

Patient says all treatment was focused on back only.

The pain is moderate to severe, and the symptoms occur frequently in the neck, at times becoming sharp and stabbing or aching pain. In the mornings, he has difficulty turning his neck to the left side. There is popping, clicking, and grinding of the neck with a range of motion and twisting and turning the head and neck. The pain is aggravated with flexing or extending the head and neck, turning his head from side to side, prolonged positioning of the head and neck, forward bending, pushing, pulling, lifting, and carrying. There is radiating pain from the neck

into his shoulders, shoulder blades, and his head, and he has been experiencing frequent headaches. The patent has difficulty falling asleep and is often awakened during the night by neck pain. There are stiffness and a restricted range of motion in the head and neck. His pain level varies throughout the day. Pain medication provides him pain improvement, but he remains symptomatic. Labor disabling the motion of typing would cause a stabbing pain in his neck. He relates he could not physically type without experiencing in the neck.

Bilateral Elbows:

Patient reports pains since working of Advanced Management Company.

The pain is severe, and the symptoms occur frequently, in the right and left elbow. The pain increases, becoming stabbing, throbbing, sensitivity to touch, and burning in the elbow. The pain radiates into his wrists and the middle and ring fingers on both hands. He has popping and tightness of the elbows. He complains of numbness and tingling in the arms and elbows, and hands. His pain increases with reaching, pushing, pulling, and lifting.

Bilateral Hands/Wrists:

The pain is moderate to severe, and the symptoms occur frequently, in the right and left wrist, hand, and fingers. The pain is aggravated with gripping, grasping, torquing motions, flexion, and extension of the wrists/hands, pinching, fine finger manipulation, driving, repetitive use of the right and left upper extremity pushing, pulling, and lifting, and carrying greater than 2-3 pounds. He has cramping, weakness, and loss of grip strength in hands and wrists and has dropped objects, as a result. There is tingling in the hands and fingers. He has difficulty sleeping and awakens with numbness, tingling and pain, and discomfort. His pain level varies throughout the day depending on activities. The pain in his hands and wrists was labor disabling when delivering notices. He held up to 400 notices and constantly dropped objects, could not deliver united postal services residential packages work anymore.

Thoracic Spine:

The pain is moderate and the symptoms occur frequently, in the upper back as times becoming achy and throbbing. There are severe muscle spasms. The pain increases with twisting and turning at the waist, forward bending, pushing, pulling, and lifting and carrying. The pain radiates into his neck and upper back, and vice. There is a burning sensation. There are numbness and tingling. The pain in his lower was labor disabling and limited his physical activities by 60%. The pain in his back was labor disabling. He could not sit at his computer for more than 10 minutes.

Lower Back:

The pain is moderate to severe, and the symptoms occur frequently, in the lower back, which increases becoming sharp, throbbing, and stabbing. The pain radiates down his buttocks, groin and back of his left thighs to his left foot. There is burning, numbness and tingling. The pain increases with activities of standing or walking as well as sitting over 10 minutes as well as activities of kneeling, stooping, squatting, forward bending, ascending and descending stairs, forceful pushing and pulling, lifting and carrying, going from a seated position to a standing position and twisting and turning at the torso. He complains of muscle spasms. He complains of pain and difficulty with intimate relations/sexual activity due to increased pain in his lower back. The patient denies experiencing bladder or bowel problems. He does awaken from sleep as a result of the low back pain. The patient self-restricts by limiting his activities. He walks with a limp due to his low back symptoms. Pain medication provides him pain improvement, but he remains symptomatic. The pain in his lower was labor disabling and limited his physical activities by 60%. The pain in his back was labor disabling. He could not sit at his computer for more than 10 minutes.

Left Hip:

The pain is moderate to severe, and the symptoms occur frequently, in both left hips, at times becoming sharp, shooting, throbbing, and burning pain. His pain travels to his left leg. He has a locking sensation in the hip. He experiences numbness and tingling in his left leg. His pain increases with moving his leg or getting up from a seated position, getting in and out of the car, sitting to use the bathroom. He has difficulty sleeping and awakens with pain and discomfort. His pain level varies throughout the day depending on activities. The pain in his left hip was labor disabling and limited his physical activities by 60%. He could not squat, stoop or use stairs without excruciating pain.

Psych:

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

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

PAST MEDICAL HISTORY:

Illnesses:

The patient denies any major medical illnesses, but has hypercholesterolemia and gastritis as well as irritable bowel syndrome.

Injuries:

In 1994, left 5th digit fracture, resolved with deformity.

In about 1994, he fell off bicycle and hit his head/helmet against the ground and helmet cracked. He reports developing difficulty studying in school and his grades worsened.

In May of 1997, while serving in the navy-military, he sustained an injury to his neck and back. He was involved in an auto accident. Treatment included examination, neck brace, sling, physical therapy, and prescribed medication. The applicant relates he made a full recovery.

In 2002, while working for a different company, he fell down the stairs and injured his mid-back. Treatment included examination, physical therapy, and prescribed medication. The patient relates he made a full recovery.

In 2007, while working for a different employer, he was hit on the back of the head and neck by the wooden beam in a carport was knocked unconscious and fell backwards with injuries to head, neck and back. Treatment included examination, physical therapy, and chiropractic treatment.

In 2013, while working for a different employer, he was picking a patient off the floor and threw backwards with injuries to neck and back. This case settled compensation. The patient made a full recovery.

The patient denies any prior non-work-related injuries.

The patient denied any new injuries.

Allergies:

The patient is allergic to Penicillin.

Medications:

Taking since April of 2020:

1. Gabapentin for restless legs, anxiety and nerve pain.
2. Adderall severe hyperactive attention disorder (ADHD).
3. Omeprazole-GERD.
4. Methocarbamol for muscle relaxant.
5. Atorvastatin calcium for high cholesterol.
6. Alternates between Aleve and ibuprofen every night for pain.
7. Lidocaine patches.

Taking since July of 2021:

1. Trazodone for sleep.

Surgeries:

The patient denied any prior major surgeries.

Hospitalization:

The patient denied any hospitalizations.

Prior to the Subsequent Injury of continuous trauma from June 5, 2015 through March 12, 2018, the patient was asymptomatic and without any disability or impairment as related to the to his Neck, Bilateral Shoulders, Bilateral Elbows, Bilateral Hands/Wrists, Thoracic Spine & Lower Back.

REVIEW OF SYSTEMS:

GENERAL:	Denies fever, weight loss, malaise, or night sweats. The patient reports night sweats which occur intermittently.
HEENT:	Denies headache or blurred vision. Denies sore throat, ear pain or nasal congestion. The patient reports headaches and blurred vision since 2017. Sees rainbows around bright lights.
CARDIAC:	Denies chest pain, orthopnea, or palpitations. Approximately 6-7 months ago the patient started to experience chest pain, palpitation and irregular heartbeat and hypertension
PULMONARY:	Denies shortness of breath, wheezing, hemoptysis, or productive cough.
GASTROINTESTINAL:	Denies hepatitis, ascites, abdominal pain, or jaundice. The patient has a history of IBS and gastritis of 15 years.
NEUROLOGIC:	Denies migraine headaches, numbness, tingling, cramping, dementia, cerebral palsy, Alzheimer's disease, epilepsy, stroke, paralysis, or TIA. The patient reports migraines, headaches, numbness, tingling, cramping.
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 stress and lack of sleep due to injury, depression or anxiety.

ACTIVITIES OF DAILY LIVING:

Reference for ADL values:

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 3-4/5.

Communication: As a result of the industrially related injury, the patient states: No difficulty with writing, typing, 3-4/5.

Physical Activities: As a result of the industrially related injury, the patient states: Difficulty with standing, sitting, reclining, walking, and going up and downstairs, with a rating of 3-4/5.

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, bus, etc., driving a car, and restful night sleep pattern, with a rating of 3-4/5.

FAMILY HISTORY:

Mother is 57 and healthy.
Father is 64 and has a heart condition.
The patient has no siblings.

SOCIAL HISTORY:

The patient is divorced. He has five children.

The patient has completed high school and some college.

The patient consumes alcohol very rarely and does not smoke.

The patient does exercise. The patient walks daily for ten minutes.

The patient does not participate in any sports activities. Formerly, he played basketball.

The patient takes care of his children, and watches television.

Physical Evaluation (September 27, 2021) – Positive Findings:

General Appearance:

The patient is a 43-year-old male right-hand dominant who appeared reported age, and was well-developed, well-nourished, and well-proportioned. The patient appears to be alert, cooperative and oriented x3. His is alert, cooperative and somewhat confused.

Vital Signs:

Pulse:	89
Blood Pressure:	128/78
Height:	6'0"
Weight:	200

Cervical Spine:

Examination revealed tenderness over the bilateral paravertebral and upper trapezius musculature and vertebral regions from C3 through C7 with hypomobility noted, with greatest tenderness over the facet joints.

Bilateral shoulder depression test positive with greater pain elicited on the right. Cervical spine compression test is positive for neck pain radiating to between shoulder blades.

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

Shoulders & Upper Arms:

Deformity, dislocation, edema, swelling, erythema, surgical scars and lacerations are not present upon visual examination of the shoulders. The shoulders are held in a nonantalgic position.

Tenderness and spasm are not present over the supraspinatus musculature, infraspinatus musculature, teres (minor/major) musculature, subscapularis musculature, periscapular musculature and deltoid musculature bilaterally. There is no tenderness over the subacromial bursa and subdeltoid bursa bilaterally. The acromioclavicular joint, glenohumeral joint and clavicle are not tender bilaterally. The triceps and biceps brachii muscles are without tenderness and spasm bilaterally and appear intact and without evidence of rupture.

Apprehension, Dugas, Hawkins and Impingement Sign orthopedic tests are negative bilaterally.

Ranges of motion of the right shoulder and left shoulder were performed without pain, spasm or weakness.

Shoulder Ranges Of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	180	180	180
Extension	50	50	50
Abduction	180	180	180
Adduction	50	50	50
Internal Rotation	90	90	90
External Rotation	90	90	90

Elbows & Forearms:

Examination revealed tenderness over the bilateral elbows at the medial and lateral epicondyles as well as flexor and extensor muscle groups.

Cozens' and Golfers' tests are positive bilaterally.

Tinel's sign at the right elbow and left elbow is negative.

Ranges of motion for elbows are 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:

Inspection of the left hand showed deformity of the fifth digit at the PIP and DIP joint due to old injury with fracture. The PIP joint is hyperextended while the DIP joint is in the flexed position.

Left Wrist:

Tenderness is not present over the volar and dorsal crease of the wrist on the left. Tenderness is not present over the carpal tunnel and carpals on the left. There is no tenderness

over the distal ulna and radius on the left. There is no tenderness noted over the anatomical snuff box and triangular fibrocartilage complex on the left. There is no mechanical block noted during ranges of motion of the wrist. There is no tenderness over the thenar hand musculature, hypothenar hand musculature and intrinsic hand musculature on the left.

Tinel's sign, Finkelstein's test, Phalen's test and reverse Phalen's test are negative on the left.

Right Wrist:

Tenderness over the volar crease of the carpal tunnels and carpals.

Right Tinel's sign is positive. Phalen's test is positive on the right.

Finkelstein's test is negative on the right.

Ranges of motion of the bilateral wrists were within normal limits.

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

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 **with the exception of left fifth digit triggering at the PIP joint.**

Bilateral hand digit ranges of motion were grossly within normal limits **with the exception of left fifth digit hyper-flexing and inability to fully extend at the DIP joint due to old healed fracture; however, please note flexion of the PIP and DIP joints was full.**

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: 20/24/26
Right: 20/22/22

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.

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 left C5 hypoesthesia.**

Upper Extremity Measurements in Centimeters		
Measurements	Left	Right
Biceps	**32**	**32.5**
Forearms	**21.5**	**22**

Thoracic Spine:

Tenderness was noted over the bilateral paravertebral musculature and tenderness and hypomobility from T7 to T12 vertebral regions.

Kemp's test is positive for increased thoracolumbar pain.

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

Lumbar Spine:

Examination revealed tenderness over the bilateral paravertebral musculature with spasming. Tenderness over the left sacroiliac joint and hypomobility and left sciatic notch tenderness. L1 to L5 tenderness and hypomobility.

Milgram's test is positive. Left sacroiliac compression test is positive.

Straight Leg Raising Test (supine / seated) was positive bilaterally for back pain and radiation of pain to the left lower extremity extending to the foot.

Right: 60 degrees.
Left: 50 degrees.

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

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.

Left Patrick Fabere test elicited increased back pain but not hip pain.

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.

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, Varus Stress test, anterior drawer test and posterior drawer test are negative.

Range of motion of the knees was without pain, spasm, weakness, crepitus or instability bilaterally.

The patient was able to squat without knee pain or weakness.

Knee Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	135	135	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 4/5, left plantar flexion 4/5, all other myotomes 5/5.**

Squatting could only be performed one-fourth down due to increased back pain.

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

Antalgic gait favoring left lower extremity.

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 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	**46**	**46.5**
Calf - at the thickest point	**40.5**	**40**
Leg Length - Anterior Superior Iliac Spine To Medial Malleolus	**101**	**101**

REVIEW OF RECORDS:

Please see Addendum 1 section of this report.

Diagnostic Impressions:

1. Cervical spine myofasciitis, M79.1.
2. Cervical facet-induced versus discogenic pain, M53.82.
3. Cervical radiculitis, left-sided, M54.12.
4. Thoracic spine myofasciitis, M79.1.
5. Thoracic facet-induced versus discogenic pain, M54.6.
6. Lumbar spine myofasciitis, M79.1.
7. Left sacroiliac joint dysfunction, sacroiliitis, M53.3.

8. Lumbar facet-induced versus discogenic pain, M47.816.

9. Lumbar radiculitis, left-sided, M54.16.

10. Bilateral medial and lateral epicondylitis, M77.01.

11. Right carpal tunnel syndrome, G56. 01.

12. Gastritis, K29.70.

13. Irritable bowel syndrome, K58.0.

14. Anxiety, depression and insomnia, F41.9, F34.1, G47.00.

15. Hypercholesterolemia, E78.00.

16. Traumatic brain injury.

17. See **Specialty SIF Evaluator's Reports For Additional Diagnostic Impressions.**

SUMMARY, CONCLUSIONS & RECOMMENDATIONS:

I recommend **MRI of the thoracic spine.**

I recommend **NCV/EMG studies of the upper and lower extremities.**

Note: The patient reports he last underwent upper and lower extremity electrodiagnostic testing in 2007.

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

A. Causation (Pre-Existing and Aggravated): As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation of cervical, thoracic and lumbar is secondary to pre-existing conditions/injuries that were aggravated due to subsequent injury of CT June 5, 2015 through March 12, 2018 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.

B. **Causation (Subsequent Injury):** As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation of bilateral elbows, right wrist and hands is secondary to the subsequent injury CT June 5, 2015 through March 12, 2018 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** cervical, thoracic and lumbar reached maximum medical improvement/permanent and stationary status prior to the time of the subsequent injury dated CT June 5, 2015 through March 12, 2018. It is within reasonable medical probability the patient's condition was **labor disabling prior to subsequent injury with a permanent partial disability as the pre-existing condition(s)/injury(ies) affected the patient's ability to work in a demonstrative way that included that included bending, lifting, gripping, torquing, pulling, pushing.**

B) **Following the subsequent Work Injury:** It is within a reasonable medical probability this patient has reached maximum medical improvement **as related to** cervical, thoracic and lumbar spine, bilateral elbows, right wrist/hand **body part(s)** and is permanent and stationary following the subsequent injury dated CT June 5, 2015 through March 12, 2018. 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 wrist/hand.

Spine:

A. Cervical Spine:

A. Patient qualifying for range of motion method due to five levels of disc protrusion/HNP as confirmed by 05/12/18 MRI and correlated clinically.

1. Cervical spine range of motion, 12% whole person impairment by referencing Tables 15-12, 15-13 and 15-14 on pages 414-415.
2. Cervical spine specific disorders, 10% whole person impairment by referencing Table 15-7 on page 404 and the patient qualifying for Category IIC, 6% due to disc protrusion/HNP plus Category IIF, 4% due to four additional level.
3. Cervical spine total, 21% whole person impairment by combining range of motion with specific disorders impairment.

B. Cervical Spine using DRE method: Patient qualifies for **DRE** category III, 18% whole person impairment by referencing Table 15-5 on page 392 due to significant signs of radiculopathy verified by imaging study with herniated disc at the level of radiculopathy.

C. Cervical spine is best represented by DRE motion method, 18% whole person impairment.

Pre-existing Cervical - I apportion **20%** for cervical spine, which equates to 4% whole person impairment.
Subsequent Injury Cervical Spine – I apportion 80%, which equates to 14% whole person impairment.

B. Thoracic Spine: Patient qualifies for DRE category II, 5% whole person impairment by referring table 15-4 on page 389 due to asymmetric loss of range of motion.
Pre-existing - I apportion **5%** of thoracic spine, which equates to 0.25% whole person impairment, which rounds to 0%.
Subsequent Injury – I apportion 95% which equates to **4.75%** whole person impairment, which rounds up to 5% whole person impairment.

C. Lumbar spine: Patient qualifying for range of motion method due to two levels of disc protrusion/HNP as confirmed by 10/17/17 MRI and correlated clinically.

1. Lumbar spine range of motion, 11% whole person impairment by referencing Tables 15-8 and 15-9 on page 407 and 409.

2. Specific disorder, 8% whole person impairment by referencing table 15-7 on page 404 and patient qualifying for category IIC, 7% due to disc protrusion/HNP plus category IIF, 1% due to one additional level.

3. Lumbar spine total, 18% whole person impairment by combining range of motion with specific disorders impairment.

4. Lumbar spine using DRE method. Patient qualifies for DRE category III, 13% whole person impairment by referencing table 15-3 on page 384 due to asymmetric loss of range of motion, disc protrusion/HNP, dermatomal sensory loss.

Lumbar spine is best represented by range of motion method 18%, whole person impairment.

Pre-existing - I apportion 20% for lumbar spine, which equates to 4% whole person impairment.
Subsequent Injury – I apportion 80% for the lumbar spine, which equates to 14% whole person impairment.

Note: During the time of continuous trauma 6/5/2015 to 3/12/2018, the patient sustained two specific injuries, 4/20/2017 and 2/14/2018 while working for the same employer; 4/20/2017 injury to the back and 2/4/2018 injury to neck and back. These injuries are inextricably

intertwined with the continuous trauma injuries and there cannot be apportionment between them.

Please note that 12/12/2018 injury is a compensable consequence of lumbar spine injury due to CT and documented radiculopathy which caused the left leg to buckle resulting in a fall and further injury to lumbar spine; therefore, apportionment is not indicated.

UPPER EXTREMITY IMPAIRMENT:

A. **Right Wrist/Hand**: Major grip strength impairment is 20% upper extremity impairment by referring tables 16-32 and 16-34 on page 509 due to 56% SLI, which equates to 12% whole person impairment by referencing table 16-3 on page 439.
Pre-existing - I apportion **0%** for right wrist/hand.
Subsequent Injury – I apportion 100%, which is 12% whole person impairment.

Final Apportionment Analysis:

A. Total Whole Person Impairment Apportioned to Pre-Existing equals 70% by combining above referenced calculated preexisting Whole Person Impairments as per undersigned with 27% Internal as per Dr. Gupta for GI with 29% Psych per Dr. Phan, with 8.5%, which rounds to 9% whole person impairment for Ocular per Dr. Kamkar with 31% Neurological per Dr. Richman for cognition and headaches.

B. Total Whole Person Impairment Apportioned to Subsequent Injury equals 39% by combining above referenced Calculated Subsequent Injury Whole Person Impairments as per undersigned with 5% Psych as per Dr. Pham.

C. Total Whole Person Impairment that I am unable to establish apportionment for is 8.5% ocular per Dr. Kamkar. Please note, Dr. Kamkar states that the patient currently has 17% whole person impairment due to natural progression of a condition that resulted in 8.5% whole person impairment prior to continuous trauma and thus 17% current impairment minus 8.5% preexisting equals to 8.5% of additional current impairment.

Permanent Work Restrictions Currently:

Cervical Spine: No lifting over 15 pounds. No repeated lifting over the head. No prolonged posturing with head and neck.

Thoracic and Lumbar Spine: No lifting over 15 pounds. No repeated bending or twisting. Must be able to change position from standing to sitting as needed. Must use lumbar brace while working.

Bilateral Elbows and Right Wrist: No repeated or forceful pulling, pushing, grasping or torqueing with both hands. No prolonged keyboarding or computer work. Must use right wrist brace and bilateral epicondylitis braces while working.

Subjective Factors of Disability:

The subjective factors of disability consist of:

Neck:

The pain is moderate to severe, and the symptoms occur frequently in the neck, at times becoming sharp and stabbing or aching pain. In the mornings, he has difficulty turning his neck to the left side.

Bilateral Shoulders:

The pain is moderate to severe, and the symptoms occur frequently, in both shoulders. The pain radiates to his arms and hands. There is numbness and tingling and burning in the arms, elbows, and hands.

Bilateral Elbows:

The pain is severe, and the symptoms occur frequently, in the right and left elbow. The pain increases, becoming stabbing, throbbing, sensitivity to touch, and burning in the elbow.

Bilateral Hands/Wrists:

The pain is moderate to severe, and the symptoms occur frequently, in the right and left wrist, hand, and fingers. The pain is aggravated with gripping, grasping, torquing motions, flexion, and extension of the wrists/hands, pinching, fine finger manipulation, driving, repetitive use of the right and left upper extremity pushing, pulling, and lifting, and carrying greater than 2-3 pounds.

Thoracic Spine:

The pain is moderate and the symptoms occur frequently, in the upper back as times becoming achy and throbbing. There are severe muscle spasms. The pain increases with twisting and turning at the waist, forward bending, pushing, pulling, and lifting and carrying.

Lower Back:

The pain is moderate to severe, and the symptoms occur frequently, in the lower back, which increases becoming sharp, throbbing, and stabbing. The pain radiates down his buttocks, groin and back of his left thighs to his left foot. There is burning, numbness and tingling.

Left Hip:

The pain is moderate to severe, and the symptoms occur frequently, in both left hips, at times becoming sharp, shooting, throbbing, and burning pain. His pain travels to his left leg. He has a locking sensation in the hip.

Objective Factors of Disability:

With regards to cervical spine, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Muscle guarding on the exam.
3. Abnormal orthopedic testing.
4. Decreased and painful ranges of motion.
5. Abnormal MRI results.

With regards to thoracic spine, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Decreased and painful ranges of motion.

With regards to lumbar spine, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Muscle guarding on the exam.
3. Decreased and painful ranges of motion.
4. Abnormal orthopedic testing.
5. Abnormal MRI results.

With regards to elbows, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Abnormal orthopedic testing.

With regards to right wrist and hand, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Abnormal neurological examination findings.
3. Abnormal orthopedic testing.
4. Decreased grip strength.

Vocational Rehabilitation Benefits:

In my opinion the patient is not a qualified injured worker as based on review of records including the Vocational Expert Madonna Garcia report dated February 24, 2020, it is determined this patient is not amenable to any form of rehabilitation and thus has sustained a total loss in their capacity to meet any occupational demands and is thus 100% disabled.

CONCLUSIONS:

I have reviewed Labor Code 4751 and there appears to be adequate evidence to conclude, with reasonable medical probability, that Mr. Disney meets initial SIBTF criteria.

1. There does appear to be adequate evidence to conclude with reasonable medical certainty that Mr. Disney had previous partial disability as per the work restrictions outlined by the undersigned.

2. The combined effect of the preexisting impairment and the impairment due to the subsequent injury is likely to result in a permanent disability equal to, or greater than, 70%.

3. 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 Mr. Disney and his 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 Dr. Mayya Kravchenko, D.C., who assisted with assembly of components of this report which was transcribed by Acu Trans Solution, LLC, 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.

Face to face time with the patient was 2 hours and 10 minutes.

Sincerely,

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

Signed this 6 day of November 2021, in Los Angeles, California.

This report is being served timely pursuant to the QME emergency regulation regarding COVID-19:

ADDENDUM TO FINDING OF EMERGENCY OF THE DEPARTMENT OF INDUSTRIAL RELATIONS DIVISION OF WORKERS' COMPENSATION REGARDING THE CALIFORNIA LABOR CODE:

TITLE 8. CALIFORNIA CODE OF REGULATIONS DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS

CHAPTER 1. DIVISION OF WORKERS' COMPENSATION FORMERLY ARTICLE 7. PRACTICE PARAMETERS.

SECTION 78. QME EMERGENCY REGULATIONS IN RESPONSE TO COVID-19 CURRENTLY ARTICLE 4. EVALUATION PROCEDURES.

SECTION 46.2; (C). QME EMERGENCY REGULATIONS IN RESPONSE TO COVID-19: DURING THE TIME THIS REGULATION IS IN EFFECT, ALL OF THE TIME PERIODS ENUMERATED IN SECTION 38 OF TITLE 8 OF THE CALIFORNIA CODE OF REGULATIONS ARE <u>EXTENDED BY A PERIOD OF 15 DAYS.</u>

ADDENDUM 1 - REVIEW OF RECORDS

Pursuant to Cal Code Regs., Title 8, § 9793(n) the parties attested to 2144 pages being provided for my review which have been received and reviewed by myself in preparation of this report.

1. September 01, 2021, Declaration & Attestion from Natalia Foley, Esq: A declaration was provided under labor code LC 4062.3, 8 CCR 9793(n) to Dr. Gofnung for review of 2144 pages of medical records.

2. September 01, 2021, Cover Letter for SIBTF Medical Evaluation, Natalia Foley, Esq: Dr. Gofnung was in receipt of a letter dated September 01, 2021 from the Workers Defenders Law Group requesting him to evaluate the patient and to review the attached medical records. He was selected to act in the capacity of Agreed Medical Evaluator in regard to the patient's Subsequent Injury Benefit Trust Fund Claim in chiropractic specialty. He was specifically asked to provide a medical legal evaluation in his area of expertise in regard to the subsequent injury - DOI: 06/05/2015 - 03/12/2018 (ADJ11231848). He was further requested to provide summary rating based on available SIBTF medical evaluations.

   He was requested to address the following issues in this case.

   a) It was requested that a determination be made regarding any pre-existing medical issues and disability within your area of specialty that were present at the time of the subsequent industrial injury.

   b) Please provide a permanent impairment rating per the AMA guides 5th edition and address the issue of apportionment. Specifically, it is requested that you provide a determination as to the percentage of cause of disability to a pre-existing condition present at the time of the subsequent industrial injury, any contribution from the industrial injury(ies) and any further natural progression, which occurred after the industrial injury.

      Please cover in your report the following topics:

      - Subjective complaints
      - Objective factors or findings
      - Current diagnosis
      - Occupational history
      - Past medical history
      - Prior injury

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

a) Please answer within the scope of your specialty:

- On the day of your evaluation does the worker have a permanent impairment of any body parts within your specialty?
- If yes, is the worker 'condition permanent and stationary as of today?
- If yes, what is this impairment rating as of today, the date of your evaluation?
- What kind of current work restrictions worker has due to his permanent impairment?
- Did worker have a preexisting condition within the scope of your specialty?
- If yes, please answers the following questions:

  (a) Was that preexisting condition permanent and stationary at the time of the last employment?

  (b) 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?

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

  (d) Was the subsequent industrial injury compensable and have resulted in additional PPD??

- Please apportion worker's condition as of today to the following?

  (a) Pre-existing condition

(b) Subsequent injury

(c) Post-subsequent injury

- 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?
- 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)?
- Did the pre-existing disability affect an upper or lower extremity or eye?
- Did the subsequent industrial permanent disability affect the opposite or corresponding body part?
- 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)?
- 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 issues to the medical doctors of appropriate specialty, please indicate what specialty is recommended.

3. <u>October 13, 2003, Initial Consultation Note, Rick A. Brian, PA-C, Community Medical Center:</u> Chief Complaint: Right pinkie pain. HPI: The patient stated that he was moving a pallet and some salt came down on the pallet pulling his finger sideways. He

felt a kind of pop. He stated that it was no straight. It was kind out of alignment. He reset it to where it was in straight position. He was able to flex it. He was still having quite a bit of pain at the distal joint. Assessment: Avulsion fracture to the right fifth finger. Plan: 1) Aluminum splint was placed to immobilize this joint. He would use this for the next six weeks. 2) Ice, elevate. At two weeks, he would go through some range of motion exercises. If he had limited range of motion, he would need to be followed by orthopedics.

4. October 13, 2003, X-Ray of Right 5th Finger, Mark W. Elliott, MD: Impression: Soft tissue swelling surrounding the right 5th PIP joint with abnormal lucency in the volar aspect of the base of the fifth middle phalanx which likely represents a fracture. Correlation regarding history of trauma and point tenderness would be benefit. No significant malalignment.

5. October 16, 2003, First Report of Accident, Brian Rick, PA-C: DOI: 10/13/03. Mechanism of Injury: The patient was removing bags of product from underneath a pallet being held by a customer. The customer dropped the pallet onto patient's right hand breaking his little finger. Accident was reported to Jack Reed.

6. October 21, 2003, Attending Physician's First Report and Initial treatment, T. Calderwood, MD: HPI: The patient reported that he had fractured his right fifth finger eight days prior. A pallet fell on his finger hyperextending it and he got an avulsion prescription at the proximal interphalangeal joint at the volar aspect of his right fifth finger. Exam: He was pretty sore still. He was put in a full hand splint and this was really hard to use at work. Instead put him in a malleable aluminum splint that would cover the entire finger and it was placed in anatomic position. It was taped in place. Diagnosis: Broken finger. Plan: Need to re-x-ray his finger in about five weeks to make sure this was healed well. He should keep the splint on all day long but take it off to wash and when he did take it off to wash, just gently move it so that he could get his range of motion back. Gave him some Lortab as he was still hurting quite a bit. Causation: This examiner noted that this was a work related accident. Work Status: Regular duty.

1. October 13, 2003, X-ray of Right Fifth Finger, Mark W. Elliott, MD, Community Medical Center: Indication: Pain. Impression: Soft tissue swelling surrounding the right fifth proximal interphalangeal joint with abnormal lucency in the volar aspect of the base of the fifth middle phalanx which likely represents a fracture. Correlation regarding history of trauma and point tenderness would be benefit. No significant malalignment.

7. December 23, 2003, ED Summary, Scott Q. Greer, MD, Community Medical Center: DOI: 12/23/03. HPI: The patient presented with right arm injury. He presented ambulatory to the Emergency Room with right arm injury. He was at work same day and was trying to kick a frozen pipe loose off the ground when his other foot slipped out and he fell on his back. He first had his right arm stretched out behind him to break the fall and he landed on the arm and then he stated that it had given way. Since then, he has had

a pain in his anterior shoulder and a burning discomfort. He was also feeling some tingling in his fifth finger and ring finger. He stated that he broke his right fifth finger approximately two months prior and has had some soreness and swelling since then. Exam: He was holding the right upper arm close against his chest and had an ice pack on his shoulder. Examination of the right upper extremity revealed tenderness over the head of the biceps and pain with forced flexion. He had painful passive range of motion and did have tenderness over the mid dorsal wrist. He had some mild swelling of the proximal fifth digit. He had intact two-point discrimination of the little finger and ring finger. He had 2+ radial pulse. ED Course: He was given a shoulder sling to wear for the next two to five days. Diagnoses: 1) Right shoulder sprain, this is primarily over the head of the biceps. 2) Right hand strain. Plan: Recommended to start gentle range of motion exercises three to four times daily after 2 days. These were demonstrated to him. He was to take an anti-inflammatory medication on a regular basis and was also given a prescription for ten Lortab tablets. Referred to Dr. Christopher Price who was on town orthopedic call if he was not improving. He was discharged to home in stable condition. Work Status: Modified duty. Restrictions: Keep right arm in a sling for the next week. Followup with private physician/orthopedist if unable to return to full work duties in 1 week.

8. December 23, 2003, X-Ray of Right Hand, Michael R. Tryhus, MD, Community Medical Center: Findings/Impression: On the oblique view only, there is a questionable bony density separated from the volar plate of the fifth middle phalanx. There is some soft-tissue swelling in this region. Subacute volar plate injury would be difficult to exclude. A dedicated lateral view of the right fifth digit would be helpful for further evaluation.

9. December 23, 2003, X-Ray of Right Shoulder, Michael R. Tryhus, MD, Community Medical Center: Findings/Impression: No evidence of acute fracture or dislocation.

10. January 05, 2004, Attending Physician's First Report and Initial Treatment, T. Calderwood, MD: DOI: 02/23/03. HPI: The patient had a fall 10 days prior on the ice at work. He landed on a partially outstretched right hand. He came in complaining of major shoulder pain to the emergency room. He was x-rayed; there was no fracture, no dislocation. He was still quite sore. He had been working at Sails at the office and normally his work was fairly physical. Again, his pain was still fairly substantial and it was mostly in the medial shoulder near the area of the coracoid. Exam: His external rotation is limited due to pain. Internal rotation was markedly limited also because of pain. Diagnosis: Rotator cuff strain. Plan: Prescribed Vioxx. He had some written exercises that were given to him at Community Hospital. He should do those gently a couple times per day. Work Status: There was just no way could he do heavy work for at least three more weeks. Advised to limit his amount of pushing, pulling, lifting to 25 lbs over the next three weeks and then would reevaluate him to see if he was able to return to work at full capacity.

11. January 26, 2004, Progress Report, T. Calderwood, MD: Interim History: The patient reported that his shoulder pain had been improving, but not quite better. He was feeling

sharp pain in coracoid region when with elevation of his arm. Plan: Prescribed Bextra. Followup in 10 days. Advised to continue modified duty until that time.

12. February 2004, Direct TV Customer Contact Center - Job Description: Job Summary: Responsible for responding to customer phone calls by listening empathetically to the customer, clarifying and assessing customer needs, and resolving billing, service and technical issues in a prompt and effective manner utilizing multiple computer systems simultaneously. Essential Duties: 1) Navigates multiple data entry systems and other relevant applications, tools and resources while speaking with customers. 2) Answers customer questions and resolves issues in a professional and courteous manner. 3) Meets established call center productivity and quality standards. 4) Communicates with internal and external customers. 5) Learns and acquires necessary skills and products and systems knowledge. 6) Probes and assesses customer needs, and positions products and services appropriately. Qualifications: 1) Ability to navigate multiple data entry systems and other relevant applications. 2) Ability to take all call types as assigned. 3) Previous customer service experience required. Working Conditions/Physical Requirements: 1) May be assigned to any call type as required. 2) Potential to move to a CSR-Intermediate and/or Senior level based on meeting tenure and performance requirements. 3) Works in an office environment. 4) Employee has limited walking requirements to other floors and to centralized files. Answers telephone calls, uses personal computer and other business machines extensively, which requires the ability to apply finger dexterity. Individual bends, reaches, pushes and pulls file drawers to file records and reports. 5) Most Center employees work on a shift basis, and as such will be required to periodically rotate shifts and regular days off. All Center employees must be willing to work all shifts, overtime, holidays and emergency shifts as required.

13. February 09, 2004, Followup Note, T. Calderwood, MD: Subjective Complaints: The patient returned same day for final follow up of his shoulder. He was doing a lot better. He had just a little bit of pain on the most extreme external rotation. Plan: Gave him a few more samples of Bextra so he would have enough to take for as much as three weeks more, one per day, but he could return back to his usual job at full capacity. He was told to be kind of cautious when he lifts above his head.

14. January 03, 2005, First Report of Accident at Montana State Fund, **unidentified provider**: DOI: 01/03/05. Mechanism of Injury: The patient was carrying box downstairs and lost footing and fell downstairs and injured his ribs, hand, and ankle. Nature of injury involved broken/bruised/contusion. Disability began on 01/03/05.

15. January 03, 2005, X-Ray of Chest, Paul Eikens, MD: Impression: No evidence of cardiopulmonary process. No evidence of rib fracture or pneumothorax.

16. January 03, 2005, X-Ray of Thoracic Spine, Paul Eikens, MD: Impression: Unremarkable x-ray of thoracic spine.

17. January 03, 2005, X-Ray of Lateral Left Ribs, James Mackay, MD: Impression: No evidence of displaced, left-sided rib fracture.

18. January 06, 2005, X-Ray of Left 5th Finger, James Mackay, MD: Impression: Three views of the 5th digit of the left hand demonstrate posterior dislocation at the proximal interphalangeal joint, which appears partial. There is associated soft tissue swelling. No definite fracture is identified.

19. January 10, 2005, Followup Note, Terence Calderwood, M.D.: Interim History: Follow-up from four days prior. The patient was in a lot of pain still, especially his neck and base of the skull with headaches. He was just coming slowly; and was certainly not ready to return to work. This examiner did get all the x-rays in from Community Hospital. His thoracic spine/right hand/ribs/chest films were normal. Left hand x-ray revealed a small fracture of his left 5th finger. Plan: He would be seen back in a week to see if he was able return to work. He was referred to PT at SPH outpatient physical therapy. He had Percocet for his pain. Work note was given to say that he could not come back to work until this examiner clear him.

20. January 17, 2005, Followup Note, Terence Calderwood, M.D.: Interim History: The patient was here to follow up same day. He was doing quite a bit better in regards to his neck, headache, neck pain, and upper back pain. He was feeling like he would probably be able to return to work on Wednesday (01/19/05) or so. On the 2nd story unrelated to his Work Comp Injury, he had developed a cough and wheezing. Assessment/Plan: Dr. Calderwood believed that this patient had an asthmatic bronchitis. Given prescription for some albuterol plus Z-Pak. Followup as needed. Work Status: Out of work until 01/19/15.

21. November 17, 2009, Progress Notes, Garrick R. Simmons, M.D.: Reason for Visit: Follow-up of history of left midureteral calculus. Assessment/Plan: 1) This examiner did carefully review the films with the patient here same day noting left-sided midureteral stone measured 6 x 4 mm. He did carefully go over the options with the patient consisting of continued observation versus surgery involving either ESWL (Extracorporeal Shock Wave Lithotripsy) or ureteroscopy. He would like to continue to attempt to pass a stone, which was certainly reasonable. Flomax was given for additional one week. 2) Historically poor fluid intake with excessive caffeine intake with instructions given here same day on stone prevention. This examiner also stressed to him about the importance of capturing the stone if at all possible to send this for stone analysis. 3) General medical health otherwise good.

22. November 25, 2009, Progress Notes, Garrick R. Simmons, M.D.: Reason for Visit: Follow-up of history of left midureteral stone. Assessment/Plan: 1) History of 6 x 4 mm left mid ureteral stone with probable progression distally. This examiner carefully went over the options once again with patient consisting of observation versus proceeding with an ureteroscopy. He would like to continue to observe at this time. He was missing significant volumes of work; however, and if he has not had progression by Monday

(11/30/09), this examiner had recommended repeat x-rays in consideration for possible treatment. 2) Also had recommended continued use of Percocet as needed as well as Flomax. Additional Flomax samples were given here same day.

23. November 25, 2009, X-Ray of Abdomen, Wayne L Davis, MD: Impression: No acute disease identified. There is some vague increased opacity projecting over the right renal pelvis, which could represent renal calculus disease but this is in part obscured by overlying stool and gas. The remainder of the examination is unremarkable.

24. December 04, 2009, CT Abdomen and Pelvis, Renal Stone Protocol, Michael A. Stewart, MD: Impression: 1) Previously seen left mid ureteral calcification is now located at the left ureterovesical junction. Again this measures up to approximately 6 millimeters. There is no significant left intrarenal collecting system dilatation. No other renal or ureteral calculi. 2) Redemonstration of a 13 millimeter low attenuation right renal lesion. There is calcification along the anterior dependent aspect of this lesion. This could be peripheral calcification or possibly dependently layering calcification. This is nonspecific and could be calyceal diverticulum or possibly mildly complex renal cyst. It is incompletely characterized in the absence of intravenous contrast. 3) No other definite acute abnormality.

25. May 23, 2010, Office Visit, Sam Mitchell, MD: DOI: 03/22/10. HPI: The patient was walking home from Direct TV previous day evening and stated that he was in the parking lot at Direct TV when he stumbled off the edge and inverted the left ankle. He fell to the ground slightly straining the right medial knee and his low back. Overnight he had been having swelling and pain on the lateral aspect of the ankle, some tingling into the 4th and 5th toes and some low back spasm. He was taking 800 mg of ibuprofen overnight and iced the ankle, elevated it. Radiological Data: X-rays were done, negative for acute fracture or dislocation. Assessment and Plan: 1) Sprain of the left ankle with mild knee sprain and low back pain: Put him into lace-up ankle support. Would use rest, ice, compression, elevation, NSAIDs (nonsteroidal anti-inflammatories), and muscle relaxants that should help him sleep at night. If no improvement after 10 days, then he would be re-evaluated with repeat x-ray to rule out hairline fracture. The knee appeared to be more of a mild sprain. This examiner was unable to totally exclude a medial meniscus tear, although it seemed unlikely as there was no pop, click or grind, but he could not really do a full McMurray's on this patient. If that worsens, he should return for re-evaluation. 2) Low back pain: Heat in the morning, ice in the evening, NSAIDs, gentle range of motion. Follow up if worsening. He did see a chiropractor and stated that he would followup again this week.

26. July 13, 2010, Office Visit, Craig McHood, MD: Chief Complaint: Low back pain. Assessment/Plan: Back disorder, not otherwise specified. Rhomboids and left shoulder. He had pain in his trapezius rhomboids and splenius capitus as well as likely from excessive use. This was the arm that he hold his children with. Recommended to start an exercise program to increase strength of his upper body and his core strength. Low back: 2 issues were there. He had L4-L5 radicular symptoms consisting of only numbness at

this time. For this, Dr. McHood might refer him to physical therapy as well as would give him a short course of steroids and initiate amitriptyline. Damage of the mouth with his sleep and might potentially help with the symptoms as well. If his symptoms persist, this examiner would obtain radiographic imaging and refer when necessary. 2nd issue was his sacroiliac pain. He had a clear history of chronic problems here and currently had pain as well. For this, stretching exercises were recommended. **Todd**, mobility, ice, heat, and begin core strengthening to prevent further injury. **His flexibilities atrocious (doubtful print)**. Recommended stretching/weight loss as well. This examiner indicated that he did not spend a lot of time on the patient's gastrointestinal issues. However, these did appear to be stress related and he was recommended getting a full dose of Prilosec at this time. This would be initiated and follow more upon next appointment. Would also talk more about depression and anxiety next appointment. As for his use of THC (delta-9-tetrahydrocannabinol), this examiner did not prescribe narcotics when individual were using THC and he was aware of this. However, there was no need for narcotics in his case. This examiner let the patient know that he believed that a better treatment for his ailments **end** THC. Would utilize the amitriptyline for his insomnia. He would followup in 2 weeks.

27. October 28, 2010, Progress Note, Bradley Ihrig, MD, Community Medical Center: Chief Complaints: 1) Left upper toothache. 2) Stomach problems. Current Medications: Omeprazole 20 mg, Ibuprofen. Diagnoses: 1) Left upper tooth partially missing with toothache. 2) Gastroesophageal reflux disease, not responding to typical proton pump inhibitor therapy. Plan: 1) This examiner continued to strongly encourage patient to get an appointment with a dentist as soon as possible. He still had antibiotic in his system with azithromycin and did not recommend repeat antibiotics at this time. He would be given strong pain medication, Percocet 5/325 mg for pain, also would switch his proton pump inhibitor to Dexilant 60 mg that he should take before his main meal in the evening. 2) He would get his baseline fasting laboratory work done today, with further follow-up based on results of his specialty referrals. 3) He was also in the process of getting a urology referral for vasectomy. 4) This examiner indicated that he would review laboratory work with patient once it becomes available.

28. November 15, 2010, Chiropractic Treatment Summary, Don R. Butler, DC, Butler Chiropractic Health Clinic PC: The patient attended chiropractic sessions from 11/30/05 to 11/15/10. He received treatment modalities that included chiropractic spinal adjustments.

29. March 07, 2012, Chart Notes, Don R. Butler, DC, Butler Chiropractic Health Clinic PC: Subjective Complaints: The patient reported that he did great for a while, then reported experiencing severe lower back pain radiating into the right lower extremity. Also reported upper neck and mid-back pain with numbness and tingling. Objective Findings: There tenderness to palpation over cervical/thoracic/lumbar spine. Decreased spinal ROM and fixation was found. Straight Leg Raise test was positive at 20 degrees. Spinal adjustments were performed on the **C6, 1 T6 L4, 5**. Assessment: His prognosis was

guarded at this time. He has had an exacerbation. Plan: Chiropractic adjustments were performed to the fixated segments above.

30. March 07, 2012, Chiropractic Treatment Summary, Don R. Butler, DC, Butler Chiropractic Health Clinic PC: The patient attended chiropractic sessions from 01/17/11 to 03/07/12. He reported treatment modalities that included chiropractic spinal adjustments.

31. February 26, 2014, Initial Chiropractic Consultation Report, Don R. Butler, DC: DOI: 02/23/14. HPI: The patient reported sustaining injuries during lifting an object weighing over 200 lbs while at work. As a result, he reported severe neck, mid back pain, low back pain with pain radiation into both legs, and headaches. Diagnoses: After examination and x-rays, he was diagnosed with cervical and lumbar disc irritation/herniation. Also, cervical, thoracic, and lumbar subluxations at C5, C6, T6, T7 and L4 and L5 were noted. Plan: He was recommended to undergo six chiropractic treatments as soon as possible, followed up with examination to evaluate his status. He was also given work restrictions until 03/10/14 because he was too unstable to do any heavy lifting.

32. March 04, 2014, First Report of Accident at Montana State Fund, **unidentified provider**: DOI: 01/23/14. Mechanism of Injury: The patient reported that the injury occurred while assisting another staff with lifting a client from the floor to the bed. The patient was lifting him up in bed. The patient had a flu that night and had suffered from really bad body aches. That morning, he felt terrible and worse pain and could barely move. Next day (Wednesday), he spent the whole day in bed. Tuesday, body aches had stopped but back was still hurting. He reported lower/mid back pain and currently had very intense pain in neck. Date of disability began on 01/23/14. **Illegible print**.

33. March 18, 2014, MRI of the Lumbar Spine without Contrast, Richard T Dahlen, MD: Impression: 1) There is a mild left neural foraminal L3-4 disk protrusion with associated posterior annular fissure. This results in mild left L3-4 neural foraminal narrowing. 2) Mild central L4-5 disk protrusion with associated posterior annular fissure. This is to the left of midline and does result in mid left L4-5 subarticular recess stenosis. There is no significant spinal canal stenosis identified. 3) Mild early degenerative disk disease, L4-5, and to a lesser extent, L3-4.

34. May 02, 2014, Chiropractic Therapy Notes, Don R. Butler, DC, Butler Chiropractic Health Clinic: The patient attended chiropractic therapy sessions from 02/26/14 to 05/02/14.

35. May 06, 2014, Neurological Consultation, Chriss A. Mack, MD, Neurological Associates: HPI: The patient was working as a C.N.A, and reported hurting his back while working. His overriding problem had been left-sided L3 radiculitis. He had an annular tear immediately adjacent to the left L3 nerve root in the L3-L4 foramen and some modest deflection of the L3 nerve root, very consistent with his clinical picture of two month's duration of symptoms. He stated he was about 50% better. Physical Exam:

Examination revealed sclera clear bilaterally and fundi had sharp discs and obvious venous pulsations bilaterally. Diagnosis: Non-surgical annular tear laterally at L3-L4, which was producing a symptomatic L3 relative radiculopathy that was relatively improving and an annular tear at L4-L5 that was not obvious clinical significance, but was probably contributing to some extent to his back symptoms. Plan: Referred to spine consultation. Advised modified work with restriction of no lifting over 40 pounds.

36. May 12, 2014, Correspondence, Don R. Butler, DC: This was a note to update on the status of patient. He has had 2 bulging discs that were causing pain radiating into his left leg with numbness and tingling. He also has had neck and mid back pain that was progressing well without any major concerns. His leg numbness and tingling was over 50% better. His severe low back pain had decreased to grade 3-6s from grade l0 range. Need to extend his treatment plan to weekly for 6 weeks followed up with examination.

37. June 03, 2014, Initial Evaluation, Valerie C. Chyle, APRN: DOI: 0l/23/14. Mechanism of Injury: Remained unchanged. Interim History: The patient reported low-back pain with a burning sensation down the left leg. He had a long history of chiropractic treatment with Dr. Don Buffer, who had been treating him "pretty aggressively" without any long-lasting results. Dr. Butler recommended an MRI, which was reviewed by Dr. Mack. Dr. Mack felt that this was not a surgical problem and referred patient to Dr. Chris Caldwell for consideration of injection therapy, but that was denied by the insurer. Dr. Mack did prescribe him Neurontin and Robaxin. With the medications and his level of pain, he was unable to return to his time of injury job. On 05/23114, he decided to stop the medication and his head cleared, but then he had more pain. His diagrams pain in the left side low back into the left buttock wrapping around the top of the left thigh into the medial aspect of the left knee and down the medial aspect of the lower leg into the top of the foot. He admits to some anxiety regarding his pain situation. Reports that this has had an effect on his mood and he feels crabby all the time. He has difficulty sleeping. He reports increased sensation of the need to move his bowels, but denies any bowel or bladder incontinence. Past Medical/Surgical History: He reports an upper neck disc bulge in2002 when he was hurt at work. He reports he had infantile asthma, but no problems since then. Diagnoses: 1) Lumbar strain with MRI evidence of degenerative changes L3-L4, L4-L5 status post work-related injury 01/23/14. 2) Long history of chiropractic treatment for multiple spine problems and injuries. 3) Diminished function secondary to the above. Plan: Dr. Mack provided a prescription for Neurontin, Robaxin. Recommended physical therapy to rehabilitate the back. Chiropractic will be stopped. Recommended physical therapy for lumbar strain.

38. June 24, 2014, Progress Report, Valerie C. Chyle, APRN: Interval History: Patient is feeling more hopeful and more mobile. He is overall feeling much better with physical therapy. Overall completed 4 sessions and last 2 sessions are not very helpful. He is back to work modified duty. Pain diagram in the very low back and left buttock with some wraparound to the top of left thigh. He rates his pain right now as a 5/10, at its worst an 8 to 9/10, at its best a 3 to 4/10. Diagnoses: 1) Lumbar strain with MRI evidence of degenerative changes L3-L4, L4-L5 status post work-related injury 01/23/14.

2) Long history of chiropractic treatment for multiple spine problems and injuries. 3) Diminished function secondary to the above. Plan: Will try low-dose amitriptyline to assist with sleep and nerve pain. Requested massage therapy. Continue physical therapy.

39. June 26, 2014, Physical Therapy Notes, Tara Wilson, MSPT: The patient attended physical therapy sessions from 06/09/14 to 06/26/14.

40. August 05, 2014, Progress Report, Valerie C. Chyle, APRN: Chief Complaint: "I want to get better. Hurt all the time, but it's frustrating and I'm at the end of my rope because l am too busy and too stressed out to get the treatment l need." Impression: Lumbar strain with MRI evidence of degenerative changes L3-4 and L4-5 status post work-related injury 01/23/14 now at maximum medical improvement. Recommendations: 1) Given basis instruction regarding stretching exercises. 2) He would indeed still benefit from PT and massage therapy regarding his low back pain. 3) Followup as needed.

41. September 17, 2014, Progress Report, Valerie C. Chyle, APRN: Chief Complaint: "I needed to come in because I've been in a lot pain and it's been hard to drive. It hurts even to breathe and I can't even take the pain." Impression: Lumbar strain with recent exacerbation. Plan: 1) Would provide with a small number of hydrocodone 5/325 mg. 2) Work slip given from 09/18/14 through 09/24/14. 3) Provided counsel same day regarding the importance of pacing and maintenance of a home exercise program. 4) Followup as needed.

42. July 11, 2016, Progress Notes, William Wu Chenwei, DO: History: The patient presented to the ED complaining of right ankle pain. He was playing basketball and tried to avoid stepping on girlfriend and while landing caused right ankle twisting injury. Reported experiencing immediate pain and had been constant since onset. There was swelling but was still able to weight bear. Diagnosis: Right ankle sprain. Plan: X-ray of the right ankle was performed, which did not reveal acute findings. Splint applied. A pair of crutches given. Prescribed Naproxen 500 mg.

43. December 12, 2016, Progress Notes, Michael Alan Lowe, MD: Chief Complaint: Chest pain. HPI: The patient presents to the Emergency Department with the above complaint. He had intermittent left sternal chest pain for 2-3 days. He stated that the pain was instantaneous and sharp without radiation. He stated that the pain would linger and become dull. Assessment: Chest pain. Plan: He was reassured that, at this time, these symptoms did not appear to represent a serious or threatening condition. He was discharged home. Advised to follow-up with PCP. Continue previously prescribed medications as directed.

44. December 23, 2016, Progress Notes, Diana Ting-Sui Wang, MD: Reason for Visit: General health checkup. Assessment/Plan: 1) Lower abdomen discomfort, possible diverticulosis, advice to increase fiber, exercise more. If persisted or worsening, to consider **flex sig**. 2) Skin lesions, actinic keratosis like, would refer to Dermatology to

consider biopsy as needed to rule out basal cell carcinoma. 3) STD screening per patient's request.

45. April 23, 2017, Progress Notes, Denise Diane Miller, NP: Reason for Visit: Abdominal pain – intermittent left lower quadrant abdominal pain x months. The patient reported severe heartburn last night. Also, dark/abnormal stool was noted same day. Assessment/Plan: 1) GERD: Labs were ordered. Follow healthy diet. Prescribed omeprazole 20 mg. 2) History of diverticulitis: Follow healthy diet. Take fluids to avoid constipation. Followup in 7-10 if not improving.

46. May 02, 2017, Progress Note, Thanh Thi Thu Ha, DO: Chief Complaint: Back pain - injury related; pinching sensation and frozen. Assessment/Plan: 1) Sciatica, left side (primary encounter diagnosis). 2) Lumbar disc disorder: The patient was advised to rest, apply ice to low back every hour for 20 minutes intervals. He declined any medications. Discussed gentle stretching exercises for the back. Avoid heavy lifting and activities that aggravate the pain. Declined physical therapy referral due to financial strain. Advised him that back pain could take several weeks to resolve. Work note given for 1 week off work. 3) Diverticulitis: Prescribed Ciprofloxacin Hcl 500 mg, and metronidazole 500 mg. Recheck in 7 days if symptoms not improved. Follow up with PCP in 1 week.

47. May 09, 2019, Progress Notes, Diana Ting-Sui Wang, MD: Chief Complaint: Abdominal pain. Assessment/Plan: 1) Abdomen pain with diarrhea - reported prior history of diverticulitis, should treat empirically with antibiotics first. Referral to colonoscopy after acute episodes resolve. Advised him to schedule appointment in 1-2 months. Advised on high fiber diet. 2) Lower back pain - needed to do back exercise, would get follow up x-ray, referred to PT. 3) He asked for 2 weeks off from work, let him know no indication for 2 weeks off at this time. Would give 4 days for diverticulitis and light duty for 1 week. Reassess as needed.

48. May 21, 2017, Progress Note, Hoang Dinh Tran, DO: Chief Complaints: Back pain and headache. Assessment/Plan: 1) Chronic low back pain > 3 months (primary encounter diagnosis): The patient was advised to take medications with food as directed. Advised to do stretching, apply heat to the area as needed and to do back exercises daily. Avoid heavy lifting and activities that aggravate the pain. Followup if pain did not improve or if neurological symptoms such as bladder or bowel dysfunction, numbness, weakness of lower extremities occurs. Follow up with physical medicine for further evaluation. Start tramadol and Robaxin as needed. Administered Toradol injection same day. 2) Atypical migraine: Advised to take medications as directed. Medication side effects discussed. Advised to recheck if vomiting, numbness, weakness, blurred vision, slurred speech or other neurological deficits occur. Try Excedrin. Take Imitrex as needed.

49. June 02, 2017, Progress Notes, Robert Mallari Bautista, MD: Chief Complaint: Back pain. Interim History: 3.5 years prior the patient hurt his back, and was treated through Worker's Compensation. Assessment: 1) Chronic low back pain. 2) Lumbosacral radiculitis. The range of treatment options, including conservative monitoring, physical

therapy, medications, interventions/injections or surgical evaluation/treatment was discussed. Plan: 1) MRI of lumbar spine without contrast. 2) Referral to physical therapy occupational therapy. 3) Prescribed Nortriptyline (Aventyl/Pamelor) 10 mg, and Cyclobenzaprine 10 mg. Continue over the counter NSAID as needed. Phone follow-up after MRI for possible consideration of epidural.

50. July 26, 2017, Progress Notes, Robert Mallari Bautista, MD: Chief Complaint: Followup – chronic low back pain. Assessment: 1) Chronic low back pain. 2) Lumbosacral radiculitis. 3) Lumbar disc degeneration. Plan: Home exercise program for his back. Back pamphlets given. Modified work for now. Continue nortriptyline. Trial of nabumetone. Continue Flexeril as needed. Return in 2 months to evaluate work status, evaluate effectiveness of exercise regimen. No injection for now; however, information regarding epidurals was given.

51. August 09, 2017, Progress Note, Chan Jennifer Nguyen, DO: Chief Complaint: Chronic back pain - worse for 1 week. Assessment/Plan: 1) Sciatica, left side (primary encounter diagnosis): No alarm symptoms, neuro exam was unremarkable. + Straight Leg Raise test was noted. Discussed physical therapy, sciatica exercises. Might take Tylenol or NSAIDs as needed for pain. Avoid heavy lifting or aggravating activities. Return to clinic if pain did not improve or if neurological symptoms such as bladder or bowel dysfunction, numbness, weakness of lower extremities occurs. Prescriptions: Prednisone 20 mg; administered Ketorolac 30 mg/ml injection. Follow up with physical medicine if symptoms was not improved in 5-7 days.

52. September 15, 2017, Progress Notes, Kelly Y Lin, MD: Chief Complaint: The patient complained lesions on face and chest. Assessment: 1) Screening for skin cancer. 2) Declines influenza vaccination. Plan: Photoprotection advised. Sunscreen at least SPF 30 or higher. Wide brimmed hats, long sleeves and protective clothing discussed.

53. October 17, 2017, Progress Notes, Robert Mallari Bautista, MD: Chief Complaint: Ongoing lower back pain. Recent lumbar MRI revealed: 1) L4-5: Mild disc degeneration. Disc bulge with associated annular tear results in mild central canal stenosis. 2) L3-4: Mild disc degeneration. Minimal disc bulge with associated annular tear. No neural impingement. Assessment: Chronic low back pain. Plan: Referral to chronic pain program. The patient was encouraged to explore MFA. Re-ordered NSAID and muscle relaxant, which he didn't request refills for due to financial constraints. Work modifications written. Discussed importance of stabilization and strengthening. This could be addressed in the pain program with pain program PT. Orders Placed in this Encounter: Erythrocyte sedimentation rate, automated. Referral pain management. Nabumetone 500 mg.

54. March 05, 2018, Progress Note, Trieu Hoang Nguyen, MD: Reason for Visit: Neck and back pain secondary to MVA same day. The patient was rear ended. Diagnoses: 1) Chronic low back pain. 2) Lumbosacral radiculitis. 3) Lumbar disc degeneration. Plan:

Shown stretch and ROM. Aggressive icing. Prescribed Nabumetone 500 mg, Flexeril 10 mg, and administered Ketorolac injection 60 mg.

55. March 12, 2018, Application for Adjudication of Claim - ADJ11231935: DOI: 02/14/18. Injured Body Parts: Back. Job Title: Assistant Community Director. Mechanism of Injury: Hit and run car accident on property.

56. March 12, 2018, Application of Adjudication of Claim - ADJ11231848: DOI: CT 06/05/15-03/12/18. Injured Body Parts: Head, back, lower extremities, upper extremities, back. Mechanism of Injury: Stress and strain due to repetitive movements.

57. March 12, 2018, Workers' Compensation Claim Form - DWC 1: DOI: 02/14/18. Mechanism of Injury: Hit and run car accident on property.

58. March 12, 2018, Workers' Compensation Claim Form - DWC 1: DOI: CT 06/05/15-03/12/18. Mechanism of Injury: Stress and strain due to repetitive movements.

59. March 12, 2018, Workers' Compensation Claim Form (DWC 1): DOI: CT 03/12/17-03/12/18. Mechanism of Injury: Stress and anxiety due to false defamatory statements, discrimination, harassment and hostile work environment.

60. April 19, 2018, Deposition of Evan Alan Disney, Volume I: **Page 1-21** – This is a 121 page deposition. The proceedings lasted for 2 hours and 18 minutes. The Deponent's full name is Evan Alan Disney. He testified that he took ibuprofen 600 mg this morning, and had been taking it once in a while. A couple weeks prior, he had taken it besides that day morning. He was given prescriptions in February. Same day, he took Ibuprofen 200 mg three pills for a long car ride from Fullerton. He took it as he knew that the car ride might make him sore. He had deposed before previously in 2003 due to a work related injury. He described that this was related to a wrongful termination. He couldn't recall much of the details of that deposition as it was 15 years prior. He further testified that he spent about 30 minutes with his attorney for same day's deposition. Same day, he was scheduled to work from 9 to 12 but had taken off of work due to deposition. His hourly rate of pay was $17.50. He drove himself a Lincoln Town Car here same day from home. He reported that he moved to California in March 2015 and had been residing there since then. His girlfriend, 12 year old daughter and his girlfriend's 8 year old was living with him now. He testified that he had served in the Navy for a year but was discharged honorably due to personality disorder. He had severe attention deficit hyperactivity disorder as well. He was currently employed by Advanced Management Company, where he started working in 06/2015. He was working as a leasing agent, but they had currently stripped him off his title. He was promoted to assistant manager of a property and was demoted for reporting a Fair Housing violation **10 shifts later**. Currently, he was performing the job of a leasing agent, but the business cards they had sent him was different from others. He actually reported a Fair Housing violation to HR for Advanced Management and was currently investigating the process to take it further. He also filed with the State of California Retaliation Complaint for the demotion of no cause. As a

leasing agent, he would manage an office, go on tours, clean as needed, move things such as packages of FedEx and UPS, and clean stairs as needed. He would also occasionally sweep, vacuum, and desk polish. They would take large packages in the office. He was not allowed to lift more than 40 lbs.

Page 22-32: When he manages an office, he would **take residents**, answer phone call, type up work orders, visit residents at their households, and would do inspections. He also would do a lot of up and down. He also would replace chairs, though chairs were old, it was hard to turn and move. Currently, his property had three employees in the office and they managed 200 units, he felt it was a high paced property. He also did a lot of paperwork and a lot of leases. Paperwork required about 30 plus signatures in a row. He testified that he could write faster than typing, and would do daily notes about three pages a day on the flow of the office. As an assistant manager, he had handled more of the responsibilities, customer relations, training people on using of lifts in the carport, walking the property and filling in. He also testified that his proper job title was assistant community director. Before worked for ANC, he was self-employed as a subcontractor for a copy center in Missoula called Missoula Copy Center. The owner was Doug Hannan, and the Deponent did odd jobs for him and managed the customers for seven years before coming out. Moreover, he was a magician, member of the Magic Castle in Hollywood. He raised money for nonprofits and prevented bullying in schools. He worked as a magician for 20 plus years. Last month, he performed 30 minutes as a magician and his average work hours were 30 minutes/month in this side of position. At a fundraiser, he did a performance on March 24, 2018 in a 10-minute set with Easy Way. He was a master of ceremonies at the Renaissance School International Talent Show on March 21, 2018. He did a film on Magic Castle performance on February 12, 2018. He testified that his magician side of job was inconsistent because he didn't have a daily regiment or routine. Sometimes, it was documented, sometimes it wasn't. Sometimes it was a donation and he was just showing up as a friend for a friend. He was never paid for the above other than Renaissance. He was also not paid for America's Got Talent audition. In the last 6 months, he had done three paid performances with Renaissance and had some performances in the Christmas season.

In addition, he testified that he had recorded a 20 minute set for the entertainment director during performance at the Magic Castle on February 12, 2018 so that he could get hired by Magic Castle at some point in his career. Two years prior, he contested on a game show called Let's Make a Deal. He further testified that, most of his work for Missoula Copy Center was paid in cash and worked there for 10 years. He had to claim on his own and he was a subcontractor for Missoula. When asked, "What would you do for them?" He testified, "Anything, he needed me to do from running deliveries to making phone calls, collecting his L5 delinquents. Job- work, piece work. The job I was working while I was doing that before I came out here was a casino job for Lucky Lil's. It was for Talent Pump Corporation. That was 2000." He added that he had been doing work for Missoula Copy Center for 10 years and still was doing when visiting him. He went twice a year for four days a pop. He went back in November for a family vacation and he had some things he had to take care of with his parents. He ran errands in trade for business

cards when he went back in November. He did not get paid but he traded for services, which he did often for him. He worked for Montana Little Lil's from December 2014 to February 2015. He was a runner. He just basically paid people their tickets and brought them their drinks. It was all walking and no bending, pushing, cleaning and it was a really easy job. It was all exchange and barter there. **Page 32-42**: At Missoula Copy Center, he didn't earn any income. They would purchase things for him for the work but they never gave him the actual money for it. He was taken out for dinner or his tank would be filled with gas, or there was a couple of occasions in which his rent was paid and he had to spend 2-3 months paying that off, but he never received cash money. However, his earning could be calculated as $9 an hour plus tips. He stopped working there as he moved to California to pursue his magic. Prior to Lucky, he worked for Opportunity Resources for almost 2 years – from 2012 to 2014 or 2011 to 2014, where he worked as a nursing assistant without the certification. His duties were taking care of residents, bathing them, cleaning them, and getting them from the bed to their wheelchairs, helping them after potty, taking them to church, and cooking them breakfast. At that time, he earned 11 bucks an hour. During the end of his employment at Opportunity Resources, around 2014, he was injured his low back. When he was lifting a resident off the floor under the direction of his supervisor and turned, something popped in his low back and caused him some severe pain and issues. He received treatment from Butler Chiropractor, Missoula, Montana.

At that point, his attorney (Steve Carey) sent him to other doctors. His case was settled and got $1000. Before working for Opportunity Resources, he worked for Direct TV from 2009 to 2011. He worked as team support specialist. Duties included handling all the supervisor calls and train his agents, holding them accountable, keeping them up and active at their stations. He worked in a call center, but worked on computer rarely. He felt that his ADHD (attention deficit hyperactivity disorder) made him perfect for the job because he was always positive and hyper. He worked as a team support specialist for six months and hourly rate of pay was $14 an hour. In addition, he testified that he had a kidney stone while working for this employer but it wasn't attributed to work. However, he also recalled that while working for Direct TV, in 2010, he sustained an injury to low back as well as a twisting injury to left ankle. He was with couple of supervisors and he tripped over something and twisted his ankle. He could not recall specifics of the incident. He remembered being off of work for ankle twist. He added that he would also have injured his low back but he was unable to recall the specifics. Regarding other workers' claims, he testified that while working for Schwan's he had filed a claim in 2012 for his neck injury with Liberty Life Assurance Company of Boston. While working for Schwan's, he was helping a customer with her groceries. Her car alarm went off and it startled him. He was smacked in the back of the head when he stood up by a 2 x 4 beam on a shed. But, then Schwan's terminated him wrongly. He ended up in losing everything at that point as well as became homeless. He was currently having Kaiser health insurance through AMC, which he used to treat at Kaiser facilities. He had been to Kaiser Garden Grove facility. He visited an ER early last year for chest pain. He testified that he had seen a chiropractor in Long Beach regarding current Workers' Compensation. He was diagnosed with diverticulitis.

Page 43-61: The Deponent's current source of income was AMC. He would charge usually $500 for his magic shows. He recently did a school performance. He was paid $300 for his school performance, which happened two Mondays prior. He would like to be a full-time magician at some point. He had always did animation videos even when he was not feeling good due to ADHD. He recently done 15-second magic related Vigo video as a new promotion, which just started this month. He recently posted a video on 04/18/18 and had received 612$. He was sharing his household with his girlfriend. She was working at Renaissance school and they were sharing her income. He had received Workers' Compensation benefits payments from an insurance company due to an injury that he sustained at **OPI**. Regarding a prior injury, he recalled that during work at Mountain Supply around 2003, he fell down a flight of stairs and had sustained an injury but details were unrecalled. He didn't know if he had filed claim. Moreover, he indicated that he was hired there 3 times and had worked for about 4 years in 3 different employments. He had received Workers' Compensation benefit two times in a life as a result of injuries at work. In May of last year, he applied for disability benefits through the State of California or EDD. He received disability benefits for 6 weeks and the benefits ran out then. He had requested doctor to certify him fit for work so he could go back to work because he needed the money. However, during those 6 weeks from May to June 2017, Dr. Robert Bautista certified him on disability for his back issues. He was out of vacation time, sick time. He got injured in April with AMC but if they reported to their property, it would affect everybody's bonus. He also recalled that he was involved in automobile accidents on two occasions in 1996 and 1997. For the 1996 accident, he denied any injuries. During 1997 accident, he was a passenger and had injuries to mid to upper back and more of shoulder areas. He had received medical treatment at United States Navy Corps Hospital, Great Lakes, Illinois.

He testified that he signed off something and he could not recall much as he was a kid. He also indicated that he was diagnosed with myofascial pain disorder in 2004. He testified that his myofascial pain disorder was considered as chronic. His low back pain triggered to bad twist in April of last year. He reported feeling of stiffness as well. He worked for Costco selling Direct TV from April until he got his job with AMC. When asked, he recalled that at AMC, his supervisor was Zenyen. He also recalled that he had got a formal warning from AMC for using company equipment for personal use. **Page 62-83**: From approximately May 2017 through June 2017, he was on FMLA (Family and Medical Leave Act) due to injury. He testified that as a result of work at AMC, his numbing and tingling of left leg recurred on full swing. During work at the same employer, he also injured lower back, left leg, left arm and left neck as well as right leg. He felt that injury was happened over time. At that time, he reported symptoms to assistant manager at Highland Pinetree. During of end 2016 at AMC, he noticed pain and stiffness in his low back. He recalled experiencing worsening left leg symptoms in 01/2017. Since February 2018, he had been feeling more symptoms in his left arm and left side of neck. His right leg symptoms started since 04/2017. He testified that he started to hurt when he was doing Thanksgiving turkey boxes for the residents. They had an assembly line from reaching boxes up in the truck and bringing them down. At that

time, he complained of stiff and sore for a while. He mentioned that Thanksgiving week was a really hard week for him because there was a lot of cleaning that week. His symptoms got worse during Thanksgiving week. He first started noticing left leg pain around 01/2017. Around that time, when he was sitting at his desk, he felt numbness and tingling. He testified that his promotion and demotion occurred in 02/2018. He testified that he had community director training with AMC. On 02/14/2018, Valentine's Day, he went into HR and also talked to the COO of the company.

The Deponent left that meeting and when was driving back to his property from the meeting at AMC and on his return, he was rear-ended, which was a hit and run accident. Then he had contacted his supervisor of the property immediately and reported injury. He went to NowCare as per supervisor referral. He testified that the accident occurred on a freeway off ramp and at times, he was really shaken. He agreed that accident actually took place off site, but not on the AMC property. On that day, he got released from class by 12:00 because he had the meeting after class. He testified that accident occurred between 12:15 and 1:15. After he left the training, he texted boss. Then, he was assigned to drive back to the property. During driving, he stopped vehicle for gas. He checked in with his boss at property. He testified that in April 2017, he tweaked his back while he was doing a tour of a unit. He would be sitting at the desk at work and was doing something, which caused spasm and burning sensation. He added that he has had a little bit of an anxiety attack also at that time. In addition, he noted that first time, he noticed pain or discomfort in right leg around 11/2017. During morning, he would feel stiffness and numbness in right leg and walking sometimes helped his symptoms. At that time, his assistant manager would ask him to do some of the onsite jobs to try to get relief. He stated that people at work knew about his pain. During 02/14/17, he was involved in a car accident but there was no damage to his car. He reported that he was shaken up, and after accident, he texted to his manager. He reported that he was already having pain before accident. He drove to Montana in 02/2017 to get his daughter and that trip was about 14 hours. He had informed his co-workers about his prior back injury. When asked about his medical background, he had reported Kaiser doctors about his intermittent back pain. Since approximately November or December 2016, he could not work through the pain, so he informed his boss about his symptoms.

Page 84-104: As per his boss, he saw the doctor at Kaiser, who gave him restriction note, but his boss did not accommodate it. Due to low back pain, he took off for l4 days in 2016. Then, EDD started around 05/2017 and lasted for approximately 6 weeks. After his EDD, doctor placed him on restriction with no prolonged sitting or standing, no lifting and minimal bending, squatting, twisting and turning. AMC accommodated his work restrictions. He also testified that AMC allowed him to come back with a minimum schedule. He was still on modified duties and was working 5 hours a day, placed by a chiropractor doctor. His modified duties were currently being accommodated. As a result of work-related injury at AMC, he sought medical attention at Kaiser in 04/2017. He went one time to a NowCare, a Kaiser Urgent Care. Furthermore, he testified that for the past 3 weeks, he had been seeing Dr. Iseke for neck symptoms and recently saw him in the past Friday. For 02/14/2018 accident, he went to Kaiser between time 3:00 and

4:00. First went to one Kaiser, though the wait line was long, which he informed to her girlfriend. She was working there, and got off on that day and met him. Then he went to second Kaiser. Doctors at Kaiser diagnosed him with whiplash and took him off for 2 days. When he visited Kaiser for his low back symptoms in 04/2017, the doctor diagnosed him with bulging disc with a narrow nerve canal. Kaiser doctor also opined that the patient's right leg and left leg pain were attributable to his low back symptoms. Recently, he talked with his chiropractor about right arm symptoms. With regard to low back issues and bilateral leg complaints, Kaiser doctor referred him to pain management. He testified that he had refused to go to pain management doctor due to financial constraints. He got massage therapy from Dr. Iseke and that helped a period of time. Dr. Iseke also had done acupuncture and muscle stimulation as well as performed an ultrasound. He had an upcoming visit with Dr. Iseke next day. He testified that currently he was stressed and depressed and believed that it was work-related. He opined that his financial situation and work was the cause of his stress. He was still trying to do his job to the best of ability as he should not have to find another job.

He also testified that he had good standing relationships with ex-wives. He first noticed stress when he got demoted on February 21st without reason and also had been pretty much in a funk ever since. When asked, "Do you have any physical symptoms in relation to your stress or depression?" He replied, "I've had increased heartburn something fierce. I can't sleep. I'm not really eating well. I don't want to get up or do anything. I'm short with my kids. My girlfriend, as nice as she is, is like, you know, don't take it out on me. My lucky go positive attitude has seemed to disappear, as it's been brought to my attention by my children and my coworkers." He added that previously also he had become stressed and depressed when he got terminated and was homeless for Schwab's. He testified that his breathing was going up and was getting lightheaded. He was feeling like he was going to throw up. If there was any emotional, he could not stop his tears as of recently. **Page 102-119**: When he got demoted without reason, he pretty much lost his mind, felt was so angry, could not sleep that night, and thrown up that day. He felt that stress was the cause of lifestyle changes. Regarding stress, he asked for referral, but could not afford the co-pay. He had seen psychologist in his earlier adulthood. He took Adderall, which helped his super stress. He just did not like the body side effects, so stopped it. He had seen mental health professionals for his ADHD. Moreover, he testified that after battle with his company, he was started with his FMLA. Then, they shorted his hours; however, he came back to work and worked hard. He applied for two promotions, but got no response. He supposed to move to a property, which was close to his girlfriend's work place, but felt bunch of lies came out of his boss and currently had no title and no direction. Currently, he was seeking legal action, which he felt as stressful.

The Deponent reported to the Retaliation Department of the State of California for defamation at work. He also sent an email to the employer on 03/27/18, regarding rectifying of issues and filing of lawsuit, but he did not get any response. He was aware that his girlfriend, Terecita Baker was previously married before entering into a relationship with him and also aware that she was currently in the process of divorce with

her significant other. Also, he recalled that he had filed bankruptcy 17 or 18 years prior. He had been evicted twice in Montana. Regarding his current pain, he reported that he was having pain in the low back. Currently, his low back pain was rated at 7.5/10 and would go up randomly. Hot water, ice, weightlessness floating in water helped his pain but Ibuprofen was not really helping that much. Currently, he was also having numbness in the left leg and tingling in the hand. He could not feel his left hand now and was also having burning, tingling down on the front side of his right leg, which occurred once every couple of weeks. He was having tightness in the left side of neck, which was challenging to drive. Due to pain, he could not play basketball anymore and could play with his kids anymore. Currently, he was unable to tie his shoes, which was very embarrassing for him because could not reach his back. He felt injuries had gotten worse and everything was just aggravated. He stated that he had gone out to dinner a couple times. He went to the Magic Castle on Sunday for his birthday and he passed his audition for the 14 members. He added that in his free time, he would watch a lot of TV. At the moment, he owns a snake Bull Python, which was helping with therapy. He testified that his girlfriend had an 8 year-old-child from her first marriage. He and his girlfriend were on food stamps because they live in a household.

61. May 12, 2018, MRI of Cervical Spine, Adil Mazhar, MD: Impression: 1) Reversal of the cervical lordosis. 2) Disc desiccation at C2-C3 down through C6-C7. Mild to moderate associated loss of disc height seen at C3-C4 down through C5-C6. 3) C2-C3. A broad based disc protrusion is identified. Disc material abuts the thecal sac. Disc measures 2.0 mm. 4) C3-C4. A broad based disc protrusion is identified. Disc material abuts the thecal sac. Disc measures 2.3 mm. 5) C4-C5. A broad based disc protrusion is identified. Disc material abuts the anterior aspect of the spine cord. Disc measures 2.3 mm. 6) C5-C6. A broad based disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord Disc measures 3.1 mm. 7) C6-C7. A broad based disc protrusion is identified. Disc material abuts the thecal sac. Posterior annular fissure is identified. Disc measures 2.3 mm. 8) Schmorl's node at inferior endplate of C3 down through C6.

62. September 06, 2018, Initial Orthopedic PQME, Todd W. Peters, MD: DOI: 02/14/18. History of Injury: The patient reported that on 02/14/18, during the course of his employment as an assistant manager, around lunch time, he was driving a 1996 Lincoln Town Car when a red car rear ended his vehicle. The impact was not that hard but it was enough to cause whiplash, he panicked and went to see a doctor afterwards. He could not recall the make or model of the car that rear-ended him as it drove off. Initial Treatment: On 02/14/18, he was referred by his employer to the Kaiser Garden Grove. He stated that an MRI of the neck was obtained and a bulging disc was found. He was unable to recall the name of the urgent care physician who examined him. He was given Flexeril 10 mg to take before bedtime and was advised to rest. He stated that he was unable to finish his shift and was not able to return to work the next day. He also stated that he was taken off work for two days. He was currently on modified duty restrictions that were declared on 08/20/18. He was advised that he could only work for four to five hours a day, and to undergo therapy three times a week. Subsequent Treatment: He stated that he began

seeing a chiropractor and received treatment in the form of shockwave therapy, acupuncture, manual manipulation and chiropractic treatment. He stated that he did not feel any benefits from any of the therapies. He stated that he had been doing therapy for five months three times a week. He reported that his physician advised him to rest for two weeks, gave him stretches on and off and watch YouTube videos of stretching exercises that could be done at home. Job Description: He worked full-time as an assistant manager, and performed duties associated with issues of residential management such as walking a person to their apartment, dealing with packages, paperwork and files, phone calls, typing contracts, and tours.

He had to stand, sit, bend, motions a lot at work and after about two or three hours of work, he would get a very bad headache and he could not concentrate. Occupational History: He began employment with Advanced Management Company on 06/l7/15 and had worked for them for three years. He was currently on modified duty restrictions that were declared on 08/20/18. He reported that his work status would expire on 08/30/18. Employers: 1) Prior to that, he was selling Direct TV at a Costco. 2) Prior to that, he moonlighted as an in-house nurse in 10/2012. He did not remember the name of the institution. 3) Prior to that, he worked as a customer service manager for Missoula Copy Center in Missoula, Montana for almost 10 years. 4) Prior to that, he worked for Mountain Supply 21 years prior. Previous Injuries: Industrial: He reported that in 04/2017, while he was meeting people around the property that he was working on, he was walking backwards and fell on the sidewalk and twisted his lower back. He reported that in 10/2012, while he was working as an in-house nurse, he hurt his lower back picking up a patient off a bed. He stated that he fell down a flight of stairs 21 years prior but had no major injuries. He was off work for a couple of days. Current Complaints: 1) He complained of aching, stabbing sensation, and weakness to the neck that was always present. He stated that the pain was radiating down to the left shoulder, left arm, left hand, left fingers, and left leg. Pain was rated at 7/10. The pain was aggravated by rotating the neck and staying in one position for a long period of time. He stated that hot baths, heat and ice application, stretching exercises, and medication helped a little in alleviating the pain.

2) He was also complaining of aching, stabbing sensation, and weakness to the left shoulder that was always present. Pain was rated as 7/10. The pain was aggravated by rotating the left shoulder. He stated that hot baths, heat and ice application, and medication helped in alleviating the pain. He also stated that he was having some difficulty doing stretching exercises, but this helped a little in alleviating the pain. 3) He was currently complaining of aching, stabbing sensation, and weakness to the left hand and fingers that was always present. Pain was rated at 7/10. He stated that hot baths, heat and ice application and medications helped to alleviate the pain. 4) He also stated that he was having some difficulty doing stretching exercises, but this helped a little in alleviating the pain. He was currently complaining of aching, stabbing sensation and weakness to the left leg that was always present. Pain was rated at 7/10. Pain was aggravated by rotating the left leg and staying in one position for a long period of time. He stated that hot baths, heat and ice application and medication helped to alleviate the

pain. He also stated that he was having some difficulty doing stretching exercises, but this helped a little in alleviating the pain. ADLs: ADLs were reviewed. Review of Records: Dr. Peters reviewed the patient's medical/nonmedical records dated from 07/11/16 to 07/24/18. Physical Exam: There was moderate paraspinal spasm over the left inferior paraspinal muscles, deep at the facet joints of the inferior cervical spine. With flexion, extension and left rotation, he complained of mild to moderate discomfort. He also had mild to moderate discomfort with rotation to the right. There was a weakly positive Spurling's sign on the left. Diagnoses: 1) Cervical sprain/strain and complaints of radiculopathy. 2) Lumbar sprain/strain with complaints of radiculopathy.

Discussion: He had a claim for a specific injury on 02/14/18, involving the neck, but there had also been a cumulative trauma injury claim filed from 06/06/15 through 03/12/18. As far as his job was concerned, he was still working at his job and stated that he had been released to return to full duty. He added that he was unable to return back to work unless he was released to full duty work, and so he requested to be return to full duty. He stated that he had been working for this company for about three and a half years, eight hours per day and five days per week. He did have some restrictions on the hours that he was allowed to work. Regarding his main complaint of low back pain, he described a specific incident in 04/2017. He noted that he was working at his current job, and was walking backwards when he twisted and fell sideways, and began to experience severe low back pain. He has had back pain prior to this incident, but stated that this injury caused increased pain, and more pain radiating down the leg. At present, he described low back pain down the left leg to the foot with numbness, tingling and weakness. His back pain was significant. Also, he described about the subject specific injury on 02/14/18, when he was stopped at an intersection and was "jarred from behind." He did not think that the strike was significant, but he had a defective headrest and therefore, his head went backwards in extension and then into flexion; whiplash-type maneuver. He stated that he had some soreness, but over the next few days he had an increase in neck pain with pain down into the left shoulder, left arm and hand. He stated that he had not experienced any previous issues with his neck over the last few years. He described numbness and tingling in the left long and ring fingers with coldness and neck pain. He had severe neck pain in the left inferior neck region that was causing difficulty when trying to sleep.

Disability Status: He was not deemed MMI at this time. Causation: This examiner opined that a portion for the cervical spine and lumbar spine was industrial, based on the submitted medical records and the patient's history as provided. This examiner found that the patient's lumbar spine was causally related to a specific fall in April 2017, while working for Advanced Management Company. The reported mechanism injury was reasonable to caused injury and the need of treatment on an industrial basis. He was then rear-ended on February 14, 2018. He stated that the hit was not very hard, but it was enough to cause a whiplash injury to his neck. This mechanism of injury was reasonable to caused injury and the need for treatment on an industrial basis. Apportionment/Impairment Rating: Deferred pending permanent and stationary status. Treatment Recommendations: He should be allowed to proceed forward with an

orthopedic surgeon/spine specialist for evaluation and treatment of the cervical and lumbar spine. This might include the possibility of epidural injections at this time. His last MRI scan of the lumbar spine was performed in 07/2017. Therefore, ordering a new MRI scan of the lumbar spine regarding direction for further treatment concerning the low back. He stated that he had an MRI scan taken of the cervical spine, as ordered by his chiropractor in 04/2018, but did not have this study in the medical records and therefore, requesting that this be sent to this examiner for review and further comment. Work Restrictions: He might continue his usual and customary duties while proceeding with additional treatment but with following restrictions: No lifting over 35 to 40 pounds; avoid overhead activities.

63. October 15, 2018, Primary Treating Physician's Permanent and Stationary Report, Harold Iseke, DC: DOI: 02/14/18; CT: 06/05/15-03/12/18. History of Injury: The patient stated that while employed with Advanced Management Company as an assistant community director, he sustained injuries on a cumulative trauma basis from 06/05/15 to 03/12/18 and on a specific date 02/14/18. He had been employed for this company for a period of two and a half years. His date of hire was in 06/2015. From 06/05/15 to 03/12/18, he started to experience headaches, pain in his back, bilateral upper extremities and bilateral lower extremities, which he attributed to constant sitting, twisting and bending that he performed at work. He also stated that the back pain worsened when he twisted his back as he was walking off a side walk. The incident was known but his employer did not make any recommendations. He managed the pain by seeking medical attention on his own around the end of 04/2017 with a private physician in Garden Grove where he was evaluated, diagnostic studies were taken, was prescribed medication, started on a course of physical therapy and returned to work with restrictions. He continued working with persistent symptoms. He continued to attend follow-up visits and treatment until approximately 09/2017 at which time despite the pain he decided to stop seeking medical attention until 02/14/18. On 02/14/18, while he was driving during work, he sustained aggravating injuries and later developed worsening headaches and sleeping problems when he was involved in a motor vehicle accident. He stated that he was exiting an off ramp and was rear-ended in a hit and run accident. He stated that he had experienced worsening pain to his back and sought medical care at Urgent Care in Garden Grove. There, he was evaluated, was prescribed medication, placed off work and discharged. No further care was rendered. He had since continued to work with restrictions on his own to present.

    Job Description: Patient worked for Advances Management Company from 06/2015 to present as an assistant community director. He worked more than 35 hours per week. His job duties included walk the properties, deal with customers, write up contracts customer service, making and taking phone, clerical work and various other duties. His 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 50 lbs. History of Treatment: Examiner has initially seen this patient on 03/29/018 for evaluation of his cumulative trauma injuries from 06/05/15 to 03/12/18 and on a specific date 02/14/18,

while working as an assistant community director for Advances Management Company. At the time of the evaluation, he complained of headaches, back pain, pain on upper and lower extremities, and sleeping problems. He was recommended with physical therapy, chiropractic treatment, acupuncture, ECSWT and medications. During this evaluation, he was still symptomatic despite reporting some improvement in pain after treatment. He was currently working. Current Work Status: He was currently working with no modified duties and his job position was demoted to leasing consultant in a full time basis. He stated that he had been performing as a magician in on call jobs for the past 20 years. Present Complaints: 1) Head: He complained of frequent occipital, frontal sharp, throbbing headache radiating to down left arm with nausea. Exacerbation with stress, activity and prolonged work. 2) Cervical spine: He complained of constant mild achy neck pain and stiffness that was becoming sharp, throbbing, burning severe pain with sudden or repetitive movement, lifting 10 lbs, looking up, looking down, bending and twisting. His pain was radiating to left hand with numbness, tingling, weakness, cramping and muscle spasms.

3) Thoracic spine: He complained of constant mild mid back pain and stiffness that was becoming sharp, throbbing, burning severe pain with sudden or repetitive movement, lifting 10 lbs, looking up, looking down, bending and twisting. His pain was radiating to left hand with numbness, tingling, weakness, cramping and muscle spasms. 4) Lumbar spine: He complained of constant moderate achy low back pain and stiffness that was becoming sharp severe pain radiating to bilateral legs with numbness, tingling, weakness, cramping and muscle spasms with sudden or repetitive movement, lifting 10 lbs, standing, walking, bending, kneeling, twisting and squatting. 5) Sleep: There was complaint of loss of sleep due to pain. 6) Psychological: He stated that due to pain, he was feeling like his condition would never improve and this was causing anxiety, stress, depression and irritability. Prior Industrial Injuries: He stated that approximately in 2006 while working for a different employer in a different state, he had sustained injuries to his neck. He received approximately one year of treatment. He stated that he made a full recovery, and the case was now closed. He stated that in approximately 2011, while working for a different employer in a different state, he sustained injuries to his lower back. He was under treatment for approximately two years and stated that he made a full recovery. This case was also closed now. Prior Motor Vehicle Accidents: He had a previous automobile accident in 1997. Medications: He was currently taking Flexeril and muscle relaxer (Relafen). ADLs: ADLs were reviewed. Physical Examination: Height: 6’1”. Weight: 215 lbs. BP: 129/71.

Cervical spine: Palpation: There was tenderness to palpation of the bilateral sternocleidomastoids, bilateral trapezii, cervical paravertebral muscles, cervicothoracic junction, spinous processes, and suboccipitals. There was muscle spasm of the bilateral sternocleidomastoids, bilateral trapezii, cervical paravertebral muscles, cervicothoracic junction, and suboccipitals. Noted decreased ROM of cervical spine. Noted positive Cervical Compression and Soto-Hall test. Thoracic spine: Palpation: There was tenderness to palpation and muscle spasm of the bilateral levator scapulae/rhomboids/scapular area/trapezii, spinous processes, thoracic paravertebral

muscles and thoracolumbar junction. Noted decreased ROM of thoracic spine. Positive Kemps' test was noted. Lumbar spine: Palpation: There was tenderness to palpation and spasm of the bilateral gluteus/sacroiliac joints/lumbar paravertebral muscles, sacrum, spinous processes, and thoracolumbar junction. Decreased ROM of lumbar spine was noted. Positive Kemps' test. Diagnoses: 1) Headache. 2) Spinal enthesopathy, cervical region. 3) Radiculopathy, cervical region. 4) Cervicalgia. 5) Spinal enthesopathy, thoracic region. 6) Pain in thoracic spine. 7) Low back pain. 8) Radiculopathy, lumbar region. 9) Spinal enthesopathy, lumbar region. 10) Sleep disorder, unspecified. 11) Acute stress reaction. 12) Major depressive disorder, single episode, unspecified. 13) Anxiety disorder, unspecified. 14) Irritability and anger. 15) Chronic pain due to trauma. 16) Myalgia. 17) Myositis, unspecified. Discussion: The patient reported an injury, which he sustained while working with Advances Management Company. In brief review, he reported having headaches, pain in his back, bilateral upper extremities, bilateral lower extremities and sleeping problems. He sought medical care at Urgent Care in Garden Grove.

He was evaluated, prescribed medication and was placed off work. No further care was rendered. When he initially presented to this examiner's office, he was recommended with physical therapy, chiropractic treatment, acupuncture extracorporeal shockwave therapy and medications. However, he remained symptomatic despite the treatments. At this time, he had reached Maximal Medical Improvement and was deemed Permanent and Stationary. Causation: Dr. Iseke indicated industrial causation for the claimed cervical, thoracic and lumbar spine injuries. Apportionment: No apportionment was indicated nonindustrial factors and 100% was apportioned to the cumulative trauma from 06/05/15 to 03/12/18 and 02/14/18 accident. Apportionment in regards to his psychological disabilities was deferred to appropriate specialist. Impairment Rating: Cervical spine: 8% WPI. Thoracic spine: 5% WPI. Lumbar spine: 5% WPI. Total WPI: 19% WPI. Future Medical Care: He should be provided future medical care for flare-ups that would be reasonably expected for his condition. Additional treatment, which might involve up to 24 sessions of physical therapy per year for any acute flare-up. In addition, due to chronic pain, the ACOEM practice guidelines also recommended acupuncture treatments to help reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effects of medication-induced nausea, promote relaxation in anxious patients and reduce muscle spasm. Acupuncture treatments in particular, were of great benefit for patients suffering with neck, mid back and low back.

In addition, he might necessitate pharmaceutical agents to include, but not limited to analgesics and nonsteroidal anti-inflammatories. These medications would be prescribed by his medical physician. Moreover, due to his residual neck, mid back, and low back, it was also medically probably that, he would require periodic orthopedic specialty evaluation, as well as medications, bracing, injections and even additional diagnostic studies (including x-rays, diagnostic ultrasound, MRI scans, EMG/NCV studies, etc.), in order to monitor for potential progression of his industrially-related injury/pathology. Orthopedic specialty consultations should be provided for consideration of possible

surgery if his symptoms significantly worsen and if so deemed appropriate and necessary by the specialist at the time of said specialty consultation. Work Restrictions: He could return to his previous occupation as assistant community director on modified duty with the following permanent work restrictions: In regard to the neck, he was precluded to no overhead activities, and no activities involving repetitive motion of the neck or involving comparable physical effort. In regard to his mid and lower back, he was restricted from heavy lifting, squatting, stooping prolonged standing, sitting, climbing, twisting, walking on uneven grounds, or other activities involving comparable physical effort. Supplemental Job Displacement Benefits: If the work restrictions noted above were not honored by his employer, then he should be considered as a Qualified Injured Worker (QIW), and therefore would be eligible for Supplemental Job Displacement Benefits.

64. December 12, 2018, Progress Notes, Uyen-Phuong Thuy Nguyen, MD: DOI: 12/12/18. Chief Complaint: Moderate low back pain secondary to fall at work. HPI: The complained of moderate low back pain x 1 hour. The pain was related to an injury, which occurred with fall down a flight of stairs when he slipped off a staircase outside of work. There was associated left lower extremity tingling. Pain was present with movement as well as with rest. Assessment: 1) Traumatic spondylopathy. 2) Right ankle joint pain. Plan: 1) X-rays of thoracolumbar spine/right ankle/lumbosacral spine. 2) Administered Ketorolac injection 60 mg (Toradol). 3) Prescribed Naproxen 500 mg and Cyclobenzaprine 10 mg.

65. December 12, 2018, Workers' Compensation Claim Form (DWC 1): DOI: 12/12/18. Patient states "I fell on stairs at work."

66. December 21, 2018, Doctor's First Report of Occupational Injury or Illness, Stephen Kiran Kumar, MD: DOI: 12/12/18. Chief Complaints: Back/leg pain (8/10). Mechanism of Injury: Fall and direct blow. Treatment History and Medications: The patient had pre-existing history of chronic non industrial lower back pain. Also had another WC claim (represented for) seen elsewhere for an MVA injury to mid back, neck. He was seen in urgent care on 12/12/18. Diagnostic Imaging: X-ray of lumbar spine: Impression: Vertebral bodies are normal in height and alignment. There is a transitional vertebral body with pseudoarthrosis on the left. Intervertebral disc spaces are well preserved, symmetric and maintained. No soft tissue abnormality is identified. Diagnoses: 1) Lumbar muscle strain, initial encounter (primary encounter diagnosis). 2) Low back contusion, initial encounter. 3) Sciatica, left side. 4) Left leg pain. Plan: Continue Medrol, Flexeril 10 mg, and Capsicum Oleoresin-Menthol-Camphor 16-24-80 mg. Administered Ketorolac injection 60 mg. PT x 6 sessions requested (2x/week x 3 weeks). Commence Motrin 600 mg once Medrol was finished after one week. Apply Salonpas patches as directed. Ice application to affected body part, 3x/day (30 min each). Modified duty starting on 12/26/18 (off work till that time). Work Restrictions: Allowed: a) Bend at the waist: Not at all. Torso/spine twist: Not at all. Squat/kneel, knee bending: Not at all. Climb stairs: Not at all. Climb ladders: Not at all. Use of scaffolds/work at height: Not at all. Other Needs/Restrictions: No driving was permitted. Followup in 3 week, or sooner if worsening symptoms.

67. January 11, 2019, Primary Treating Physician's Progress Report (PR-2), Stephen Kiran Kumar, MD: Chief Complaints: Back and leg pain. Treatment since Last Visit: PT x 6 to commence 01/14/19. He finished Medrol dose pack with some improvement (mild). Diagnoses: 1) Lumbar muscle strain, subsequent encounter. 2) Low back contusion, subsequent encounter. 3) Sciatica, left side. Plan: Continue NSAIDS and topical/OTC meds; Flexeril was refilled. Would start PT on 01/14/19. Continue modified work. Followup in 2 weeks.

68. January 28, 2019, Primary Treating Physician's Progress Report (PR-2), Stephen Kiran Kumar, MD: Chief Complaints: Back and leg pain. Treatment since Last Visit: Completed 3/6 PT sessions. The patient had finished Medrol dose pack initially with some improvement (mild). Diagnoses: 1) Lumbar muscle strain, subsequent encounter. 2) Low back contusion, subsequent encounter. 3) Sciatica, left side. Plan: Continue Ibuprofen and Methyl Salicylate. Advised to discontinue Flexeril and switch to Robaxin. Requested additional PT x 6 as well as chiro x 8 sessions. MRI of lumbar spine was ordered. Continue modified work (anticipate loosening work restriction next visit – lifting driving restrictions). Followup in 2 weeks.

69. February 13, 2019, Primary Treating Physician's Progress Report (PR-2), Stephen Kiran Kumar, MD: Chief Complaints: Back and leg pain. Treatment since Last Visit: Completed 6/12 PT sessions and 1/8 chiro sessions with Dr. Soloway. Diagnoses: 1) Low back contusion, subsequent encounter. 2) Sciatica, left side. 3) Lumbar muscle strain, subsequent encounter. Plan: Continue Ibuprofen and Methyl Salicylate. Continue PT/chiro. MRI of lumbar spine was ordered to rule out herniated disc. Continue modified work (restrictions advance slightly same day - lifted driving restrictions). Followup in 3-4 weeks or as needed.

70. March 08, 2019, Primary Treating Physician's Progress Report (PR-2), Michael Joseph Gruba, MD: Chief Complaints: Back/leg injury. Treatment since Last Visit: The patient had completed 10/12 PT sessions at clinic and he reported that he did not want to continue at. He would like to switch to doing PT at where he was doing chiropractic. He had completed 6/8 chiro sessions with Dr. Soloway. Diagnoses: 1) Lumbar disc disorder. 2) Lumbar muscle strain, initial encounter. 3) Low back contusion, initial encounter. 4) Sciatica, left side. 5) Left leg pain. Plan: Treatment Rendered: Goal of treatment was to get him to his pre-existing baseline level of pain in his lower back, not pain free status since he had pre-existing chronic non industrial low back pain, which had preceded this industrial event. MRI appeared to show new left sided disc protrusion at L3-L4 with left sided nerve impingement that could correlate with his symptoms. Based on MRI, lumbar epidural steroid injection at left L3-L4 level was recommended. Also, recommended renewal of physical therapy at a new clinic (Dr. Soloway's therapist ideally), 1-2/week x 3-6 weeks, 6 more sessions. He had completed 10/12 with good improvement in symptoms and function. Recommended renewal chiropractic, 1-2 x/week x 3-6 weeks, 6 more sessions. He had completed 8/8 sessions with good improvement in function and symptoms. Advised to continue Robaxin, ibuprofen and

tiger balm patches. Activity status: Ok for modified work/activity. Followup in 4 weeks with Dr. Kumar, sooner if worsening symptoms.

71. March 21, 2019, Compromise & Release for ADJ11231848; ADJ11231935; ADJ11804165; ADJ12037148: DOI: CT: 06/05/15 to 03/12/18; 02/14/18; 12/12/18; CT: 03/12/17 to 03/12/18. Injured body parts: Head, upper extremities, back, lower extremities, back, body system, stress and psych. The parties agreed to settle the above claims on account of the injuries by the payment of the sum of: 50,000$.

72. September 30, 2019 (DOE), February 24, 2020 (DOR), Subsequent Injuries Benefit Trust Fund Vocational Opinion, Madonna R. Garcia, MRC, VRTWC: DOI: CT: 06/05/15-3/12/18, 03/12/17-03/12/18, 12/02/18, 02/18/18. Introductory Comments: This assessment included a face to face interview with the patient, a review of his occupational history, medical history and records, physician assessment of his medical conditions and labor disablement, and appointment involving percentage of disability apportioned to the subsequent injury, and pre-existing injuries and illnesses, vocational assessments, transferable skills, the labor market analysis and the patient was amenable to vocational rehabilitation. A thorough evaluation was conducted of him through vocational testing, research through the OASYS system, the Employment Development Department (EDD), the Dictionary of Occupational titles, the Social Security Administration (SSA), the Occupational Employment Quarterly (OEQ), and pertinent case law to determine the patient's pre-injury labor disablement, as well as the post-injury labor market access and ability to compete in the open labor market. This examiner explained to him about her position as an Applicant Vocational Expert and informed him that she would not be providing ongoing vocational counseling. She informed him that the information derived during the evaluation would not be considered confidential and that his findings and opinions would be summarized in a report that would be provided to his attorneys and the Subsequent Injuries Benefits Trust Fund. Current Sources of Income: He did not meet his monthly expenditures. He stated that his monthly expenditures included his mortgage, utilities, food, clothing and his children's expense, which was about $3600 and he was only receives VA benefit of $1331/per month. Current Work Status: He was currently working as a Magician on a part-time basis to support his family.

    Employment History: 1) Employer Name: Advances Management Company. Dates Employed: Jun 2015- Aug 2018. Job Title: Assistant Community Director. City: Irvine. Zip: 92618. Duties: **DOT Code**: 188.117-110 **Housing-Management Officer**. Directs and coordinates activities concerned with providing advice and technical assistance to housing authorities and evaluating housing management programs. Develops policy and standards for guidance of local housing organizations in establishing and maintaining uniformity in operation of housing projects. Studies operation of housing projects, notes trends and needs, and evaluates efficiency of housing programs. Prepares regulations, procedures, and instructions for operation of housing projects based on analysis of operations. Approves or disapproves requests for waivers to policies, standards, and procedures. Consults with and advises housing personnel of public and private groups concerning needed improvements in housing operations. Advises and

assists Managers, Housing Project (profess. & kin.) and staffs of local housing authorities concerning problems, such as eliminating excess costs, improving livability features and maintenance care of dwelling units, making more effective use of project facilities and community services, and promoting satisfactory relationships among tenants, housing project personnel, public officials, and private agencies. Leads public meetings and serves on committees to stimulate efforts of national, local, and private housing agencies and to emphasize housing needs of military personnel and low-income families. 2) Employer Name: Missoula Copy Center. Dates Employed: 10 years. Job Title: Customer Service City: Missoula, MT. Zip: Duties: DOT Code: 299.367-010. Customer-Service Clerk. Alternate Titles: Customer-service specialist, Post Exchange.

Performs any combination of following tasks in Post Exchange: Arranges for gift wrapping, monogramming, printing, and fabrication of such items as desk nameplates and rubber stamps, and repair or replacement of defective items covered by warranty. Takes orders for such items as decorated cakes, cut flowers, personalized greeting cards and stationery, and merchandise rentals and repairs. Prepares special order worksheet. Keeps record of services in progress. Notifies customer when service is completed and accepts payment. Acts as wedding consultant (retail trade). Assists customers to select and purchase specified merchandise [personal shopper (retail trade)]. Keeps records of items in layaway, receives and posts customer payments, and prepares and forwards delinquent notices [layaway clerk (retail trade)]. Issues temporary identification cards from information on military records. Approves customer's checks and provides check cashing service according to exchange policy. Answers customer's telephone, mail, and in-person inquiries and directs customers to appropriate sales area [information clerk (clerical)]. Resolves customer complaints and requests for refunds, exchanges, and adjustments. Provides customers with catalogs and information concerning prices, shipping time, and costs. Activities of Daily Living: Activities of daily living were reviewed. Current Medications: Neurontin, Robaxin. Effects of Medications on Full Time Employment: He was taking prescription medication as indicated above that was severely limiting his ability to function in a full-time work setting. Medication usage could limit an employer from fully considering him from full time gainful employment. He was taking Neurontin (Gabapentin) 3 x per day for his leg pain and help to prevent seizures.

The medication side effects included dizziness, drowsiness, weakness, blurred vision, and headaches. The side effects of the gabapentin would make it difficult for him to return to his career as Assistant Community Director. This was a job that requires stooping, bending, reaching and the medication would negatively affect him during his work. He was also taking Robaxin (methocarbamol) 750 mg, 2-3x/day, which was a muscle relaxant and caused sedation for nerve pain. The medication was working by blocking nerve impulses or pain sensations that were sent to one’s brain. The side effects of this medication included dizziness, fast heartbeat, feeling of warmth fever, headache, hive-like swelling on the face, eyelids, lips, tongue, throat, hands, legs, feet, bladder control, loss or memory, nausea and unusual tiredness. His job as a Community Director involved lifting, varying, pushing, pulling 20 lbs occasionally, and frequently up to 10

lbs. Also, walking and standing frequently, pushing and pulling of arm and leg controls, reaching occasionally, extending hand(s) or arm(s) in any direction, handling occasionally, seizing, holding, grasping, turning, or otherwise working with hand or hands, handling, talking frequently and hearing frequently as part of his job duties. Thus, the medication side effects would severely limit his employability as he would be unable to operate machinery or be unable to safely drive a motor vehicle for long distances as employment. Review of Records: Ms. Gracia reviewed the relevant medical records that included the reports of Dr. Iseke, DC, Dr. Peters, QME, and Dr. Chyle, APRN. Additional Comments: Dr. Iseke and Dr. Peters had listed the following impairments to functioning for this patient: Activities of Daily Living - Mild Impairment. Social Functioning - Mild Impairment. Concentration - Mild Impairment. Adaptation - Mild Impairment.

Opinions and Conclusions: Based on research with the sources noted, considering the synergistic effect of his functional limitations, while also considering his pre-existing non-industrial and industrial injuries, combined with his industrial injury, this examiner believed that this patient had incurred a one hundred percent (100%) loss of labor market access. This determination was an accurate representation of his level of disability. In this case, the vocational evidence comes in contrast to the usual application of the schedule for rating permanent disabilities. The schedule should not apply in this case as the actual effect of the industrial injury and the pre-existing problems leads to a total loss of earnings and total permanent disability. To the extent a mechanical application of the schedule might lead to a different result, the actual facts of this case contradicting the application. In this examiners' opinion, he qualified as one hundred percent (100%) totally vocationally permanently disabled. She had determined this patient was not amenable to any form of vocational rehabilitation. His functional limitations combined with the intensity, duration, and nature of his chronic and disabling pain would preclude his pre-injury skills and academic accomplishments. She did not believe that he was amenable to any form of vocational rehabilitation and thus had sustained a total loss in his capacity to meet any occupational demands (AMA Guides). This results in patient experiencing a total loss of labor market access (Leboeuf), and a total loss of future earning capacity (2005 PDRS) irrespective of any "Impermissible factors".

73. October 12, 2019, MRI of Lumbar Spine without Contrast, Eli J. Bendavid, MD: Impression: 1) L3/4 and L4/5 degenerative disc disease. No significant stenoses.

74. June 03, 2020, PT Evaluation, Sharleen T Regan, DPT, Veteran Hospital: The patient was seen for PT evaluation.

75. June 23, 2020, X-Ray of Elbow, Lee Chang, MD: Impression: No x-ray evidence of acute displaced fracture. Soft tissue swelling about the elbow.

76. June 23, 2020, X-Ray of Chest, Mazhar Khan, MD: Impression: There is no radiograph finding of consolidation/pleural effusion/pneumothorax. The cardiomediastinal silhouette is within normal limits. The pulmonary vascularity is within normal limits.

No suspicious radiograph abnormality is identified in the visualized peripheral soft tissues and osseous structures; mild degenerative changes in axial and appendicular skeleton.

77. June 23, 2020, Ultrasound Scrotum and Contents, Simon Abramson, M.D.: Impression: 1) Relatively mild left hydrocele. 2) 5 mm left epididymal head cyst/spermatocele. 3) Negative for testicular torsion nor significant epididymo orchitis.

78. June 26, 2020, VVC GI Visit Note – Initial Consultation, Alyssa Choi, MD, Veteran Hospital: Reason for Visit: Heartburn, diarrhea, fecal incontinence. Assessment: 1) Heartburn. 2) Diarrhea. 3) Fecal incontinence. 4) Anemia. 5) Family history of hemochromatosis. Plan: a) EGD with BRAVO off PPI and tums x 7 days. b) Take duodenal and h pylori biopsies. c) Carafate in the meantime. d) Check stool c diff, o & p, culture, TSH, TTG-IgA, total IgA. e) Check ferritin, iron saturation, B12, folate. f) Imodium as needed. g) If no improvement of fecal incontinence despite resolution of diarrhea, then discuss anorectal manometry next visit. h) Avoid NSAIDs. i) Follow up in RTC after EGD 3 months.

79. August 03, 2020, Subsequent Injury Benefits Trust Fund Psychological Eligibility Evaluation Report, Nhung Phan, Psy.D.: DOI: CT: 06/05/15 to 03/12/18; CT: 03/12/17 to 03/12/18; 02/14/18; 12/12/18. Pre-Existing Disability History: This patient was currently "disabled" and had no source of income. His employment duties as an Assistant Manager/Community Director included: running an 80-unit complex and cleaning apartments. He stated that he was "responsible for everything." He recently worked for a while until the Covid-19 pandemic of March 2020. He had been unemployed since that time. History of Childhood Events: He was born and raised in Missoula, Montana. He was raised by both parents. His father worked as a police officer, emergency medical technician, and firefighter, while his mother was a full-time housewife. He indicated that his mother was bipolar; though she was undiagnosed or was unaware that she was bipolar. He indicated that he believed she took lithium medication. He had no brothers or sisters. He was the only child. He recalled that during his childhood he was "always picked on, always hyper, and always quick to get emotional." He stated that his mother verbally abused him up until the 7th grade. He stated he plotted to kill her, but his father interceded. He stated she would say, "I wish you were never born." These experiences affected him emotionally. He reported that these experiences still affected him, "Words don't mean anything to me, so I tend to hurt others without thinking. I built up walls too." He also stated that his family life was generally okay. His health was generally good. He got along with his family at times and, other times, they disagreed with each other, like all families do. He described his childhood as "happy," although he estimated that he first experienced emotional difficulties in his life when he was at a "pretty young age," though he could not remember the exact age.

    He stated that he was always fighting with his mother and he had no "good" memories. He noted with regard to his childhood, teenage years, and adult years "it all seemed hard." Academic History: Educationally, this patient reported doing adequately in

school completing up to 12th grade. He graduated from high school. He admitted having a learning disability in school being diagnosed with attention-deficit hyperactivity disorder (ADHD) and mood disorder at 19 years old. School was difficult. He "got good at getting by," but was still emotional. He admitted being suspended in 8th grade for being mischievous, hyper, and impulsive. He denied ever being expelled from school. He lied and shoplifted before the age of 11. He "ran around" school and could not sit still. He attended University of Montana, but did not graduate from college. Military Service: He had served in the Navy for one year, though he did not provide the dates of service. He was honorably discharged and stated that he was diagnosed with a personality disorder while serving in the military, but could not specify what type of personality disorder. Relationship History (before and after subsequent injury): He had been in four long-term relationships in his lifetime. He had two seven-year marriages (he had been married twice and divorced twice). He was currently in a cohabitating relationship with his partner for five years. He noted that he was feeling "neutral to angry" about his most recent divorce. He was happy with his current relationship prior to the subsequent injuries, though he stated that his relationships were "always good at first." Since his injury, he had been unhappy with his sexual performance, stating that he had no libido and his "stuff doesn't work." He had two stepchildren. He also stated that he had one biological son, age 12, and four biological daughters, ages 14, 19, 19 (twins), and 2l. He was residing in San Bernardino, California. During same day's evaluation, inquired him if there were any coexisting family stressors that could be contributing to his presenting psychological complaints, and he denied this to be the case. Work History: He recalled that he had been with 32 employers in the last 20 years and stated that there were too many to list. He gave no other information about his employment.

He stated that he had been unemployed in 2005 and "on and off" since that time. At present, he was unemployed because of the Covid pandemic. He noted that he had difficulty getting out of his bed and going to work and did not show up to work constantly. Before his subsequent injuries, he was terminated from a couple of jobs, because he could not get out of bed. He stated that he could not perform the duties that he was hired for. He had a tendency to stand up to authorities and defend subordinates. He estimated that there had been four jobs that he was able to keep for three years or more. Prior to this Workers' Compensation claim, he had other Workers' Compensation claims, for which he received benefits. Medical History (Before and after Subsequent Injury): Before the subsequent injuries, he had infantile asthma. He was hospitalized at 2 years old after falling off a table, breaking a plastic wall socket with his head. He had gastroesophageal reflux disease (GERD) and irritable bowel syndrome in 1996, and back pain and migraines in 1997. He believed that his medical problems were a result of psychotropic medications of Depakote and Zoloft while he was in the Navy. He took these medications for four weeks and never took them again. He was not sure of the condition he took the Zoloft for, but the Depakote was for seizures. He noted that he had been hit in the head at least four times in high school from playing football and basketball, and that he these sports "played hard." He lost consciousness briefly approximately three times. He was hospitalized once at 19 years old after encountering a motor vehicle accident. He went to an emergency room, because he was emotionally

overwhelmed and was hospitalized for three or four days. In 1997, he got into a verbal argument with the commander in the Navy and was admitted into a psychiatric hospital once for being a danger to himself as a result. He stated that he had not been medically disabled before his injury. After the subsequent injuries, he developed medical problems of 10% hearing loss in his right ear.

According to medical records of Dr. Mark W. Elliott, MD from Community Medical Center dated 10/13/03, he fractured his right fifth finger on 10/13/03. The impression was noted to be as follows: Soft tissue swelling surrounding the right fifth proximal interphalangeal joint with abnormal lucency in the volar aspect of the base of the fifth middle phalanx, which likely represented a fracture. He was removing bags of product from underneath a pallet being held by a customer. The customer dropped the pallet onto his right hand breaking his little finger. According to his medical records, he sustained three injuries in the state of Montana before he moved to California. He sustained an injury on 10/13/03 when he was removing bags from underneath of a pallet while a customer dropped the pallet on his right hand and broke his right fifth finger. He also sustained a head injury. He sustained an injury on 12/23/03 when he fell down at work on his right hand and injured his right hand and right shoulder. He sustained an injury on 02/26/14 when he was working as a nurse at some local health facility. He was lifting a heavy patient who weighed over 200 lbs. He injured his mid back/neck/low back. According to medical records of First Report of Accident at Montana State Fund dated 01/03/05, he sustained an injury on 01/03/05. He fell down stairs injuring his ribs, hand, and ankle. Nature of the injury involved broken/bruised/contusion. He was treated at Community Hospital. According to medical records of Initial Consultation and History at Butler Chiropractic Health Clinic by Dr. Don R. Butler, DC dated 02/26/14, he had a date of injury on 02/23/14. He was a lifting a person with his co-worker from the floor who weighed 220 lbs. He injured his low back, mid back, and neck with immediate onset of pain for three days. He had a prior mid back problem in 2008. According to medical records of First Report of Accident at Montana State Fund dated 03/04/14, he had a date of injury on 01/23/14 (Thursday). He assisted another staff with lifting a client from the floor to the bed.

He had a flu that night and was suffering from really bad body aches. That morning, he felt terrible and worse pain and could barely move. The next day, he spent the whole day in bed. On Tuesday, his body aches had stopped, but his back was still hurting. According to medical records of Initial Orthopedic Panel Qualified Medical Examination by Dr. Todd W. Peters, MD dated 09/06/18, he had a specified injury on 02/14/18. He sustained injury to his back while working as an Assistant Manager for Advanced Management Company on 02/14/18. On 02/14/18, during the course of his employment as an Assistant Manager, around lunch time, he was driving a 1996 Lincoln Town vehicle when a red vehicle rear ended his vehicle. The impact was not that hard, but it was enough to cause whiplash. He panicked and went to see a doctor afterwards. The diagnoses were noted as follows: Cervical sprain/strain and complaints of radiculopathy. Lumbar strain/strain with complaints of radiculopathy. According to his medical records, he sustained a specific injury on 12/12/18 when he fell at work and injured his right leg

and right arm. According to medical records of Primary Treating Physician's Permanent and Stationary Report by Dr. Harold Iseke, DC dated 10/15/18, he sustained injuries on 02/14/18 and CT: 06/05/15-03/12/18. From CT: 06/05/15 to 03/12/18, he started to experience headaches, pain in his back, bilateral upper extremities, and bilateral lower extremities, which he attributed to constant sitting, twisting, and bending. The back pain worsened when he twisted his back as he was walking off a sidewalk. The incident was known, but his employer did not make any recommendations. On 02/14/18, while he was driving during work, he sustained aggravating injuries and later developed worsening headaches and sleeping problems when he was involved in a motor vehicle accident. He stated that he was exiting an off ramp and was rear-ended in a hit and run accident.

He stated in approximately 2011 while working for a different employer in a different state, he sustained injuries to his lower back. Prior to his employment with Advanced Management Company, he had already been partially permanently disabled with 60% of rated disability with the following diagnoses: 1) Residuals, fractured left pinky finger. 2) Tinnitus, bilateral hearing loss. 3) Adjustment disorder with depressed mood. 4) Irritable bowel syndrome and GERD (gastroesophageal reflux disease). 4) Tension headaches. 5) Erectile dysfunction. 6) Left lower radiculopathy of the sciatic nerve. 7) Degenerative arthritis thoracolumbar spine. 8) Cervical strain. 9) Loss of vision. Medications: Adderall, gabapentin, Vitamin D, Lipitor, ibuprofen and Flexeril.

Medical/Psychological Conditions and Incidences (Before Subsequent Injury):

Infancy: Asthma.

2 years old: Hospitalized after falling off a table, breaking a plastic wall socket with his head.

High school: Hit in the head at least four times and lost consciousness three times.

19 years old: Bike accident resulting in head injury.

19 years old: Began developing depression while in the Navy, but more so after his motor vehicle accident.

19 years old: Motor vehicle accident and hospitalized for three or four days.

19 years old: Had suicidal thoughts of killing self.

1996: GERD.

1997: Irritable bowel syndrome.

1997: Back pain.

1997: Migraines.

1997: Depakote and Zoloft while he was in the Navy.

1997: Got into a verbal argument with the commander and admitted into a psychiatric hospital once while in the Navy for being a danger to himself.

1997: Received counseling from a psychologist for 4-5 weeks while in the Navy.

1998 or 1999: Discharged from the Navy for being diagnosed with a mood disorder and personality disorder.

Age 30s: Death of grandfather.

2008 plus: Homelessness.

Unknown: Loss of vision, legally blind without prescriptive glasses.

Unknown: Tinnitus, bilateral hearing loss.

Unknown: Erectile dysfunction.

Unknown: Tension headaches, left lower radiculopathy of the sciatic nerve, degenerative arthritis thoracolumbar spine, and cervical strain.

10/13/03: Residuals, fractured left pinky finger.

01/03/05: Fell down stairs injuring his ribs, hand, and ankle involving broken/bruised/contusion.

2008: Mid back problems.

2011: Sustained injuries to his lower back.

02/23/14: Injured his mid back/neck/low back while lifting a heavy patient working as a nurse.

Medical/Psychological Conditions and Incidences (after subsequent injury):

Unknown: 10% hearing loss in his right ear.

Pre-existing Psych Symptoms: a) Adjustment disorder with depressed mood. b) Traumatic brain injury. c) Sleep disorder. d) Male erectile disorder.

Pre-existing Psychiatric Diagnoses:

Axis I: Episode of mental/clinical disorder: a) Adjustment disorder with depressed mood. b) Traumatic brain injury. c) Sleep disorder due to a general medical condition, insomnia type. d) Male erectile disorder. e) Pain disorder associated with a general medical condition.

Axis II: Personality Disorder: No diagnosis.

Axis III: Physical disorders and conditions: Status per the review of the medical records above.

Axis IV: Severity of psychosocial stressors: Moderate.

a) Sequela to work-related injury, including cognitive, physical, and emotional problems, as well as occupational and financial problems.

b) Non-Industrial and concurrent stressful issues were identified and these include: mood disorder not otherwise specified, personality disorder not otherwise specified, motor vehicle accident, suicidal thoughts, homelessness, death of grandfather, received counseling, took psychotropic medications, and medical conditions.

Axis V: Global Assessment of Functioning (GAF) Current – 51.

Discussion of Pre-Existing Disability Rating: Based on this clinical picture and the impact on his functioning, the examiner opined that this patient met criteria for adjustment disorder with depressed mood; traumatic brain injury; sleep disorder due to a general medical condition insomnia type; male erectile disorder; and pain disorder associated with a general medical condition. Additionally, his GAF score was 51 - which was equivalent to a WPI of 29%. This GAF falls into the 51-60 decile, which was described by the 2004 Permanent Disability Rating Schedule. Dr. Phan opined these disorders significantly impacted the patient's occupational functioning causing pre-existing labor disablement, evidenced by his work terminations due to his inability to come to work as a result of not being able to get out of bed, discharge from the Navy for mental health problems, and difficulties performing his job duties as a result of a traumatic brain injury (TBI) and depressive symptoms. His symptoms had reached a plateau and he was able to work for other companies for a brief period before he became industrially injured in spite of his psychological impairment. Thus, these psychological diagnoses were permanent and stationary prior to his subsequent industrial injuries of CT: 06/05/15 - 03/12/18, CT: 03/12/17-03/12/18, SI: 02/14/18 and SI: 12/12/18. Consequently, the following actual psychological work restrictions existed prior to the subsequent injury: a) Due to his symptoms of mood/depression, personality disorder, and chronic pain, he required a flexible work schedule to accommodate his need for weekly psychotherapy sessions and monthly psychiatric consultations. b) An understanding supervisory to provide feedback to him in a sensitive manner due to his fragile personality traits and emotional dysregulation. c) Slow increase in complexity of job

duties and tasks given his deficits with concentration, focus, and memory related to his ADHD diagnosis and mood disorder. d) Promoting as much predictability as possible in the employee's daily tasks. e) Providing clear guidelines and instructions, possibly in writing. f) Allowing for flexibility with regard to pace of work and timing of breaks.

g) Working as part of a team to decrease the employee's sense of loneliness or isolation. Avoiding excessive work hours, overtime, and insisting on him taking normal breaks and a lunch. f) No assignment of excessive job pressures such as multiple, frequent deadlines, or frequently working with difficult people. g) Frequent feedback on performance by an understanding supervisor to accommodate his low self-esteem (due to his mood/depression and personality issues). This examiner reinstated that these actual pre-existing restrictions provided evidence of the patient's actual labor disablement that was present prior to his subsequent industrial injury. Subsequent Industrial Injury: History of Subsequent Injury: He reports that he worked at Advances Management Company beginning 06/05/15 and last worked in 03/12/19. He injured himself on CT: 06/05/15-03/12/18; CT: 03/12/17-03/12/18, SI: 02/14/18, and SI: 12/12/18 while employed as an Assistant Manager. He injured his head, upper extremities, back and spinal cord, and lower extremities, and sustained a psychiatric injury from a hostile work environment. He reported all claimed injuries below were sustained from Advanced Management Company. He finished his employment with them as a Community Director. He had held other titles of leasing agent and assistance community director throughout his employment with this employer. #Injury1 (Orthopedic Injury: CT: 06/05/15-03/12/18): Remained unchanged. #Injury 2 (Psychiatric Injury: CT: 03/12/17-03/12/18. He reported, "I got rear ended in a work related car accident on 02/14/17. This injury contributed to the continuous psychiatric injury of CT: 03/12/17-03/12/18. I just got promoted to manager and all of a sudden I got demoted, because I reported my manager's wrongdoing. I complained and they finally promoted me to a leasing agent position. They put me back in an old position even though they said it wasn't my fault. They would not accept my applications as an equal opportunity employee…

….I got no response, so I filed something (can't remember) and then they interviewed me. I felt threatened of losing my job due to my direct supervisor's wrongdoing. They said I was driving drunk on the property and I never drank. They tried to really to get me to quit. It was wrongful termination, I think they promoted me to shut me up finally. After I was promoted, they put me in an office with cameras and schedule that no one had. It was discriminatory action on the employer. This exacerbated my depression and stress. I couldn't sleep and did not want to go to work. I was excelling and had no write ups. I had 42 yelp reviews and did an excellent job. They punished me for making them follow their own rules. The company was breaching their own policy." #Injury 3 (Orthopedic Injury: 02/14/18): Remained unchanged. [Author's Comment: During this interview, he claimed a psychiatric component to this injury on 02/14/18]. #Injury 4 (Orthopedic Injury: 12/12/18). He reported, "I fell down the stairs after checking an apartment. I hit the fourth stair down. My left leg went underneath me and I skipped the step. The stair broke my phone. If it wasn't for my phone, I would have broken my back. I hurt my back and left leg. I needed to keep my job and they kept fighting me to keep my job. I

settled for $12,000 out of desperation to take care of my family. I had to move my entire family. This was my last employable date at work. It says I resigned. This caused a lot of stress. We settled on 03/12/19. It almost destroyed my family. My girlfriend almost left me. The kids were all my responsibility, because their mom left her two kids to go live in Pakistan with a 24 year old man who she eventually married. I haven't seen my two kids since they were little." [Author's Comments: During this interview, he claimed a psychiatric component to this injury on 12/12/18]. He stated, "With my four year job, people liked me. There were people who didn't like my personality, because I'm straightforward. I never had a verbal fight with anyone I worked with. I don't get volatile with people. I care about people and defend people. My depression interfered with my jobs before, because I didn't want to get out of bed. The biggest thing that got me in trouble was because of pain since the car accident in 1997. I have been homeless with my family five times. Depression stemmed from the navy, I think."

Subsequent Injury Psychiatric Diagnoses:

Axis I: Episode of Mental/Clinical Disorder. a) Major depression, single episode, severe. b) Generalized anxiety disorder, moderate. c) Pain disorder associated with both psychological factors and a general medical condition. d) Male erectile disorder. e) Male hypoactive sexual desire disorder. f) Sleep disorder due to a general medical condition, insomnia type.

Axis II: Personality Disorder: No diagnosis.

Axis III: Physical Disorders and Conditions: Status per the review of the medical records above.

Axis IV: Severity of Psychosocial Stressors: Severe. 1) Sequela to work-related injury, including cognitive, physical, and emotional problems, as well as occupational and financial problems. 2) Non-Industrial and concurrent stressful issues were identified and these include: suicidal ideations, financial problems, etc.

Axis V: Global Assessment of Functioning (GAF): Current 48.

Disability Status: Given the length of time that had expired and the consistency of psychiatric symptoms since their inception, it as this examiner's opinion that the patient's psychiatric disability was now permanent and stationary. Impairment Rating: Corresponding to GAF – 48, a WPI of 34% was indicated. Also, based upon his chronic sleep dysfunction, a pre-existing sleep disorder related to being in the Navy, and his Epworth Sleepiness Scale score of 2, the level of his current sleep impairment was equal to an 11% disability rating attributed to the chronic pain and psychological symptoms that arose as a result of his subsequent injury. Based upon his moderate sexual dysfunction of Class 2 impairment, the level of his current sexual impairment was equal to a 13% disability rating attributed to the chronic pain and psychological symptoms that arose as a result of his subsequent injury. Causation of Subsequent Disabilities and

Labor Impairment: This examiner opined that the subsequent psychiatric injury was predominantly caused by the actual events of subject employment. Apportionment: As stated earlier, he had a pre-existing psychiatric disability that was Permanent and Stationary, ratable, and work limiting. His rating was as follows:

Preexisting Psychiatric Impairment: 29 % WPI from GAF of 51.

Dr. Phan believed that this patient's psychiatric condition was aggravated by the subsequent injury and the subsequently experienced a significant psychiatric deterioration. He believed that the increase of his psychiatric impairment was due solely to the subsequent injury. His current psychiatric disability rating was as follows:

Current Psychiatric Impairment: 34%WPI from GAF of 48.

The subtraction method is applied: 34 % WPI minus 29 % WPI: 5%

5% WPI apportioned to the subsequent injury.

Pre-existing Disability	Subsequent Disability
Psychiatric disability – 29%	Psychiatric disability increased by 5% to 34%

It had to be noted that the preponderance of psyche impairment only goes to causation of the psyche injury, not causation of the psyche disability.

80. August 04, 2020, EGD Upper Endoscopy, Mark Salem, MD, Veteran Hospital: Impressions: 1) The diaphragmatic impression, end of the gastric folds and z-line 41 cm from incisors. 2) Esophagitis in the distal esophagus. 3) The mucosa of the stomach appeared normal. 4) Duodenal inflammation was found in the duodenal bulb; a biopsy was performed in the 1st part of the duodenum, duodenal bulb, and 2nd part duodenum.

81. August 06, 2020, Surgical Pathology Report, James Y Han, MD: Postoperative Diagnosis: Diarrhea, GERD. Operative Findings: Mild duodenitis, random biopsies taken to rule out celiac. Normal stomach, random biopsies taken to rule out H. pylori, esophagitis grade.

82. August 06, 2020, Comprehensive Independent Medical Evaluation in Neurology SIBTF Evaluation Report, Lawrence M. Richman, MD: CT: 06/05/15-03/12/18; CT: 03/12/17-03/12/18; 02/14/18; 12/12/18.

    1) Did the worker have an industrial injury?

Answer – Yes, this patient suffered injuries as follows – continuous trauma June 05, 2015 – March 12, 2018, Continuous trauma March 12, 2017 – March 12, 18, December 12, 2018 and February 14, 2018.

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

Answer - No. The patient was evaluated by a Panel Qualified Medical Evaluator, Dr. Todd Peters, orthopedist on September 06, 2018, who diagnosed him with cervical and lumbar strain/sprain and a supplemental report was issued by Dr. Todd Peters on November 28, 2018 at which time he recommended lumbar epidural injections. Dr. Peters did not provide an impairment rating. The records did not indicate that the patient had reached maximal medical improvement.

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

Answer - Yes. The patient had a pre-existing history of a motor vehicular accident while in the U.S. Navy in 1997 causing neuralgic pain of the right-side of the scalp, chronic, impaired sleep from pain of the right-side of the scalp from the motor vehicle accident in 1997 with a 0 Epworth Score, a post-concussive syndrome associated with difficulty with memory, concentration and word-findings, as well as difficulty with irritability as a result of the motor vehicle accident of 1997, affirmative responses Clinical Dementia Rating Scale from Table 13-5, low back pain with lumbar radiculopathy of the left lower limb in the S1 distribution from the motor vehicular accident of 1997, tinnitus of the right ear from the firing of a weapon while in the navy in 1996 associated with chronic tinnitus, increasing low back pain with lumbar radicular symptoms in the left lower limb from an injury that occurred when he fell down a staircase while employed by Mountain Supply Plumbing in Missoula, Montana, a history of blunt head trauma in 2005 while employed by Schwan's Frozen Foods in Missoula, Montana resulting in increasing cognitive complaints/post-concussive syndrome, increasing headaches from the injury of 2005 while employed by Schwan's Frozen Foods, increasing low back pain with radicular symptoms down the left lower limb in the S1 distribution while lifting a client while employed as a home health specialist in 2013, a concussion when he fell off a bicycle associated with headaches; however, there were no cognitive complaints, a prior history of Attention Deficit Disorder/Hyperactivity Disorder requiring treatment with Adderall, a history of depression diagnosed in childhood, Honorable Discharge from the navy for depression and cervical radicular symptoms of the left upper limb in the C6 and C7 distribution. He had pre-existing radicular symptoms of the left upper and left lower limb; the former in the C6-7 distribution and the latter in the S1 distribution. The former again following a motor vehicular accident in 1997 while serving with the U.S. Navy, as per the aggravated prior fall while employed by Mountain Supply Plumbing Company in Missoula, Montana; the latter following a motor vehicular accident on September 10, 1997 while serving in the U.S. Navy associated with a whiplash injury of the cervical spine.

4) Did the pre-existing disability affect an upper or lower extremity or eye?
Answer - Yes. The patient's pre-existing disability affected the left upper and left lower limbs as noted in the last paragraph of number 3.

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

Answer - Yes. The medical records indicated, from a chiropractor dated February 04, 2018, that the patient experienced bilateral upper and lower extremity pain on a continuous trauma basis, as well as a sleep disorder.

6) Is the total disability equal to or greater than 70% after modification?

Answer - Unknown at this time. It was recommended that the Panel Qualified Medical Evaluator provide further assessment of the patient's cervical and lumbar complaints and also take into consideration of his report of radicular symptoms in the left upper and left lower limbs.

7) Is the employee 100% disabled or unemployable from other pre-existing disability and work duties together?

Answer - The patient was not 100% disabled from the industrial injury.

8) Is the employee 100% disabled from the industrial injury?

Answer – This examiner recommended that the patient be further evaluated by the Panel Qualified Medical Evaluator in orthopedics regarding the patient' s cervical and lumbar spine complaints including radicular symptoms on the left and possibly on the right, as well, and provide an impairment rating.

9) Additional records reviewed?

Answer - Yes.

10) Are evaluations or diagnostics needed?

Answer - No.

Summary of Surgical and Medical Problems: The patient was employed by the Advanced Management Company for three years and nine months. He last worked on 12/12/18. His job required prolonged sitting and walking. There was frequent squatting, occasional crawling, reaching above shoulder level, crouching, kneeling, frequent lifting up to 10 lbs and occasional lifting up to 34 lbs. He also had repetitive use of his right hand with simple grasping and fine manipulation with use of a keyboard and telephone.

He worked around building construction, drove a vehicle and was exposed to paint fumes. He had a part time avocation as a magician. He reported having sustained several injuries during his course of employment. There was a continuous trauma claim during 06/05/15 through 03/12/18 involving the head, upper limbs, spine and lower limbs. There was another continuous trauma claim between 03/12/17 through 03/12/18 for emotional stress when he was subjected to defamation, as well as lies about his own person. He claimed that this emotional stress caused him headaches and difficulty sleeping. He reported that there was a specific injury on 12/12/18 in which he fell down eight steps and sustained injuries to his back or buttocks or both. He reported that there was another injury on 02/14/18 when he was driving to work and was rear-ended. He sustained injuries to his low back, neck and left shoulder. Current Medications: Adderall, gabapentin, ibuprofen, Flexeril and Lipitor. ADLs: ADLs were reviewed. Physical Exam: Cranial nerve examination: Noted convergent insufficiency of 30-cm from the nasion. Sensory examination: He showed diminished sensation predominantly in the C7 distribution of the left upper limb. Gait and station: He had a broad-based gait. Tandem gait was unstable. Review of Records: Dr. Richman reviewed the patient's medical/nonmedical records dated from 10/13/03 to 02/24/20.

Diagnoses: 1) Pre-existing post-traumatic/post-concussive syndrome. 2) Pre-existing attention deficit/hyperactivity disorder. 3) Pre-existing post-traumatic headaches. 4) Pre-existing traumatic induced neuralgia of the right scalp. 5) Pre-existing cervical radiculopathy on the left. 6) Pre-existing lumbar radiculopathy on the left. 7) Pre-existing convergence insufficiency resulting from the head injury he sustained during his course of employment with Schwan's Frozen Foods, 2005. Discussion and Recommendations: Dr. Richman indicated that he has had an opportunity to evaluate this patient and review his pre and post injury medical records. He did report having sustained multiple blows to the head beginning with a concussion when he fell off a bicycle in childhood without loss of memory or concussion, as well as while working with the U.S. Navy when he was involved in a motor vehicular accident in 1997 associated with post-concussive symptoms of impaired memory and concentration, as well as neuralgic pain on the right-side of the scalp, which had been persistent and chronic. His concussive complaints were further aggravated by a fall down seven or eight steps while employed by Mountain Supply Plumbing in Missoula, Montana prior to his date of hire with Advances Management Company. He suffered a whiplash injury from a motor vehicular accident, as well as back pain. There was further increasing back pain from the fall down the stairs at Montana Supply Plumbing. He reported another injury while employed by Schwan's Frozen Foods when a 2' x 4' piece of wood hit the base of his head and neck resulting in altered mental status and being dazed. This examiner opined that, this was contributory to the patient's cervical radicular symptoms on the left. He reported having experienced increasing memory problems by approximately 20% from the injury of 1997 while in the U.S. Navy. He reported an injury to his low back while lifting a client as a home care health specialist in 2013, which further increased his lumbar spine complaints in the S1 distribution, which ordinarily fall into a Diagnosis-Related Estimate Category III rating, giving the

dermatomal pattern. His current findings of the cervical spine in the C7 distribution would correspond for a Diagnosis-Related Estimate Category III rating, as well.

This would be further addressed by the Panel Qualified Medical Evaluator in orthopedics. He also had an attention deficit/hyperactivity disorder, which would also impact his cognitive functioning. He had a history of depression since childhood, which would serve as another cause and source for a cognitive impairment, as well as a separate impairment, which should be addressed by a Board Certified Psychiatrist with respect to Subsequent Injury Fund claim. His current head complaints were rated as a 10 (out of 10) on a sharp magnitude consistent with neuralgic pain. His cervical spine pain was described as a 10 and his low back pain was described as a 7. He reported impaired sleep; however, his Epworth Sleepiness Score was 0. His neurologic examination showed diminished sensation in the left upper limb in the C7 distribution. He showed a mildly unstable gait. Medical records provided for review included an emergency department report dated 12/23/03 referring to a longer standing history of headaches. A treating physician's report dated 01/05/05 referring to patient falling ten days earlier on ice at work sustaining injuries to the right shoulder and right hand. A report dated 01/03/05 referring to him falling down stairs injuring his right hand, ribs and ankle. A report dated 02/26/014 from a chiropractor referring to him injuring his low back, mid back and neck. He had intermittent numbness and tingling of the right lower limb, numbness and tingling in the left arm, hand, fingers, and headaches. In a neurologic consultation on 05/06/14 referring to him having an abnormal MRI scan of the lumbar spine with impingement of the left L5 nerve root and, to a lesser degree, the right L5 nerve root. It showed diminished sensation of the left lower limb in a dermatomal pattern at two levels, which would qualify for a Diagnosis-Related Estimate Category III rating for range of motion analysis. Also a medical report dated 06/03/14 revealed muscular complaints, as well as difficulty sleeping. There was diminished sensation in the left limb in the L4-5 and L5-S1 distribution and given the two levels identified this would qualify for a Diagnosis-Related Estimate Category III rating.

There was an MRI scan of the cervical spine dated 05/12/18 showing multilevel disc disease and cervical lordosis and findings not consistent with the patient's findings on same day's examination. There was a report from Dr. Peters dated 09/06/18, which refers to the patient's prior motor vehicle accident, ongoing complaints of pain in the neck radiating pain into the left arm, left hand and fingers, which was representing a Diagnosis-Related Estimate Category III rating for radiculopathy, which was not fully addressed. The left lower limb complaints from the back were associated with weakness of the left lower limb. He showed a positive Spurling’s sign on the left associated with cervical radiculopathy. He was diagnosed with cervical sprain with radiculopathy and lumbar sprain with radiculopathy. An impairment rating was not provided. His deposition of 04/19/18 did make reference to an Attention Deficit/Hyperactivity Disorder (AD/HD). He described his job activities. He reported being injured while working at Schwan's Frozen Foods in 2012 in which he injured the back of his head by a 2' x 4' beam. He sustained an injury while working for Opportunity Resources in 2014 injuring his back while lifting a resident. He reported another injury while working for AMC. He

reported a motor vehicular accident 02/14/18 in which he was "shaken up," although there was no damage to his car. He reported difficulty with sleep on page 100 of his deposition. He reported previously being stressed, depressed and was homeless at the time that he worked for Schwan's Frozen Foods. He reported taking adoral for AD/HD. In summary, he had pre-existing neurologic complaints. Neurologists do address cervical and lumbar radiculopathy. This examiner opined that the patient did have pre-existing cervical and lumbar radiculopathy, which would fall into Diagnosis-Related Estimate Category III ratings. Absent an analysis of the Panel Qualified Medical Evaluator, based on the patient's physical findings, complaints and imaging providing substantial medical evidence, this examiner opined that the patient would qualify for a Diagnosis-Related Estimate Category III rating from Table 15-3 for the lumbar spine with an 11% whole person impairment, which was pre-existing and predated his date of hire for AMC.

For the cervical spine, he would qualify for a Diagnosis-Related Estimate Category III with a 16% whole person impairment from Table 15-5 that predated his date of hire by AMC. For the post-traumatic/postconcussive syndrome, as well as the impact of AD/HD, he falls into Class II of Table 13-6 and qualifies for a 16% whole person impairment. As it related to his cognitive complaints, there was 100% apportionment of permanent disability to pre-existing and nonindustrial factors. For his cervical and lumbar spine with radiculopathy symptoms, this examiner noted that he would need more information from the Panel Qualified Medical Evaluator who addresses what percentage of apportionment would be directed to the patient's employment for AMC. It was likely that the patient had a higher level of impairment within Diagnosis-Related Estimate Category III for each level. For his headache complaints, given the neuralgic quality, this should be addressed in Table 13-11, the section for the trigeminal nerve, given the neuralgic pain that he had experienced, predating his date of hire for AMC. From Table 13-11, the patient would fall into a Class II rating and qualify for a 15% Whole Person Impairment. He also opined that the patient's neuralgic pain would impact his cognitive complaints, which would also impact his neuralgic complaints. Depression was also known to further impact cognitive and pain complaints, which should be further addressed by a Board Certified Panel Qualified Medical Evaluator. In this examiner's opinion, KITE would be applicable for the patient's headaches complaints and cognitive complaints were not applicable to his cervical and lumbar spine complaints. His final whole person impairment for his pre-existing conditions predating his date of hire by AMC were calculated as follows: 16% was added to 15% to equal 31%. A 31% combines with 16% to equal 42%. A 42% combines with 11% to equal 48%. His final whole person impairment rating was 48%. As had given the patient a score of 0% in the Epworth Sleepiness Scale, no impairment rating was provided for sleep.

83. August 08, 2020, Subsequent Injury Benefits Trust Comprehensive Medical-Legal Report, Sameer Gupta, MD (Internal Medicine): DOI: 03/12/17; CT: 03/12/17-03/12/18; CT: 06/05/15-03/12/18; 02/14/18; 12/12/18. Identifying Data: The patient reported sustaining injuries to the neck, lower back, left hand, right arm, eye (vision loss), head (headaches), and psyche (stress, depression, irritability), while working as a community director for Advanced Management Company SIBTE as a result of repetitive

work activities as well as specific incidents. Mechanism of Injuries: #1) He reported being involved in a cumulative trauma injury. In 04/2016 he began developing increased pain in his neck, lower back, as well as increased headaches, after he had stepped off a sidewalk and stumbled backwards and “Jared" his entire body. He continued to perform his customary work duties in pain. He sought medical treatment. #2) In about late 2017 or 2018 he began being harassed by the HR department and he felt he was the "black sheep" of the company. He requested an interview to be promoted to assistant community director and after sending several letters, he obtained an interview and given the job. Shortly thereafter, he was attending the assistant community director class and felt he was being looked at. He felt his director was not following the policy following the death of a resident. On 02/14/18, he was driving home after attending the assistant community director's class while stopped on an off ramp, when he was rear-ended. He developed increased pain in his neck and lower back. He reported the accident to his supervisor and sought medical treatment. He began developing increased headaches, depression, and irritability, secondary to stress. He sought medical treatment at Kaiser Permanente Emergency Room in Costa Mesa. He was examined and diagnosed with a whiplash. He was taken off work for three days. Secondary to the harassment and being mistreated by his supervisor, he began documenting issues occurring at work. In late 02/2018, a "surprise" meeting with the COO and regional manager secondary to an incident that occurred the day prior with a security guard. His girlfriend was dropping him off at work and parked in a parking spot to pick up his vehicle.

A security guard approached him and said they were not allowed to park at that particular space and he explained he was only picking up his vehicle and the security guard kept telling them about the issue. There were vehicles were parked behind him that prevented him from backing up. He then maneuvered his car back and forth between two empty spots and was able to leave the parking lot. He was told he had backed into a gate, which he did not. A resident issue came up and he emailed his supervisor regarding the issue and was told a meeting was going to be hostile. He took a day off and had stomach issues. He received word that he was being transferred to another location and being demoted. He was given a box of business card with no job title listed on it. In March/April 2018, he began developing blurred vision, which he attributed to looking at a computer monitor for prolonged periods of time. He retained legal counsel and was referred him to Dr. Iseke, a chiropractor. He was examined, x-rays were taken, a course of chiropractic and physical therapy was initiated, and released to work with a restriction of no stair climbing, no lifting greater than 10 pounds, no stooping, squatting, and be able to move about as needed. His work duties entailed answering and making telephone calls and inputting information into a computer. In late 09/2018, a job became available as a community director; however, he was told he could not apply secondary to his restrictions. He wrote letters to the City of Santa Ana and HR. This made him angry. Later, the position became available, he obtained an interview and was hired. Cameras were installed in his office directing toward his desk and was always being watched. #3) On 12/12/18, he was descending stairs when his left leg became weak and he fell onto his back and slid down about eight steps. His cell phone that was in his back pocket broke in half. He was having difficulty breathing and noted increased pain in his neck and lower

back. He "hobbled" to the office and sent his supervisor a text and calling his supervisor with no response.

Pre-Existing Labor Disabling Condition: 1) Upper Gastrointestinal Issues: The examinee noted a longstanding history of gastroesophageal reflux disease. He described the gastroesophageal reflux disease as being since 1997. He noted that this worsened from 1997 to 1999 partly in conjunction with the use of ibuprofen in high doses for pain related issues from injury from the Navy. The heartburn was described as being were constant daily **year-round** the mid epigastric burning pain. There was some radiation of the acid into the mouth approximately 2 to 3 times a month currently. He also noted that every 2-3 months, he would wake up with a fires/burning sensation in his throat. It was significant enough that wakes him out. He recollected recently having an upper endoscopy at the VA and was still awaiting results of it. He also got a Bravo study and was awaiting results for this as well. He stated that he had tried Omeprazole several times in the past - 1 tab once a day. Most recently he had tried it for 2-3 months without any relief. Since it had not helped him out he was no longer taking it. He was currently taking Tums tablets between 5 times a day up to 20 times a day to see if this helps out with his issues. He stated that this was helping out but very minimally. He was still getting a lot of breakthrough issues. He would also switch up to Pepcid anywhere from 1-5 tablets a day, which improved the symptoms a little bit but not enough even after taking 5 tablets a day - many days. Sometimes, he would even take baking soda with water to help him out, which could relieve it a little bit temporarily but still would be getting significant breakthrough issues. He had also tried various dietary restrictions including reducing spicy foods, reducing foods with tomatoes but despite this, he was still getting significant breakthrough symptoms. 2) Lower Gastrointestinal Issues: He noted a longstanding history of irritable bowel syndrome. He noted that he had symptoms that alternate between diarrhea and difficultly having a complete bowel movement. He also noted intermittent episodes of mild lower abdominal pain along with bloating and occasional gas. The symptoms were constant, chronic, and moderate with frequent/intermittent flare-ups.

He did note having accidents in the past with diarrhea and having to carry around a 2nd set of clothes because of this. He has not had a colonoscopy yet. He noted that the symptoms started around 1997 but had slowly progressed over the years and had reached a quite problematic level. He did note that his symptoms were worse with stress. He noted that there was a stool study that was pending that would hopefully be done in the course of the next 1-2 months. He also recently had been prescribed some medicine to use whenever he develops diarrhea. He has not had a chance to try yet as he just recently got the prescription in the mail. He also recollected several times having symptoms consistent with the diverticulitis treated with antibiotics with good results. He could not recollect if they did imaging studies at that time. He did not have insurance for much of his life. Only recently did he get VA benefits to help get some of these issues addressed. Current Complaints: 1) Asthma. 2) Headaches. 3) Vision - he complained of bilateral blurred vision and recurrent watery eyes. 4) Psyche - he complained of depression, anxiety, nervousness, and irritability. 5) Neck - he complained of recurrent pain in his

neck with a stabbing sensation in his neck, with pain radiating to his left shoulder blade. He has recurrent popping and continuous stiffness in his neck. The pain was aggravated with turning his head from side to side, looking up and down, tilting his head to the sides, and reaching. Associated symptoms included recurrent numbness and tingling in the fingers of his left hand. 6) Mid back - he complained of continuous aching and recurrent sharp, pressure, and burning pain in the mid back. His symptoms were aggravated with bending, twisting, turning, reaching, and prolonged sitting, standing and walking. 7) Left hand: He believed that the numbness and tingling in the left hand is radiating from his neck. 8) Lower back: He complained of continuous aching and recurrent sharp, pressure, and burning pain in the lower back, with pain radiating down the left leg to his third and fourth toes. He also had pain radiating to left testicle. He had recurrent tingling in the left leg. Weakness was noted in the left lower extremity.

The symptoms were aggravated with bending, twisting, turning, reaching, ascending and descending stairs, and prolonged sitting, standing, and walking. His symptoms were alleviated with medication, hot baths, and showers. Psyche: He complained of depression, anxiety, and nervousness. Sleep: He complained of difficulty sleeping. He was sleeping an average of four hours of interrupted sleep per night. Medications: Adderall, ibuprofen, Lipitor, Vitamin D, gabapentin, Omeprazole, Pepcid. ADLs: ADLs were reviewed. Review of Records: Dr. Gupta reviewed the patient's medical/nonmedical records dated from 10/13/03 to 02/24/20. Physical Exam: Height: 6'. Weight: 198 lbs. Blood Pressure: 129/86. Abdomen: There was mild mid-epigastric tenderness to palpation. There was also bilateral very mild lower abdominal diffuse tenderness. Assessment/Plan: 1) Upper GI issues of medication associated gastritis and GERD (gastroesophageal reflux disease) - pre-existing prior to the subsequent injury in question: Request additional records to fully evaluate, but for now would give preliminary medical opinions based on the current information available. 2) Lower GI issues of irritable bowel syndrome and diverticulitis - pre-existing prior to the injury in question. 3) Current wheezing on the exam, with childhood history of asthma, with denial of significant asthma flare up, use of asthma medications or recent imaging studies per recollection: By clinical history no evidence of significant ratable asthma prior to the injury. However, the following requests were made given the current wheezing on exam (to be done by the treating providers in the VA if possible): a) Full PFT with DLCO and Total Lung Capacity along with a Methacholine challenge. b) To consider albuterol inhaler or other inhaler to see if this helps with the wheezing on the exam. c) Request CT scan of the chest without contrast to screen for any pulmonary pathology contributing to the symptoms. 4) Neurological issues of traumatic brain injury and headaches, cognitive issues etc - at least in part pre-existing prior to the industrial injuries in question: Deferred to the QME neurology on the case.

5) Vision issues: Referred to QME ophthalmology to determine if pre-existing condition versus component that was industrial in nature. Possibly related to the traumatic brain injury: Defer to QME neurologist as this was outside the scope of this examiner's knowledge. 6) Sleep disorder issues, unclear etiology, not fully worked up: based on AMA guides, needed evaluation by a sleep specialist; referred to QME sleep specialist to

evaluate this issues. 7) Erectile dysfunction since the military, unclear trigger, possible industrial contribution: referred to QME urologist to further evaluate this aspect of his condition. Also request treating provider to consider further evaluation and treatment of this disorder. 8) Various different musculoskeletal issues: deferred to the QME musculoskeletal specialist on the case. Impairment Rating (preliminary ratings based on the currently available information/medical records): Upper GI issues: 25% WPI. Lower GI issues: 2% WPI. Asthma: 0% WPI. Causation: This examiner opined that the patient's upper and lower GI issues did have a non-industrial causation was pre-existing prior to the subsequent industrial injury. Apportionment: He added that patient's 100% of the upper GI and lower GI issues were related to preexisting condition and that 0% were related to the recent industrial injury. He also noted that there might be some aggravation of the upper and lower GI issues but the current impairment assessment was for the preexisting conditions that he had even prior to the recent industrial injuries. WPI: Pre- Existing Work Restrictions Related to the GI Issues: There was evidence of a pre-existing labor disabling condition, which was present prior to his employment. These conditions would cause interfere with his ability to work in an environment where he did not have ready access to a restroom.

84. August 08, 2020, Comprehensive Independent Medical Evaluation SIBTF Evaluation Report (Chiropractic), Paul J. Marsh, DC: DOI: CT 06/0515-03/12/18; CT 03/12/17-03/12/18; 03/12/15-02/14/18.

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?

Unknown currently. Recommended a medical evaluation with respect to the patient's non-muscular skeletal injuries.

3) Did the worker have a preexisting labor disabling permanent disability?

Yes.

4) Did the preexisting disability affect an upper or lower extremity, or eye?
Yes.

5) Did the industrial permanent disability affect the opposite and corresponding body part?

Yes

6) Is the total disability equal to or greater than 70% after modification?

Unknown currently. Recommended additional medical evaluations with respect to his non-musculoskeletal injuries.

History of Subsequent Injuries: Remained unchanged. History (Previous Non-Work Related): It should be known to all parties that the above-mentioned work-related injuries were not appropriately addressed by the treating physicians, but would be accounted for on same day's evaluation and anything that was not musculoskeletal in nature would be deferred out to the appropriate medical specialist i.e. internal medicine, psych, neurology, etc. Regarding non-work related injuries, the patient stated that he had suffered a multitude of injuries involving his head, face, upper/lower extremities, left shoulder, lower extremities, respiratory system, GI tract and reproductive tract.

a) At age 2, he stated that he had a trip and fall injury, where he fell off a coffee table impacting his head on a wall socket. He stated that he was taken to the emergency room, his wounds were cleaned, and stitches were administered (4).

b) At age 9, he stated that he had an accident where his cousin was swinging a golf club and it impacted his face. Loss of consciousness was noted after the impact. Luckily, his father was an EMT certified and he was evaluated on scene. At the time it appeared that his loss of consciousness was brief and that his cognitive condition was improving with time and thus no medical treatment was sought out right.

c) At age 11, he stated that he had an accident where his cousin was swinging a baseball bat and impacted the left side of his cranium/face. Loss of consciousness was noted after the impact. Luckily, his father was on the scene again and evaluated him. At the time it appeared that his loss of consciousness was brief and that his cognitive condition was improving with time and thus no medical treatment was sought out.

d) In high school, he stated that he was highly active in sports and played basketball and football. Multiple injuries were noted in football and he also noted on a couple occasions that he fell while playing basketball impacting his head on the hardwood floor.

e) In his sophomore year, he had a bicycle accident where he went over the bars injuring his left thigh (hematoma) and concussion with loss of consciousness, and whiplash type injury involving his neck.

f) In 1996, he stated that he elected to and enrolled in the US military—Navy (As an electrician technician). In boot camp, he noted that he fractured his left pinky finger. Right after the accident in question, his supervisor sent him to the hospital, and examination was done, x-rays were taken, and his finger was splinted accordingly.

Unfortunately, it never healed correctly and to this day he had a deformed pinky finger (swan-neck deformity).

g) In 03/1997, he was in automobile accident (head-on collision when he was a passenger when traveling on the base and in uniform). During the course of the accident, he stated that his seatbelt malfunctioned, and when thrown forward, the airbag exploded into his abdomen/lap allowing him to impact his face/cranium on the dashboard and ultimately **melting** his uniform to his skin. Emergency transport was performed, and he was taken to Navy Hospital at Great Lakes. An examination was done x-rays were taken of his neck, and low back. On a prophylactic basis, he was given a cervical spine collar, medications were prescribed and later that evening, he was released but told to follow-up if his symptoms get worse.

h) With the multiple head injuries, he stated that it was around April or May 1997 the US Navy pulled him out of school, tested him and he was told that to complicate matters he also had ADHD, and micro-seizures in his head. Medications (**were prescribed**) and he was referred out to psych. Because of his injuries he was discharged honorably.

i) He stated that he was born and raised in Montana and after being discharged from the US military, he went back home and started working at a company called CM Manufacturing. He started working as a general laborer. During his career, he also worked himself up to different positions - quality control inspector/manager. In 1998, he stated that while on the job site, he cut his right index finger when using a hammer. Shortly after the accident he did his best to stop the bleeding, notified his supervisor and was told to go to the emergency room. At the emergency room, his wounds were cleaned and dressed appropriately with approximately 4 stitches.

j) In 1999, he stated that he entered a 3 on 3 basketball tournament and injured his left rotator cuff. An examination was done, and he was given a sling and was told to rest. If his condition did not improve, he was told that he might need therapy and/or surgery later.

k) In 2001, he went to work for a company called Mountain Supply (Show room sales of plumbing supplies including but not limited to sinks, showers, and faucets). On one occasion, he stated that he was walking down a flight of stairs carrying boxes of product (2 cast iron sinks) and sustained a slip and fall type injury. He slid down and claimed injuring his lower lumbar spine and mid back. After the accident/injury, he notified his supervisor, and was taken by the supervisor to the emergency room. An examination was done, x-rays were taken of his lower back, mid back and neck. Medications were prescribed and he was told to take 2 weeks off work. No other treatment was sought out; however, he stated that shortly thereafter he changed his job.

l) In 2005, he stated that he returned to work at Mountain Supply, this time working in the warehouse. In the summer of 2005, he had an injury to which he broke his right pinky finger when a pallet was dropped on top of it. No lost time of work was noted; however, he stated that he worked a full duty capacity with a splint for about 6–8 weeks.

m) In 2007, he stated that he was working for Schwann's frozen food as a delivery driver. In the process of delivery in a car port, he stated that he hit his head on a 2 by 4 giving himself a "whiplash" type injury involving his head and neck. Shortly after the injury he reported it to his supervisor and was sent to the local emergency room. An examination was done and x-rays were taken and additional diagnostic testing including but not limited to CT and/or MRI was performed. Treatment for his injury consisted of chiropractic and during his care he was let go. It was around that time that all treatment for the most part stopped other than the occasional treatments with a chiropractor on an as-needed basis. During the course of his care he was diagnosed also with diverticulitis & migraine/cluster headaches due to stress.

n) After being fired for being injured on the job, he stated that he suffered hardship and became stressful secondary to suddenly being homeless for approximately 2 years. This caused an abnormal amount of psychological damage. Because there was no income, he was unable to get the appropriate medical treatment for a psychological injury.

o) Around 2011, he went back to school at the University of Montana. During his care, he was evaluated by student health and was told that he had suffered from ADHD. Around that time, he also got his own insurance and when following up with the PCP, he was told that he had suffered scarring on the esophagus secondary to GERD.

p) Around 2012, he states that he finally got a new job and went to work at a company called ORI "Opportunity Resources Incorporated." His position was that of an in-home health care provider. One evening, he stated that a resident was found on the floor and he and a coworker did their best to lift the resident up and transfer them back to the bed. In the process he injured his lower back again. Shortly after the accident/injury he notified his supervisor and was sent to his chiropractor who he had seen in the past. Examination was done, x-rays were taken, and he was told that he needed another MRI. Noted on MRI was 2 bulging discs. Treatment included chiropractic, physical therapy, massage and medical specialist evaluation. He noted that he was never given the appropriate permanent and stationary evaluation nor was his disability related; however, out of court they settled his case with a monetary award.

Present Complaints: 1) He had a chief complaint of low back pain that was radiating down his left leg to his toes. The pains were best described as burning in nature with numbness and tingling as well. Pain was rated as 8/10 and constant. 2) His secondary complaint was that of sleep disturbances and stated that he was only getting

approximately 2-4 hours a night of restful sleep and that his sleep patterns were broken up due to pain, stress, anxiety, and GI issues. 3) He had a tertiary complaint of psychological condition that he best described as a sense of hopelessness, depression, fatigue. To complicate matters, he stated that that his father had 3 jobs, which could best be described as Superman (firefighter, police officer and EMT). But because of the patient's conditions, he had been unable to find gainful employment and has had tried 32 different jobs over the course of his life. He stated that he always had tension headaches, and was still getting migraine headaches to this day, and a lot of this was coming from his neck and shoulder region. He rated his current pain at 6-9/10. The pains in his neck and head were best described as gripping, with episodes of sharp pain. There was associated nausea and visual disturbances with migraine headaches. He stated that he was suffering from restless leg syndrome, which could be associated with a slight tremor as well and if he did not take his medications (gabapentin and Flexeril). There was no chance of him to sleep at night. On occasion, he stated that he was getting arthritis type aches and pains in his 2 pinkies, and was finding himself catching his left pinky on things at times causing a sprain strain type injury. 4) Non-orthopedic complaints included memory loss with inability to form accurate and/or complete sentences; and difficulty to concentrate for any length of time. Medications: Adderall, Gabapentin, Lipitor, Flexeril, Ibuprofen OTC. Review of Records: Dr. Marsh reviewed the patient's medical/nonmedical records dated from 10/13/03 to 02/24/20. Physical Exam: Height: 6 ft. Weight: 198 lbs. BP: 128/87. Cervical spine: Palpation of the cervical and/or thoracic spine musculature revealed left-sided levator scapula and suboccipital tenderness.

There was left-sided muscle guarding and/or active trigger points +3 in nature in the surrounding musculature as well. Maximal Foraminal Compression test was positive, indicative of posterior element compression, and/or irritation. Axial Compression test was negative for radiculopathy; however, localized pain was noted indicative of possible discogenic pain. Shoulder Depression/Neural Tension test was positive, indicative of possible underlying herniated nucleus pulposus/radiculopathy (pain was travelling in a well delineated dermatomal pattern) on the left with numbness and tingling was noted along the C7 and/or C8 dermatomes. Cervical Distraction test was positive with relief of pain noted. Decreased ROM of cervical spine was noted. Thoracic spine: Palpation of his thoracolumbar spine musculature revealed a generalized neck and shoulder tenderness. Muscle guarding and/or latent trigger points +1 in nature in the surrounding musculature was noted as well. Orthopedic and Neurologic tests: Kemp's test was positive, indicative of posterior element compression, and/or irritation; more so on the left. Bilateral Leg Lowering test was positive, indicative of posterior element compression, and/or irritation; more so on the left. Lumbar spine: Palpation of his thoracolumbar and lumbosacral musculature revealed left-sided lower lumbar and gluteal tenderness. There was muscle guarding and/or active trigger points (+3 in nature) in the surrounding musculature. Orthopedic and neurologic tests: Valsalva test was positive with pain noted in the lower lumbar spine, which was radiating down to refer out to the left hip region. Seated Straight Leg Raising/Neural Tension test was indicative of possible underlying herniated nucleus pulposus/radiculopathy (pain was travelling in a well delineated dermatomal pattern) on the posterior aspect to his thigh.

Axial Compression/Quadrant tests were negative for radiculopathy; however, localized pain was noted indicative of possible discogenic pain. Kemp's test was positive, indicative of posterior element compression, and/or irritation near the thoracolumbar junction; more so on the left. Bilateral Leg Lowering test was positive, indicative of posterior element compression, and/or irritation near the thoracolumbar junction; more so on the left. Sciatic notch/nerve palpation was tender to the touch on the left. Eli's Femoral Nerve Stretch test was painful on the left with pain noted in the lower back, which was wrapping around to the anterior thigh. Diagnoses: 1) Lumbar spine herniated nucleus pulposus with radiculopathy. 2) Sciatica. 3) Cervical spine herniated nucleus pulposus with radiculopathy. 4) Thoracolumbar facet irritation. 5) Tension headaches. 6) Migraine headaches. 7) Positive orthopedic screening consistent with mild thoracic outlet syndrome. 8) Swan-neck deformity of #5 digit on the left. 7) TMD (thoraco mandibular joint) dysfunction. 8) Multiple ankle sprains as a teen playing sports. 9) Asthma. 10) Poor vision/double vision/"watering of his eyes." 11) Chest pain/anxiety. 12) High cholesterol. 13) Gastroesophageal reflux disease/irritable bowel syndrome. 14) Frequent urination at night. 15) Kidney stones. 16) Erectile dysfunction (presumably from the low back injuries, airbag, and psych). 17) High cholesterol. 18) Anxiety, depression. 19) Memory loss. 20. Sleep disorders. Causation: Based upon the medical records presented to and the history taken at the time of this evaluation, it appeared that this patient had musculoskeletal, impairment and/or disability, which could be directly correlated to both industrial and nonindustrial causes to which apportionment was clinically indicated. Based upon the medical records presented and the history taken at the time of evaluation, it appeared that he had non musculoskeletal impairment and/or disability that of which would need to be evaluated by the appropriate specialists including but not limited to psychology, internal medicine, rheumatology, and dental/HEENT.

Rating of Pre-Existing Labor Disabling Conditions: a) Lumbar spine and sciatica had 8% WPI. b) Cervical spine with tension headaches & migraine headaches had 11% WPI. c) Thoracic spine had 0% WPI. d) Thoracic outlet syndrome/disorder had 1% upper extremity impairment, which was equivalent to 1% WPI. e) Hands: This examiner noted that currently, this patient had complaints of arthritis type pain with visible deformities noted (swan-neck deformity). The current literature points to arthritis as the underlying cause for this and other similar characteristic deformities (boutonniere deformity, swan-neck deformity, & ulnar deviation). While this was a musculoskeletal disorder, it was best evaluated by a medical physician who specializes in rheumatoid and/or other arthritic conditions and would be deferred to the appropriate QME. f) Temporal mandibular joints: Currently, he had complaints of temporomandibular joint pain with altered mandibular gait. While this was a musculoskeletal disorder, it was best evaluated by a medical/dental physician who specializes in these types of conditions and would be deferred to the appropriate QME. g) Non MSK issues that need to be address by the appropriate medical specialists: i) Asthma. ii) Poor vision/double vision/"watering of his eyes." iii) Chest pain/anxiety. iv) High cholesterol. v) GERD/IBS (gastroesophageal reflux disease/irritable bowel syndrome). vi) Frequent urination at night. vii) Kidney

stones. viii) Erectile dysfunction (presumably from the low back injuries, airbag, and psych). ix) High cholesterol. Disability Status & Permanent Work Restrictions: Regarding the open labor market and with respect to the muscular skeletal conditions listed, he had permanent prophylactic work restrictions, which had clearly exceeded his previously described job duties and needed vocational training/voucher. It should be known to all parties that he did have a number of non-muscular skeletal issues, which might impair his ability to compete on the open labor market and/or supersede this examiner's permanent/prophylactic work restrictions as follows: No lifting, pushing, or pulling of greater than 10-20 lbs from floor to waist. No overhead work. No repetitive gripping/grasping and/or fingering. No prolonged postures including but not limited to sitting and/or standing. This was contemplating that the injured worker was best suited for a sedentary type job with the ability to change task and/or position at will to prevent a flare-up or exacerbation.

85. September 23, 2020, VVC GI Visit Note, Robert H Lee, MD: Reason for Visit: Heartburn, diarrhea, fecal incontinence. Assessment: 1) Heartburn. 2) Diarrhea. 3) Fecal incontinence. 4) Anemia. 5) Family history of hemochromatosis. Plan: a) Omeprazole 20 mg; Yogurt with fruit, or milk. b) Discussed option of anti-reflux surgery (Lap nissen fundoplication) if no symptom improvement despite medication optimization. He was amenable to the possibility. c) Check stool c diff, o & p, culture, TSH, TTG-IgA, total IgA when he returns to town. d) Check ferritin, iron saturation, B12, folate. e) Imodium as needed. f) If no improvement of fecal incontinence despite resolution of diarrhea, then discuss anorectal manometry next visit. g) Avoid NSAIDs. h) RTC 4 months.

86. November 10, 2020, Comprehensive Otolaryngology Subsequent Injury Benefits Trust Fund Evaluation, Paul M. Goodman, MD: DOI: CT 06/05/15 to 03/12/18; CT 03/12/17 to 03/2018. Subsequent Injury: The patient reported that in 2018, he fell down 13 stairs, injuring his back, leg, and hip. He fell flat on his back with no loss of consciousness. He had chronic lower back pain with bulging discs, a hip disorder, and leg discomfort. His case was settled in 03/2019 with an unknown rating. Pre-Existing Disability: He had a history of hearing loss and tinnitus. Current Complaints: He has had difficulty with tinnitus and hearing loss since 1997. He was still having difficulty with hearing and tinnitus. With respect to his hearing, it seemed to be more decreased on the right side. On one-to-one conversation, he would be hearing fairly well. With any sort of background noise, he claimed to have disability of not understanding words. He had an injury in the United States Navy in basic training in 1997, when he was shot to the right ear with subsequent buzzing in the ear. He has had tinnitus since 1997. The hearing itself had been stable. He apparently had a hearing test in the Navy, but none recently. The hearing did affect him. In addition, he did have attention deficit disorder and the hearing deficit did, indeed, was making him worse. He was playing the TV louder than for other family members. His was constant and was "very bad." It was interfering with his hearing and sleeping.

The left ear has had a low-frequency hearing loss since 12/2018 with a faint buzz. The majority of the tinnitus was in the right ear. He had occasional dizziness but there was no true vertigo. In summary, he complained of both hearing loss and tinnitus, occurring well before the subsequent injury. Medications: Adderall, gabapentin, Flexeril, atorvastatin, and Omeprazole. Physical Examination: Weight: 211 lbs. BP: 154/93 on the right and 145/86 on the left. Nose: Nasal examination revealed a midline septum with the nasal mucosa normal in appearance. Audiometric Evaluation: A complete audiometric evaluation was performed on 11/13/20 at Sonus Hearing Care Professionals in Corona, California and taken by Nancy Nicholson, MED-CCCA. This revealed a sensorineural hearing loss in the high frequency in the right ear. The left ear was normal. Speech reception threshold was 20 dB bilaterally with 100% word discrimination. Middle ear and eustachian tube functions are normal. Review of Records: Dr. Goodman reviewed the patient's medical/nonmedical records dated from 10/13/03 to 08/08/20. Diagnosis: Left sensorineural hearing loss with tinnitus. Causation and Apportionment: This examiner opined that 100% of the claimed injury was due to pre-existing hearing loss and tinnitus, which caused some limitations in the patient's ability to compete in the open labor market with some difficulty maintaining concentration of clearly hearing over a telephone or soft-spoken individuals. Permanent Impairment Rating: He had 1% WPI impairment rating for his hearing and tinnitus.

87. November 11, 2020, Subsequent Injuries Benefit Trust Fund Medical-Legal Evaluation in Orthopedics, James M. Fait, MD: DOI: CT 06/05/15 to 03/12/18; CT 03/12/17 to 03/12/2018; 12/12/18, 02/14/18. History of Injury: Remained unchanged. Current Complaints: The patient complained of recurrent pain in his neck with a stabbing sensation in his neck, with pain radiating to his left shoulder blade. He also had headaches. In addition, he had recurrent numbness and tingling in the fingers of his left hand. He had recurrent popping and continuous stiffness in his neck. The pain was aggravated with turning his head from side to side, looking up and down, tilting his head to the sides, and reaching. He complained of continuous aching and recurrent sharp pressure and burning pain in the mid back. His symptoms were aggravated with bending, twisting, turning, reaching, and prolonged sitting, standing and walking. His symptoms were alleviated with hot baths and showers. He reported frequent stabbing pain radiating from the left side of the neck into the left shoulder blade and down the back of the left arm. There was also numbness and tingling on the front and inner side of the elbow radiating down the inner side of the left forearm down to the left wrist. Symptoms were coming and going. They were made worse with gripping, grasping and repetitive head movements. He complained of continuous aching and recurrent sharp pressure and burning pain in the lower back, with pain radiating down the left leg to his third and fourth toes. He also had pain radiating to left testicle. He had recurrent tingling in the left leg with weakness noted in the left lower extremity. The symptoms were aggravated with bending, twisting, turning, reaching, ascending and descending stairs, and prolonged sitting, standing, and walking. His symptoms were alleviated with medication, hot baths, and showers. In addition, he complained of difficulty sleeping. He was only sleeping an average of four hours of interrupted sleep per night.

Review of Records: Dr. Fait reviewed the patient's medical/nonmedical records dated from 10/13/03 to 10/20/20. Physical Exam: General: It should be noted that the patient had some difficulty recalling various events in the distant past and was unclear about exact dates or timing with many of his injuries. Gait: He demonstrated a slight limp favoring the left lower extremity. He stated that this was due to back pain and stiffness with pain radiating into the left leg. Cervical spine: There was tenderness to palpation and paraspinal spasm in the left posterior paracervical musculature. ROM was restricted. Shoulders: ROM was slightly restricted bilaterally. Wrist/Hands: On examination of the left small finger, this examiner noted that there was obvious hyperextension of the PIP joint of the left small finger with a corresponding flexion contracture of the DIP joint characteristic of a swan neck deformity. There appeared to be instability of the PIP joint to varus-valgus stress. Thoracic spine: There was mild diffuse tenderness to palpation throughout the entire thoracic spine especially caudal to the shoulder blades and the lower thoracic spine. Lumbar spine: There was tenderness to palpation noted throughout the entire lower lumbar spine in the right and left paravertebral musculature but no paraspinal spasm was noted bilaterally. Faber's test was positive on the left. ROM was restricted. Sensation was diminished over the left lateral thigh, left lateral calf and dorsolateral aspect of the left foot in the L5 dermatome. Knees: Trace patellofemoral crepitus was noted bilaterally. The patella tracks centrally bilaterally. Deep tendon reflexes were 1+ and brisk at the knees and ankles. Calves: Trace bilateral pedal edema was noted. Diagnoses: 1) Cervical spine degenerative disc disease C2-C3 through C6-C7 with a 2.3 mm broad-based disc protrusion at C3-C4, a 2.3 mm broad-based disc protrusion at C4-C5, a 3.1 mm broad based disc protrusion abutting the anterior aspect the anterior aspect at C5-C6, and a 2.3 mm disc protrusion with posterior annular fissure at C6-C7 per MRI of 05/12/18.

2) Contusion right shoulder status post slip-and-fall, 12/23/03. 3) History of right small finger fracture volar plate, middle phalanx, 12/2002 without residual deformity. 4) Chronic swan neck deformity left small finger, pre-existing. 5) Lumbar spine L3-L4 annular tear and midline L4-L5 annular tear with intermittent symptoms of left lower extremity radiculitis, pre-existing. 6) Thoracic spine sprain-strain, pre-existing. 7) History of headaches, stress, anxiety - further discussion deferred. Causation: In the absence of medical evidence to the contrary, based on reasonable medical probability, it was opined that there was sufficient medical evidence to indicate that this patient did have a pre-existing disabling condition regarding his cervical spine, lumbar spine, thoracic spine and left hand prior to commencement of employment with Advanced Management Company. Also, there was sufficient medical evidence to indicate the applicant sustained a subsequent injury in April 2017 to the lumbar spine, injury to the cervical spine and lumbar spine as a result of a motor vehicle collision on February 14, 2018 and an injury to the cervical spine and lumbar spine as a result of a fall down the stairs on December 12, 2018. These were the result of industrially related injuries while employed as a leasing agent for Advanced Management Company. Apportionment: With regard to the cervical spine, it was opined that 40% of his current impairment and disability was apportioned to the motor vehicle collision that occurred in the US Navy, the result of which he received an honorable discharge, 10% was apportioned to the

motor vehicle collision of 12/14/18 and 50% was apportioned to the industrial slip-and-fall of 12/12/18. With regard to the lumbar spine, it was opined that 20% of his current impairment and disability was apportioned to the motor vehicle collision that occurred while on active duty in the US Navy, 40% was apportioned to the injury sustained while working as a caregiver on 01/23/14, 5% was apportioned to the injury in 04/2017 stepping off of a sidewalk, 5% was apportioned to the motor vehicle collision of 02/14/18 and the remaining 30% was apportioned to the industrial slip-and-fall of 12/12/18. With regard to the left hand, it was opined that 100% of his current impairment and disability was apportioned to the fracture that he apparently sustained while in the US Navy. With regard to the thoracic spine condition, it was opined that 100% of his current impairment and disability was apportioned to the injury he sustained as a caregiver on 01/23/14. There was no documentation of any thoracic spine pain or injuries or complaints prior to that period of time.

Pre-Existing Impairment Rating: Cervical spine: 8% WPI. Thoracic spine: 5% WPI. Lumbar spine: 12% WPI. Right upper extremity: 4% WPI. Subsequent Impairment Rating: He had sustained subsequent injuries to the cervical and lumbar spine. There was no evidence of subsequent injury to the thoracic spine or left hand, therefore, no subsequent impairment rating was indicated for the thoracic spine or left hand. There was a subsequent impairment rating for the cervical spine. There were now complaints of radicular pain radiating to the left upper extremity roughly in the C7 and C8 dermatomes. Therefore, he would best be reflected as DRE Cervical Category III and in this examiner's opinion, this would represent 15% Whole Person Impairment. With regard to the lumbar spine, he had persistent complaints of low back pain and radiating symptoms in the L5 dermatome. These symptoms appeared to have worsened in degree and therefore this would represent 13% Whole Person Impairment of the lumbar spine. In this examiner's opinion, there was sufficient medical evidence to indicate that the patient sustained a subsequent injury in 04/2017 to the lumbar spine, injury to the cervical spine and lumbar spine as a result of a motor vehicle collision on 02/14/18 and an injury to the cervical spine and lumbar spine as a result of a fall down the stairs on 12/12/18. These were the result of industrially related injuries while employed as a leasing agent for Advanced Management Company. Pre-Existing Work Conditions Prior to Commencement of Employment with Advanced Management Company: In this examiner's opinion, the patient was permanently precluded from lifting greater than 20 lbs, pushing or pulling greater than 20 lbs, repetitive bending and twisting at the neck or waist for more than two hours per shift and repetitive gripping or grasping, or fine motor movements of the left upper extremity for more than two hours per shift. Current Work Restrictions: He was currently precluded from lifting greater than 10 lbs, pushing or pulling greater than 10 lbs. He was permanently precluded from repetitive bending or twisting at the neck or waist. He was permanently precluded from prolonged standing or sitting for more than 30 minutes without a five-minute break. He was currently precluded from repetitive gripping or grasping with the left upper extremity for more than two hours per shift.

88. December 15, 2020, Comprehensive Supplemental Independent Medical Neurological Evaluation Report (Neurology), Lawrence M. Richman, MD: Discussion: This examiner was responding to a correspondence from the Workers' Defenders Law Group dated 10/14/20.

    a) With respect to the first question regarding opposite or corresponding body parts, this examiner noted that within his specialty, the patient previously sustained a traumatic brain injury in 1997, corresponding to body parts impacted resulting in a pre-existing disability that would include his complaints of neuralgic-type headache pain over the right side of the scalp occurring numerous times per month, as well as impaired sleep, all of which were body parts or components of body parts of the central nervous system. Similarly, he had sustained a traumatic brain injury in 2005 while employed by Schwann's Foods associated with altered mental status and corresponding body parts of blurred vision, which would involve both eyes; each eye was a separate body part and an impairment of each eye would impact the opposite and vise-versa.

    b) With respect to the second request regarding a traumatic brain injury, this examiner believed that Diffusion Tensor Imaging would provide some information regarding the extent of the patient's brain injuries; however, standard parameters for traumatic brain injuries were still evolving. An alternative approach would be that of Positron Emission Tomography or SPECT brain imaging. With respect to the injury of 12/12/18, there was no substantial medical evidence to show that the patient sustained a clinically significant traumatic brain injury.

    c) With respect to the third question regarding the 12/12/2018 incident, this examiner had been informed that the patient was considered to have reached maximal medical improvement previously on 10/15/18. He had also been informed that there was a subsequent injury of 12/12/18 when the patient fell at work injuring multiple body parts; however, he was not evaluated for any particular injury from this fall. He did not have sufficient medical records to address whether there was any clinical event or labor-disabling neurologic injury from that fall. He added that he would be agreeable to review additional medical records, as they become available.

    d) With respect to question number four, this examiner was informed that the patient had never been evaluated by a neurologist for his industrial injuries. Based on review of the patient's medical records corresponding to injuries sustained after his date of hire, there was reference to the patient having experienced difficulty with sleep in 06/2014, on 02/14/18 the latter from a nonindustrial motor vehicular accident, as well as headaches reported by a chiropractor on 02/14/18 following a motor vehicular accident. It was noteworthy that that examiner did not give an impairment rating for sleep, but did give an impairment rating for headaches, some of which, in Dr. Richman’s opinion predated the patient’s date of hire and some of which was present subsequent to his date of hire. Dr. Richman opined that 20% of the patient's headache complaints were present subsequent to his date of hire, which would leave him with a

whole person impairment of 12% from Table 13-11. There was no evidence of any significant head injury post-date of hire.

89. January 12, 2021, Subsequent Injuries Benefits Trust Fund Evaluation, Babak Kamkar, OD: DOI: 12/12/18; CT: 06/05/15-03/12/18; CT: 03/12/17-03/12/18; CT: 02/14/18-12/12/18. History of Subsequent Injuries: Remained unchanged. History of Other Injuries: The patient stated sustaining several injuries not related to his work. He has had multiple injuries since age 2, involving his head, face, upper and lower extremities, reproductive system, and GI tract. Work Status: He was currently unemployed because of the Covid-19 pandemic. He reported that he had not worked since his 03/12/19. Pre-Existing and Industrial Disabilities: His current ocular complaints included right temporal and ocular pain, light sensitivity, glare sensitivity, watery eyes, and double vision. He was bothered by intermittent sharp pain in the right temporal region radiating to his right orbital and ocular regions. The pain would last up to 15 seconds, usually happens 2-3 times monthly. He had been experiencing this sharp pain since 02/2020. Before 02/2020, he was experiencing burning sensation that he described as "dropping lava on the top of the head," which was resolved after chiropractic therapy. He reported glare sensitivity during the night, which was making him difficult to drive at night. He recalled having this symptom for several years predating his industrial injuries. He has had sun sensitivity since 02/2020. In addition, ever since his injuries, he reported experiencing intense bright light sensitivity 2-3 times a month. This intermittent light sensitivity could last up to 6 hours. During these visual disturbances, he would be experiencing headaches, which were alleviated by ibuprofen. He stated difficulty in reading with or without glasses. He had difficulties working on the computer screen with glasses for more than 10 minutes. This was a relatively new problem in the past year. He reported watery eyes for the past 1-2 years. He had difficulty wearing contact lenses. He was usually wearing contact lenses 2-3 times a week, no longer than 4-5 hours each time. He was also experiencing double vision since February 2020. He had double vision when he was looking at something closer than 2 feet. His first eye exam was at age 10 and he started wearing glasses since 4th grade. He started wearing contact lenses since 9th grade. His last eye exam was about a year prior. Medications: Adderall, Gabapentin, Lipitor, Flexeril, Ibuprofen.

Review of Records: Dr. Kamkar reviewed the patient's medical/nonmedical records dated from 10/13/03 to 08/08/20. Physical Exam: Uncorrected Vision Far (20 feet): Right Eye 20/600. Left Eye 20/600. Both eyes 20/400. Uncorrected Vision Near (16 inches): Right Eye RS 250. Left Eye RS 250. Both eyes RS 160. Corrected Vision: He had brought in a pair of prescription eyeglasses. The powers were neutralized as follows: OD - 6.25 -1.50 x 015. OS - 6.25 -0.75 x 180. Visual acuity at far with these glasses: Right eye - 20/20. Left eye - 20/20. Both eyes - 20/20. Visual acuity with these glasses at near (16 inches): Right eye - RS 40. Left eye - RS 40. Both eyes - RS 20. He was experiencing halos when examining his eyes with light. He was dilated with standard dilating drops of 1% tropicamide and 2.5% phenylephrine in both eyes. Fundus exam was performed through dilated pupils. Diagnoses: 1) Subjective visual disturbances. 2) Glare sensitivity. 3) Dry eye syndrome, mild, non-industrial. 4) High myopia, bilateral.

5) Regular astigmatism both eyes. 6) Beginning presbyopia. MMI Status: The patient had reached MMI status. Causation: The subsequent industrial injury did not cause any ocular impairment in this case. The cause of visual impairment was likely 100% natural and pre-existing. Apportionment: The visual impairment was 100% apportioned to natural causes. Looking backwards to the time of each portion of the impairment, the following conclusions were made: Pre-existing to the injuries: 7 5% (photophobia and glare) + 1.0% (visual fields): 8.5%. Current: 15% (photophobia and glare) + 1.0% (visual fields) + 1.0% (dry eyes): 17.0%. Total current WPI from an ocular standpoint: 17%. Future Medical Care: He needed annual eye examinations. Work Preclusions: He was suffering from sensitivity to light and glare. Work preclusions included working outdoors under the sun and working under bright artificial lights, such as stadiums and concert halls. Due to his disabling glare at night, any occupation that involves driving at night could be hazardous to him and others. Examples included delivery services, bus and transportation jobs, emergency vehicle jobs, police or security jobs, ride sharing jobs, chauffeur, etc. Dry eye syndrome was labor disabling. Work preclusions included any job that increases dry eyes, such as working in windy environments, working long hours in front of a computer screen, working in air-conditioned rooms, or working with aerosolized chemicals.

90. April 16, 2021, Psychiatric Note (Tele Visit), Anna Lisa G. Gacula, MD: Reason for Visit: Followup visit; initial visit with this provider on 11/19/19. DSM-5 Diagnoses: ADHD; **MDD**, recurrent, Moderate **(SC)**. Treatment Plan: 1) Continue Adderall 20 mg/10 mg; gabapentin 300mg/600mg. 2) Intake appointment on 05/05/21 for community therapy. 3) Tele visit in 3 month. Aware to call if need sooner appt. 4) Brief supportive therapy and empathic listening provided same day. 5) Educated patient about the importance of exercising regularly and following healthy diet.

91. June 24, 2021, Case Manager Medication Refill Note, Gacula, NP, Veteran Hospital: Current Active Medications: Acetaminophen 500 mg, Atorvastatin calcium 40 mg, Cholecalciferol 125 mcg (d3-5,000 unit), 4) gabapentin 300 mg, Lidocaine 5% patch, loperamide HCL 2 mg, methocarbamol 500 mg. Inactive Outpatient Medications: Amphetamine/Dextroamphetamine 10 mg, Omeprazole 20 mg. Comments: Request sent for medication refill.

Eric E. Gofnung Chiropractic Corp
6221 Wilshire Blvd Suite 604
Los Angeles, CA 90048
United states

Phone (323)933-2444
Fax (323)933-2909

Date

Evaluator

Summary/Discussion

Calibration Certificate

Device ID	Device Type	Date of Examination
19EE89	Muscle Tester	9/27/2021

Last Factory Calibration

Date
5/28/2014

Last Full Calibration

JTECH Recommended Drift Limits	Drift from Factory Calibration	Date & Time
±20%	2.0%	1/20/2021 3:59:10 PM

Last Zero Calibration

JTECH Recommended Drift Limits	Drift from Factory Calibration	Date & Time
±20%	2.0%	1/20/2021 3:59:10 PM

Patient Information

Name: Evan Disney
Gender: Male
Birth Date: 4/17/1978
Dominant Hand: Right

Primary Insurance

Secondary Insurance

Employer

Referral

Attorney

Care Providers

Range of Motion - Inclinometry

Spine Range of Motion

The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using the dual inclinometry protocols outlined in the AMA Guides to the Evaluation of Permanent Impairment.

% Norm	Difference	Result	Norm	Cervical ROM
74%	13°	37°	50°	Cervical Flexion
52%	29°	31°	60°	Cervical Extension
49%	23°	22°	45°	Cervical Lateral Left
51%	22°	23°	45°	Cervical Lateral Right
53%	38°	42°	80°	Cervical Rotation Left
56%	35°	45°	80°	Cervical Rotation Right

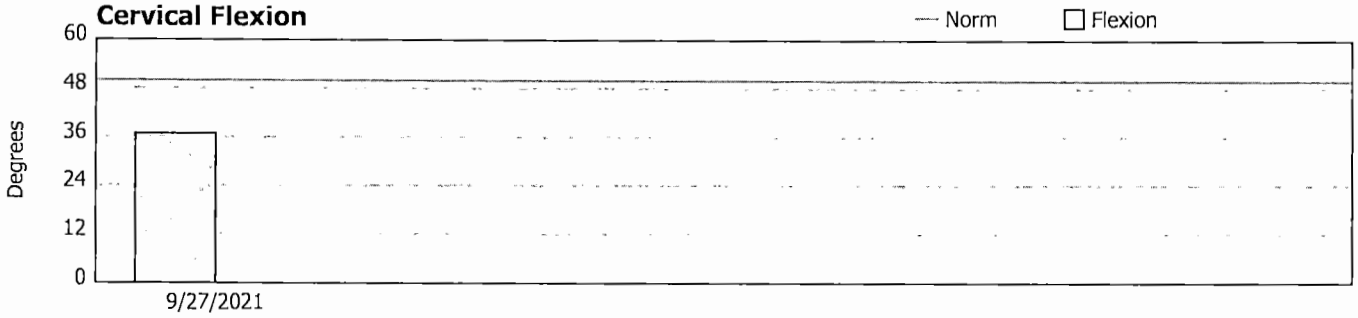
% Norm	Difference	Result	Norm	Thoracic ROM
–	–	2°	–	Thoracic Minimum Kyphosis
60%	18°	27°	45°	Thoracic Flexion
63%	11°	19°	30°	Thoracic Rotation Left
50%	15°	15°	30°	Thoracic Rotation Right

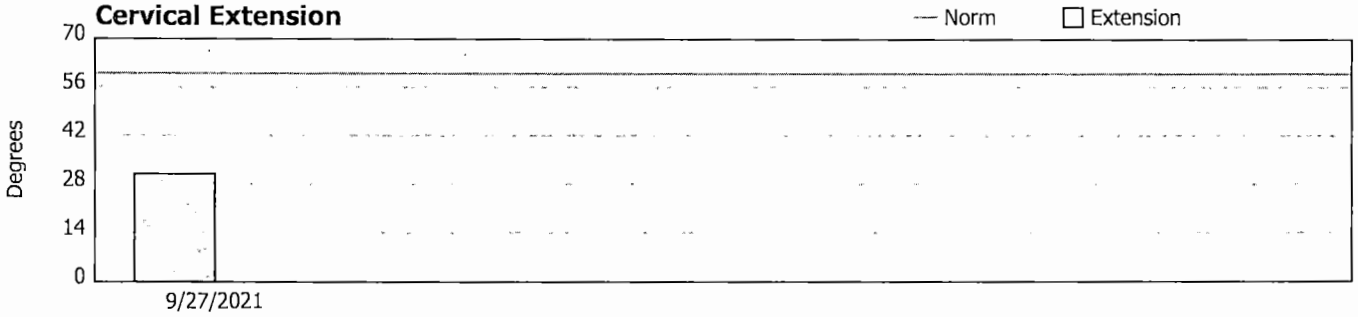
% Norm	Difference	Result	Norm	Lumbar ROM
75%	15°	45°	60°	Lumbar Flexion
52%	12°	13°	25°	Lumbar Extension
60%	10°	15°	25°	Lumbar Lateral Left
56%	11°	14°	25°	Lumbar Lateral Right

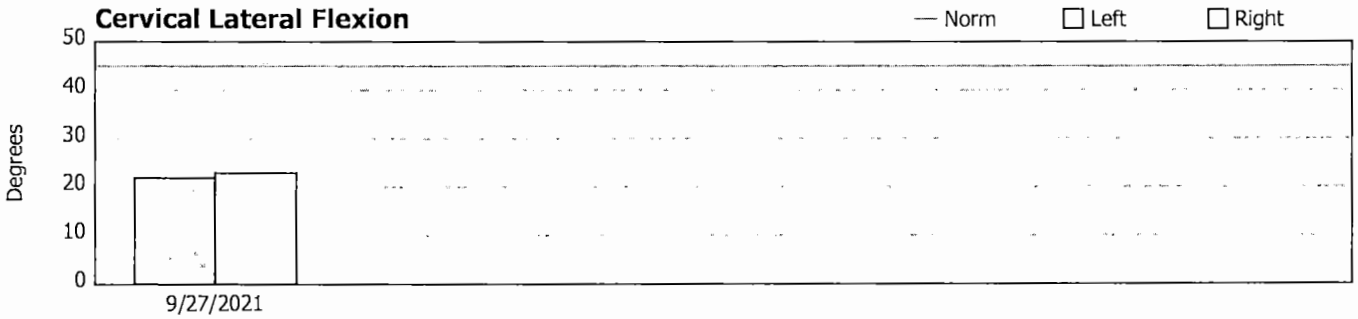
According to the AMA Guides, "An accessory validity test can be performed for lumbosacral flexion and extension... If the straight-leg-raising angle exceeds the sum of sacral flexion and extension angles by more than 15°, the lumbosacral flexion test is invalid. Normally, the straight-leg-raising angle is about the same as the sum of the sacral flexion-extension angle... If invalid, the examiner should either repeat the flexion-extension test or disallow impairment for lumbosacral spine flexion and extension."

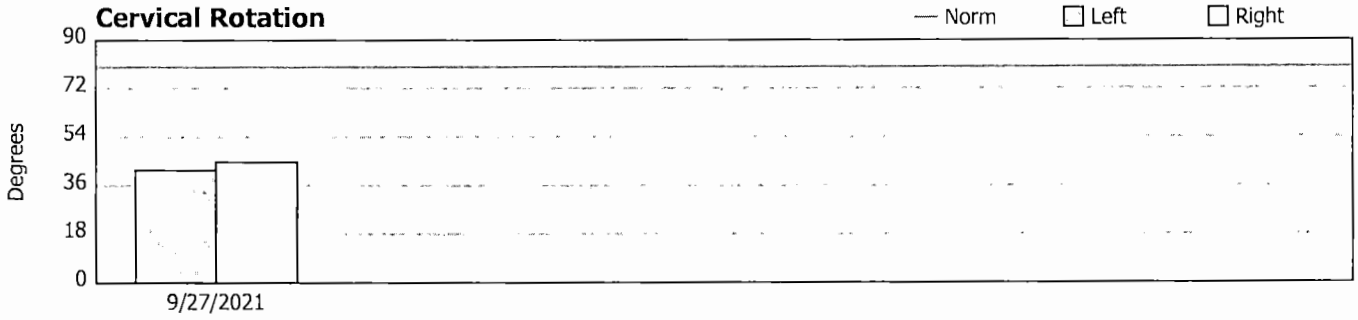
Unless otherwise noted, the table(s) above show current test results compared to American Medical Association normative values.

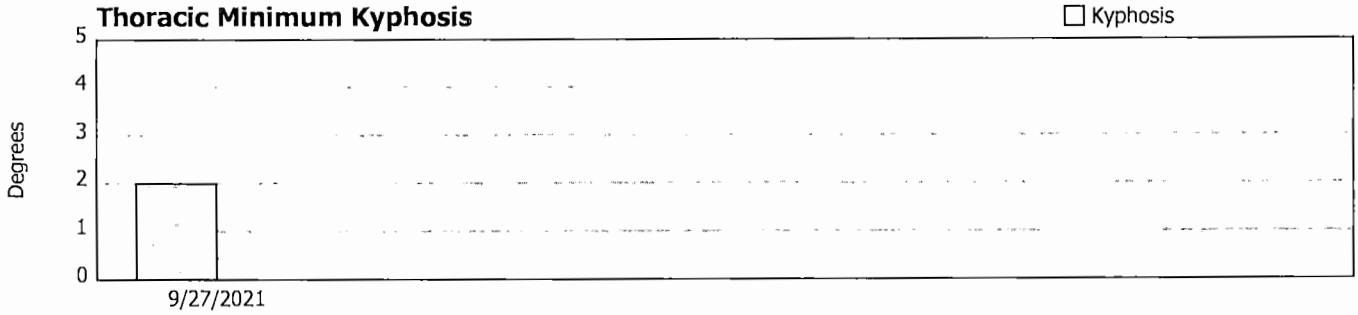
Spine Range of Motion Progress

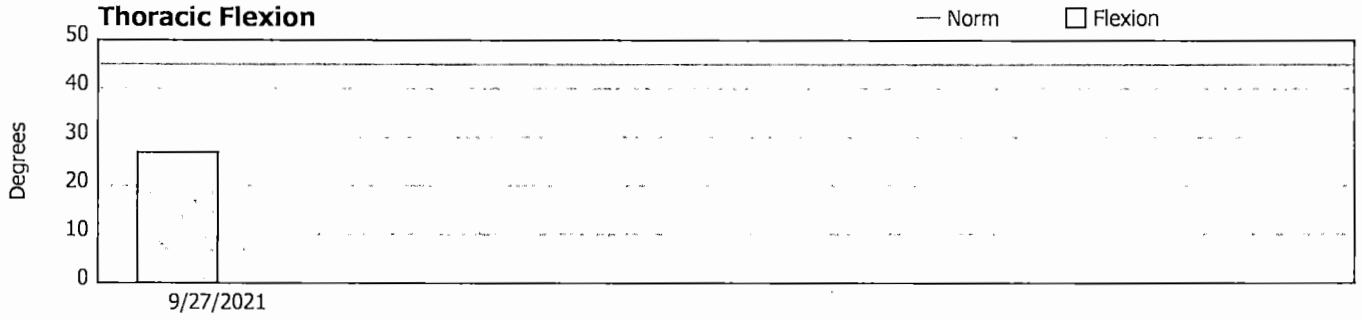

Cervical Flexion
Norm
Flexion
Degrees
60
48
36
24
12
0
9/27/2021

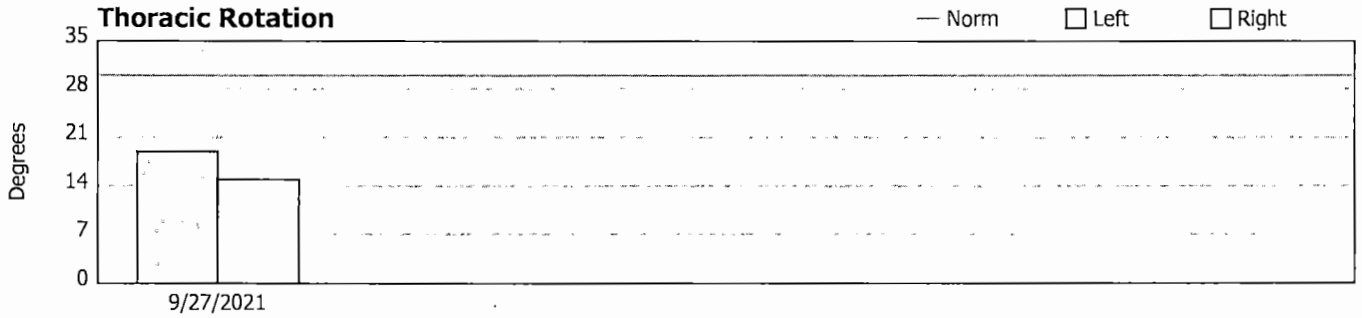

Cervical Extension
Norm
Extension
Degrees
70
56
42
28
14
0
9/27/2021

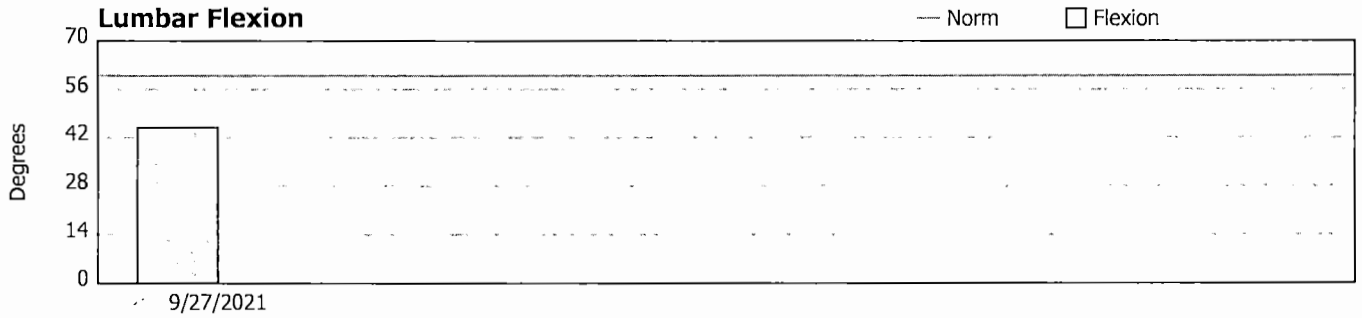

Cervical Lateral Flexion
Norm
Left
Right
Degrees
50
40
30
20
10
0
9/27/2021

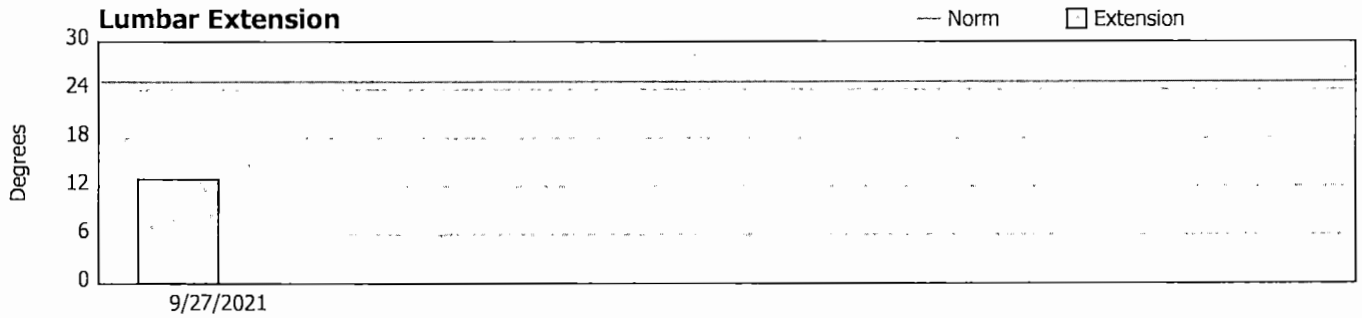

Cervical Rotation
Norm
Left
Right
Degrees
90
72
54
36
18
0
9/27/2021

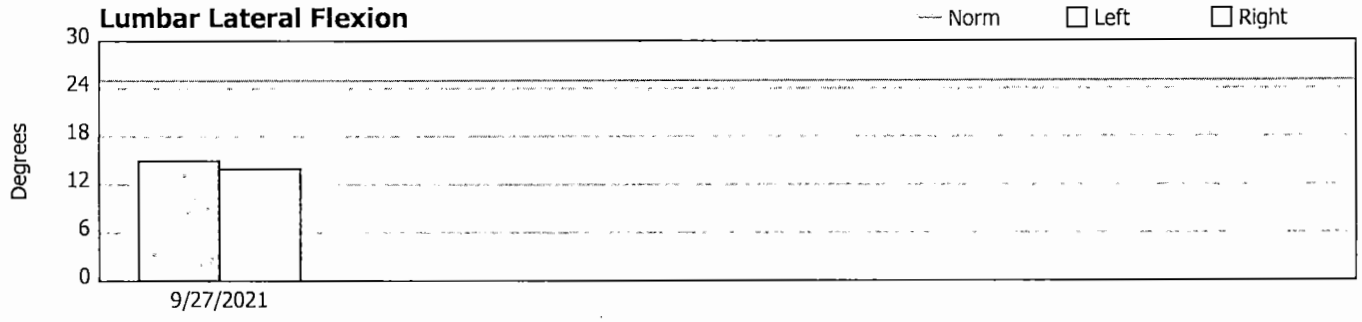

Thoracic Minimum Kyphosis
Kyphosis
Degrees
5
4
3
2
1
0
9/27/2021


Thoracic Flexion
Norm
Flexion
Degrees
50
40
30
20
10
0
9/27/2021


Thoracic Rotation
Norm
Left
Right
Degrees
35
28
21
14
7
0
9/27/2021


Lumbar Flexion
Norm
Flexion
Degrees
70
56
42
28
14
0
9/27/2021


Lumbar Extension
Norm
Extension
Degrees
30
24
18
12
6
0
9/27/2021


Lumbar Lateral Flexion
Norm
Left
Right
Degrees
30
24
18
12
6
0
9/27/2021

Custom Spine Range of Motion

The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using dual inclinometry protocols.

Custom Spine Range of Motion Progress

Extremity Range of Motion

The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using the single and dual inclinometry protocols outlined in the AMA Guides to the Evaluation of Permanent Impairment.

The table(s) above show current test results compared to American Medical Association normative values.

Extremity Range of Motion Progress

Custom Extremity Range of Motion

The patient's range of motion was objectively evaluated with Tracker ROM from JTECH Medical using single and/or dual inclinometry protocols.

Custom Extremity Range of Motion Progress

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RE: EVAN DISNEY vs ADVANCES MANAGEMENT COMPANY, S. I. B. T. F.
WCAB: ADJ11231848 (DOI: 06/05/2015 - 03/12/2018)
SIBTF#: SIF11231848

DATE: 09/01/2021

COVER LETTER FOR AME EVALUATION

DEAR DR. ERIC E. GOFNUNG DC:

This office represents the above referenced applicant. You have been selected to act in the capacity of **AME (Agreed Medical Evaluator)** in regard to the applicant's Subsequent Injury Benefit Trust Fund Claim in chiropractic specialty.

You are specifically asked to provide a medical legal evaluation in your area of expertise in regard to the subsequent ADJ11231848 (DOI: 06/05/2015 - 03/12/2018).

We further request that you provide summary rating based on available SIBTF medical evaluations.

It is requested that a determination be made regarding any pre-existing medical issues and disability within your area of specialty that were present at the time of the subsequent industrial injury.

Please provide a permanent impairment rating per the AMA guides 5th edition and address the issue of apportionment.

Specifically, it is requested that you provide a determination as to the percentage of cause of disability to a pre-existing condition present at the time of the subsequent industrial injury, any contribution from the industrial injury(ies) and any further natural progression which occurred after the industrial injury.

Please cover in your report the following topics:

- Subjective complaints
- Objective factors or findings
- Current diagnosis
- Occupational history
- Past medical history
- Prior injuries
- Pre-existing labor disabling condition
- Prior injuries' causation

- Rating of pre-existing labor disabling conditions
- Pre-existing work restrictions
- 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
- Activities of daily living

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

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

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

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

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

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

6. **IF YES,** please answers the following questions:
   (a) Was that preexisting condition permanent and stationary at the time of the last employment?
   (b) 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?
   (c) Did worker have a subsequent injury within the scope of your specialty?
   (d) Was the subsequent industrial injury compensable and have resulted in additional PPD?

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

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

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

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

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

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

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

RATING DETERMINATION:

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

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

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

PRE-EXISTING DISABILITY DISCUSSION

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

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

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

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

DISCUSSION OF SUBSEQUENT INDUSTRIAL INJURY

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

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

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

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

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

If you need any additional testing, please advise so.

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

Thank you for your anticipated courtesy and cooperation herein.

Very truly yours,

By Natalia Foley, Esq
WORKERS DEFENDERS LAW GROUP

PROOF OF SERVICE

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

751 S Weir Canyon Rd Ste 157-455
Anaheim CA 92808
Tel: 714 948 5054

2. I served the following documents:

COVER LETTER FOR AME EVALUATION

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

- Date of Mailing: 09/01/2021
- Place of Mailing: Los Angeles, CA

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

Date: 09/01/2021

By Irina Palees, Legal Assistant
to Attorney Natalia Foley

Name and Address of each Person to whom Notice was Mailed

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

ERIC E. GOFNUNG CHIROPRACTIC CORPORATION
6221 WILSHIRE BLVD SUITE 604
LOS ANGELES, 90048

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

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

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ERN: 13792552

TO: ERIC E. GOFNUNG CHIROPRACTIC CORPORATION
6221 WILSHIRE BLVD., SUITE 604
LOS ANGELES, 90048

SUBSEQUENT INJURIES BENEFIT TRUST FUND
160 PROMENADE CIRCLE, STE. 350
SACRAMENTO, CA 95834

RE: EVAN DISNEY vs ADVANCES MANAGEMENT COMPANY, S. I. B. T. F.
WCAB: ADJ11231848 (DOI: 06/05/2015 - 03/12/2018)
SIBTF#: SIF11231848

DATE: 09/01/2021

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

I, Natalia Foley, hereby declare:

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

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

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

I declare that the total page count of the documents provide to the physician per attached list of Exhibits is 2144.

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

Executed this 16 day of June, 2021, at Anaheim, CA

_____

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

EVAN DISNEY vs ADVANCES MANAGEMENT COMPANY, S. I. B. T. F.

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List of Exhibits:

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Ex 01	A copy of C&R dated 3/12/2019	15
Ex 02	P&S report by PTP Dr. Harold Iseke, dated 10/15/2018	12
Ex 03	PQME Todd W Peters, MD, initial report dated 9-6-2018	15
Ex 04	Medical records relevant to the accident 2-23-2014	42
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Ex 08	MRI of cervical spine dated 05-12-2018	03
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Ex 33	Liberty mutual Medical Records	1109
Ex 34	Veteran Hospital Records	82
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All exhibits can be downloaded here:

https://www.dropbox.com/sh/ng2x6faky1tbzys/AABwChKcoZTIf9KqUvdcLjlWa?dl=0

PROOF OF SERVICE

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