CALIFORNIA SPORTS CARTILAGE INSTITUTE

GREGORY T. HEINEN, M.D.

DIPLOMATE, AMERICAN BOARD OF ORTHOPEDIC SURGEONS

FELLOW, AMERICAN ACADEMY ORTHOPEDIC SURGEONS

BOARD CERTIFIED IN ORTHOPEDIC SURGERY AND SPORTS MEDICINE

FELLOWSHIP TRAINED IN ARTHROSCOPY AND SPORTS MEDICINE

AME/QME CERTIFIED

ARCADIA OFFICE

301 West Huntington Drive
Suite #617
Arcadia, California 91007
Phone # (626) 574-9745
Fax # (626) 574-8741

RIVERSIDE OFFICE

4100 Central Avenue
Suite #101
Riverside, California 92506
Phone # (951) 781-5965

02-28-2018

LWP Claims Solutions, Inc
PO Box 349016
Sacramento, CA 95834

ATTENTION: JUDY DUVALL, Ms.
Claims Adjustor

PATIENTS NAME:	**FLOREEN ROOKS**
DATE OF BIRTH:	**06-20-1949**
EMPLOYER:	**D'VEAL CORP**
OCCUPATION:	**THERAPIST**
DATE OF INJURY:	**04-16-2006**
DATE OF EXAM:	**02-28-2018**
CLAIM NUMBER:	**SAC0000196443**

Panel Qualified Medical Evaluation
Comprehensive Orthopaedic Evaluation

Dear JUDY DUVALL, Ms.:

FLOREEN ROOKS is a 68 Y/O , F who was evaluated in my office in Riverside, CA on 02-28-2018 for a requested Initial Orthopedic/Neurologic PQME regarding the above mentioned Workers Compensation case. The following is a report of that evaluation. Neck, Both shoulder, both wrist and hands, mid back, left knee, right ankle, left foot.

SOURCE OF FACTS

The facts were obtained from the patient by medical historian, Annie Phan, or

from the medical records noted later in this report.

OCCUPATIONAL HISTORY

Ms. ROOKS works for D'VEAL CORP as a marriage and family THERAPIST. The patient has worked there for 12 years. She was a marriage and family counselor therapist. Physical job duties: walking, standing, driving to clients, repetitive hand motions, significant typing, climbing. She stopped employment April 2016. In intake over the last couple of years on computer 2-3 hours/day

PREVIOUS WORK-RELATED INJURIES

The patient reports left knee injury getting out of the car. She does not recall the year of which this happened at same employer. She had surgery for torn meniscus. She states she has swelling all the time. She also had injury to her toe to the left foot. She had recovery with this for the toe. Knee still hurt. .

PREVIOUS MOTOR VEHICLE OR SIGNIFICANT ACCIDENTS

The patient denies any.

HISTORY OF INJURY

Ms. ROOKS works for D'VEAL CORP as a THERAPIST. The patient denies any previous injuries to their lower extremities, upper extremities, back.

She states she sustained a cumulative trauma injury from her 12 years of employment. She is unable to recall specific date when she first noticed symptoms. She developed pain to her from repetitive use of her upper extremities and lower extremities. She drives significantly to clients homes going in and out of cars (on average < 5 week (intake department) over the last 3 years...prior to this approximately 6-7 times/day). She estimates that she would have to drive to clients approximately 5 times per week with her current intake job. She would have to climb up and down stairs of clients home (1-2 short flights of steps per day). She would have to type intake reports everyday (2-3 hours/day). She states that she also developed psyche issues (awaiting psyche eval and looking forward to this). She states that she has also seen a doctor for her eyes. She doesn't remember when she started developing symptoms. Never sought care for any of these issues prior to Dr. Nissanoff (see below).

She notes that she would change her daily practice. She did not like driving freeways as eyesight changed. She was getting nervous about this and joined carpools.

She suffered harassment from one of her co-workers (CEO of the company). She states that he got into her face and pushed a phone to her face. She was unable to go to work for the next two days. She is paranoid at this time if anyone gets close to her.

She did not have any treatment from the time she left to the time she saw Dr. Nissanoff

She was sent in June 2017 to Dr. Jonathan Nissanoff. She has had ongoing care with this doctor once a month. She also has ongoing care with Dr. Javid Ghandehari for medication refills. Both doctors she was sent to by her attorney. She sees him once a month for refill for Ibuprofen and Gabapentin.

Requests for x-rays, physical therapy, tens units, and psychiatrist have been request but have not been approved. She has not had any care up to this point.

CHIEF COMPLAINTS

For neck, she has on and off pain. This radiates down her back. She has to turn neck slowly.

For back, she states pain is debilitating. She is unable to move when back gets stuck. She can have this shoot down her back. Sometimes can hardly walk.

For bilateral shoulders, she has constant aching to the top of her shoulders. This radiates down to her elbow for both shoulders. No numbness or tingling. No locking/catching. No popping.

For bilateral hands, she has stiffness and locking. She states this is painful. No numbness or tingling. Stiffen and she can not move them.

For bilateral knees, she has swelling and constant ache. She is unable to walk at times. This more frequent. She feels instability in both knees. She feels balance is an issue. No numbness or tingling.

PAST MEDICAL HISTORY

HTN

Family History
fam hx - cancer

SURGICAL HISTORY

Past Surgical History:

DATE OF PROCEDURE	PROCEDURE
	eye surgery at 20 years --
	LT ANKLE
	LEFT KNEE MENISECTOMY

ALLERGIES TO MEDICATIONS

Allergies:
1. Penicillin V Potassium -

CURRENT MEDICATIONS

Ibuprofen 800 mg, Gabapentin 100 mg

SOCIAL HISTORY

Marital Status: S
Social History:

SUBSTANCE	AMOUNT	COMMENT	MARITAL STATUS
Alcohol	OCCASIONAL		
Smoking	CURRENT	3 cigs/day	

REVIEW OF SYSTEMS

Constitutional: **NO** stomach pain.
Eyes: **early cataracts**
Ears: **NO** hearing loss, otorrhea or ear pain.
Nose/Mouth/Throat: **NO** pain with swallowing. Mild cold
Cardiovascular: **NO** chest pain or palpations.
Respiratory: **NO** cough, shortness of breath or wheezing.
Gastrointestinal: **NO** diarrhea, constipation, blood in stools, abdominal pain, vomiting or heartburn.
Genitourinary: **NO** urinary frequency, hematuria, incontinence, or dysuria.
Skin: **NO** rash or bothersome skin lesions.
Neurological: **NO** numbness or tingling except sometimes into the hands
Psychiatric: **Trauma related anxiousness**

Hematologic/Lymphatic: **NO** easy bruising, easy bleeding, or swollen glands.
Allergic/Immunologic: **NO** itching, sneezing, watery eyes, clear rhinorrhea or recurrent infections.
Endocrine: **NO** history of diabetes.

I have reviewed at least ten organ systems with (positive and negative) responses individually documented by the patient. The completed "Review of Systems" form has been placed into the patient's permanent medical record and has been signed by the patient.

PHYSICAL EXAM

Vital Signs:

BP SYST	BP DIAST	PULSE	HT	WT
148	88	76	65	213

Respirations are regular. * alert and orientated, well-nourished, well-developed, and in no apparent distress. Mood and affect are appropriate.

CERVICAL SPINE

Cervical range of motion is expressed in degrees,
Flexion: 42
Extension: 18
Rotation (R/L): 60/60
Lateral tilt (R/L): 28/14

There is no tenderness, swelling, spasm or atrophy to the neck specifically. She does have tenderness to her bilateral trapezii muscles..

Foraminal compression tests do not elicit any radicular symptoms.

Spurling's test for cervical radiculopathy is negative bilaterally.

Compression and percussion over the brachial plexus in the supraclavicular fossa, Adson's maneuver, modified Adson's maneuver and Roos' elevated arm stress tests are negative bilaterally for brachial plexopathy, including thoracic outlet syndrome.

RIGHT SHOULDER

No atrophy or deformity.

Range of motion is expressed in degrees:
Abduction: 140
Forward flexion: 150
Extension: 30
Adduction: 30
External rot: 70
Internal rot: 40

Inspection of the shoulders reveals no swelling, scar or deformity. There are no skin lesions, abrasions, or infection.

There is no crepitus with active or passive range of motion of the shoulder.

There is tenderness over the coracoacromial arch. Hawkins/Neer impingement signs are positive. The patient has minimal weakness of the rotator cuff. Jobe's test for supraspinatus tendinopathy is positive. Resisted external rotation with the arm at the side is negative for infraspinatus tendinopathy.

The lumbar lift-off test is negative for subscapularis tendinopathy.

No biceps tenderness to palpation. Speed's test is negative for bicipital tendinitis. Testing for instability of the biceps tendon is negative. O'Brien's test is negative.

No AC joint tenderness. Horizontal adduction and compression test is negative for AC joint arthritis.

No scapular winging.

Examination for anterior instability reveals there is a negative anterior drawer test and negative load/shift test. There is a negative apprehension/relocation test. There is no excessive anterior translational laxity.

Testing for multi-directional instability shows there is a negative sulcus sign and no evidence of generalized ligamentous laxity. There is no excessive anterior or posterior translation.

LEFT SHOULDER EXAM

No atrophy or deformity.

Range of motion is expressed in degrees:
Abduction: 150

Forward flexion: 150
Extension: 40
Adduction: 30
External rot: 80
Internal rot: 80

Inspection of the shoulders reveals no swelling, scar or deformity. There are no skin lesions, abrasions, or infection.

There is no crepitus with active or passive range of motion of the shoulder.

There is no tenderness over the coracoacromial arch. Negative Hawkins/Neer impingement sign. The patient has no weakness of the rotator cuff strength. Jobe's test for supraspinatus tendinopathy is negative. Resisted external rotation with the arm at the side is negative for infraspinatus tendinopathy.

The lumbar lift-off test is negative for subscapularis tendinopathy.

No biceps tenderness to palpation. Speed's test is negative for bicipital tendinitis. Testing for instability of the biceps tendon is negative.

No AC joint tenderness. Horizontal adduction and compression test is negative for AC joint arthritis.

No scapular winging.

Examination for anterior instability reveals there is a negative anterior drawer test and negative load/shift test. There is a negative apprehension/relocation test. There is no excessive anterior translational laxity.

Testing for posterior instability shows the load/shift test is negative and there is a negative posterior apprehension sign. There is no excessive posterior translational laxity.

Testing for multi-directional instability shows there is a negative sulcus sign and no evidence of generalized ligamentous laxity. There is no excessive anterior or posterior translation.

BILATERAL ELBOW EXAM

Elbow range of motion is expressed in degrees, actual/normal:
Extension: 0/0
Flexion: 130/135
Pronation: 80/80

Supination: 85/85

There is no crepitus.

There are no skin lesions or abrasions.

There is no ulnar nerve instability at the elbow. The passive elbow flexion and percussion tests are negative for cubital tunnel syndrome.

There is no pain distal to the lateral epicondyle with resisted forearm supination and wrist extension found with radial tunnel syndrome.

The patient has no tenderness over the lateral epicondyle and no pain with resisted wrist or middle finger extension as found with lateral epicondylitis.

There is no tenderness over the medial epicondyle. Resisted wrist flexion causes no discomfort over the medial epicondyle.

The biceps tendon is intact at its insertion. There is no tenderness over the bicipital tendon.

There is no ligamentous instability to varus/valgus stressing of the elbow.

The patient has full active flexion and extension of the elbow against resistance without difficulty.

Provocative testing for medial nerve entrapment by lacertus fibrosis, pronator teres or flexor digitorum superficialis is negative. The pronator compression and percussion tests are negative for proximal forearm median nerve entrapment.

BILATERAL WRIST EXAM

Wrist range of motion is expressed in degrees, actual/normal:
Dorsiflexion: 60/70
Palmar flexion: 65/75
Ulnar deviation: 40/40
Radial deviation: 20/20

Per patient, no stiffness today

There are no skin lesions or abrasions.

There is no swelling She reports minimal volar tenderness about the wrist but without provocative testing today.

There is no tenderness along the first extensor compartment and Finkelstein's test is negative for de Quervain's tenosynovitis.

The patient has no pain over the first, second or third extensor compartments or in the area of intersection syndrome.

There is no pain, crepitus or hypermobility with manipulation of the distal radioulnar joint. The patient has no tenderness over the triangular fibrocartilage.

The patient has no pain with forced ulnar deviation of the wrist found with ulnar abutment syndrome.

Triquetrolunate ballottement is negative.

The pisotriquetral grind test is negative.

Watson's scaphoid shift test is negative.

The thumb metacarpal axial grind test is negative for CMC arthritis

No Tinels or Phalens

Distally neurovascularly intact

THORACIC SPINE

The patient reports tenderness from T8-T10.

No spasm is noted.

LUMBOSACRAL SPINE EXAM

Inspection reveals no cutaneous lesions.

There are no incisions. There are no skin lesions or abrasions.

The lumbar spine is tender at the Lumbosacral junction..

There is mild spasm.

There is sacroiliac joint tenderness. FABER test is equivocal.

Lumbosacral spine range of motion is expressed in degrees,
Flexion: 72 (distal tibia)
Extension: 10 with pain
Lateral bend right: 26
Lateral bend left: 32

Seated straight leg raise is negative bilaterally to 60 degrees. Supine straight leg raise is negative bilaterally in that there is no leg pain with straight leg raise maneuver

Passive hip range of motion is symmetric and painless. No tenderness. No buttock pain.

RIGHT KNEE EXAM

Knee range of motion is expressed in degrees.

RANGE OF MOTION, actual/normal

Extension: 0/0
Flexion: 110/130

There is no effusion.

There are no skin lesions or abrasions.

While standing, the patient does not have excessive varus or valgus alignment.

There is patellofemoral crepitus No patellar instability. The patella tracks well clinically. There is no tenderness around the patellofemoral joint. Patellofemoral compression test is negative. The Q-angle is normal.

The patient has no instability to varus/valgus test in full extension, 30 degrees or 90 degrees of flexion.

Testing for anterior cruciate ligament instability shows that the Lachman, anterior drawer and pivot shift tests are negative.

Testing for posterior cruciate ligament instability shows that the posterior drawer test, posterior sag sign and quadriceps active tests are negative.

There is no tenderness over the medial or lateral joint line and there is a negative McMurray's test. The compression/rotation test is negative for a meniscal tear.

The patient has full extension against resistance without difficulty.

LEFT KNEE EXAM

Knee range of motion is expressed in degrees.

RANGE OF MOTION, actual/normal

Extension: 0/0
Flexion: 100/130

There is no effusion.

There are no skin lesions or abrasions.

While standing, the patient does not have excessive varus or valgus alignment.

There is patellofemoral crepitus no patellar instability. The patella tracks well clinically. There is tenderness around the patellofemoral joint. Patellofemoral compression test is positive. The Q-angle is normal.

The patient has no instability to varus/valgus test in full extension, 30 degrees or 90 degrees of flexion.

Testing for anterior cruciate ligament instability shows that the Lachman, anterior drawer and pivot shift tests are negative.

Testing for posterior cruciate ligament instability shows that the posterior drawer test, posterior sag sign and quadriceps active tests are negative.

There is tenderness over the medial > lateral joint line and there is a negative McMurray's test when loading the compartments. The compression/rotation test is positive for a meniscal tear.

The patient has full extension against resistance without difficulty.

RIGHT ANKLE

Full range of motion and normal examination no provocative testing. No

tenderness

LEFT ANKLE EXAM

Ankle range of motion is expressed in degrees, actual/normal:

Dorsiflexion: 0/15
Plantar flexion: 15/40
Eversion: 15/20
Inversion: 10/35

Stiff range of motion with crepitation
There are no skin lesions or abrasions. There is crepitus with motion. Healed scars noted.

There is medial and lateral tenderness and, swelling, No atrophy or palpable abnormalities.

The anterior drawer test is negative. There is no lateral ligamentous laxity but does elicit some pain

FOOT:

There is no deformity of the feet.

There is a flat longitudinal arch.

There are no skin lesions or abrasions.

There are no areas of tenderness of the foot proper.

The patient's toes are all warm and pink with brisk capillary refill.

Thompson's test is negative for Achilles tendon rupture.

The patient has good/intact dorsiflexion and plantar flexion strength against resistance.

Distally neurovascularly intact

DIAGNOSTIC STUDIES

Xrays: See the report.

REVIEW OF RECORDS

Medical records measuring 5 inches and a prolonged deposition were received and reviewed in their entirety. Only pertinent information is summarized.

MEDICAL REPORTS:

12/13/06 - Progress Note - Kaiser Permanente - Kelly Ching, M.D. Patient presented with nausea and vomiting x2 days, aches, chills, neck pain, diarrhea and cramping. **Assessment:** Essential hypertension; obesity; smoker; gastroenteritis.

06/26/07 - Progress Note - Kaiser Permanente - Felisa Mamiit, LVN. The patient was seen for placement of PPD test.

06/28/07 - Progress Note - Kaiser Permanente - Felisa Mamiit, LVN. PPD reading negative.

08/09/07 - Progress Note - Dreamweaver Medical Group - Signature Illegible. Handwritten notes indicated the patient sustained work injury on this date after a slip and fall onto her left hip from ground level. Injury to left hip, left knee and left ankle. Ankle was the worst. Also pain in the right shoulder as well. **Assessment:** Left hip, knee and ankle pain. **Plan:** Rx Naprosyn, x-rays and off work.

08/09/07 - Doctor's First Report of Occupational Injury or Illness - Dan Le, D.O. Date of injury was 8/09/07. Employer was D'Veal Family & Youth Services. The patient slipped on a piece of cucumber and fell onto concrete ground. She fell onto her left hip from ground level. No pop or crack was noted. She complained of pain in the left hip, left knee and left ankle. The ankle was the most painful. **Diagnoses:** Left hip, knee and ankle pain. **Treatment**

Rendered: Naprosyn 500 mg b.i.d. p.r.n. pain, and ice packs. Follow-up in three days. **Work Status:** Modified work.

08/09/07 - Initial Orthopedic Consultation - Kenneth Jung, M.D. Patient sustained injury to left ankle on 8/09/07. She reported slipping on a piece of cucumber and injuring her knee and ankle. She was initially seen and given a cane and elastic ankle brace, as well as anti-inflammatories. She reported sharp, achy, cramping, incapacitating pain that hurt most of the day. There was swelling, tenderness and giving way. She had a history of a left ankle fracture after falling down stairs approximately 14 years prior and underwent open reduction/internal fixation, for which injury did not occur at work. Physical examination was performed. X-rays were reviewed and showed extensive degenerative changes including anterior osteophytes of the tibia and talus. **Impression:** 1) Left ankle post-traumatic arthritis, status post open reduction/internal fixation ankle fracture. 2) Industrial injury secondary to fall. 3) Ankle pain after industrial fall. **Plan:** No acute injuries after recent fall. Likely exacerbation of pre-existing condition, post-traumatic arthritis. A lace-up ankle brace was recommended. Scheduled to see Dr. Gambardella for left knee. **Work Status:** TTD until 9/10/07 evaluation with Dr. Gambardella.

08/10/07 - X-rays of Left Ankle - Pacific Medical Imaging & Oncology Center - Richard Chao, M.D. Impression: 1) Old post-traumatic changes of the malleoli status post prior open reduction/internal fixation. 2) Secondary deformity and secondary osteoarthritic changes at the distal tibia and talus.

08/10/07 - X-rays of Left Knee - Pacific Medical Imaging & Oncology Center - Richard Chao, M.D. Impression: 1) Generalized demineralization. 2) Suspect small loose body within the central joint. 3) No acute fracture nor subluxation demonstrated.

08/10/07 - X-rays of the AP Pelvis and Lateral Left Hip - Pacific Medical Imaging & Oncology Center - Richard Chao, M.D. Impression: No acute

fracture, nor hip dislocation demonstrated. Joint spaces appeared preserved. No pelvic fracture identified.

08/14/07 - Progress Note - Dreamweaver Medical Group - Signature Illegible. Handwritten notes are somewhat illegible. Patient felt moderately better. Continued left ankle swelling. **Assessment:** 1) Left ankle sprain. 2) Left knee (illegible). 3) Left hip pain. Rx Ultram. Limited work.

08/14/07 - Work Status Report - Dreamweaver Medical Group - Signature Illegible. The patient was given work restrictions in relation to the left ankle sprain and left knee pain, as well as left hip pain. Patient referred for physical therapy and MRI.

08/27/07 - Progress Note - Dreamweaver Medical Group - Signature Illegible. Handwritten notes are somewhat illegible. Left knee, ankle and hip injury. Pain and swelling in left knee. **Assessment:** Left knee sprain with swelling. **Plan:** MRI of left knee to rule out meniscal tear, physical therapy and MRI.

08/27/07 - Work Status Report - Dreamweaver Medical Group - Signature Illegible - Patient TTD until 9/04/07 for diagnosis of left ankle sprain and left knee sprain. Patient referred for physical therapy and MRI of the left knee.

09/04/07 - Medical Record Review - Kenneth Jung, M.D. Medical records were reviewed in relation to the 8/09/07 industrial injury.

09/10/07 - Comprehensive Orthopedic Evaluation - Kerlan Jobe Orthopedic Clinic - Ralph Gambardella, M.D. The patient sustained injury to the left knee on 8/09/07. Patient employed by D'Veal Family and Youth Services. She slipped on a piece of cucumber and fell, landing on her entire left side. The ankle was the most painful. Patient was unsure, but thinks she landed

on her left side. She had persistent left knee discomfort and swelling. Diffuse tenderness over the medial side of the knee. No previous history of left knee injury. Physical examination was performed. **Impression:** 1) Synovitis of the left knee with underlying early degenerative osteoarthritis of the left knee including patellofemoral early arthrosis with mild patellofemoral malalignment, left and right knees. 2) Pes bursitis, left knee. **Recommendations/Discussion:** Patient had evidence of underlying pre-existing early degenerative osteoarthritis of the left knee and further sustained a work-related injury that resulted in a flare-up of her arthritis. She denied having symptoms prior to the work injury. Pre-existing disease was present on x-rays. Diagnostic testing was not recommended. Physical therapy was advised. Rx Voltaren. **Work Restrictions:** The patient was restricted to sedentary work.

11/12/07 - ED Provider Notes - Kaiser Permanente - Kristen Duyck, M.D. The patient complained of right foot pain and swelling, which was constant and aggravated by walking. Onset: "sat". Pain was moderate in severity. 58-year-old female complained of right foot pain and left ankle pain since Saturday when she tried to prevent a car from rolling into the street and tried to jump in the driver's seat at which time she twisted the ankle and turned foot under. She denied other injuries, denied knee pain. **Active Problem List:** Obesity; smoker; osteoarthritis. Blood pressure was 175/107, pulse 70, respiration 18. Physical examination performed. X-rays of the ankle (unspecified) showed no fracture; hardware in place. X-rays of the foot (unspecified) showed fourth and fifth metatarsal fractures. **Assessment:** Foot fracture. Follow-up with orthopedics. Keep moonboot on as recommended. Patient taken to ortho cast room. Patient discharged in stable condition.

11/12/17 - X-rays of Right Foot - Kaiser Permanente - Matthew Tan, M.D. Impression: Fracture at the right fourth and fifth metatarsal bone. Spiral fracture. No significant displacement. Moderate soft tissue swelling of right foot.

11/12/07 - X-rays of Left Ankle - Kaiser Permanente - Matthew Tan, M.D. Impression: 1) No osseous fracture. 2) Status post open reduction/internal fixation of the left distal fibula and the tibia. 3) Severe degenerative joint disease of the left ankle.

11/12/07 - Orthopedic Consultation - Kaiser Permanente - Jennifer Graham, M.D. Patient presented with ankle injury. She complained of right foot pain. Date of injury was 11/10/07. Pain rated 9/10. She was attempting to stop a car from rolling into the street and twisted her right foot. On examination, there was moderate tenderness over the ATFL and fourth and fifth metacarpal heads with moderate swelling over the forefoot. There was minimal tenderness over the left ankle ATFL with mild swelling. X-rays were reviewed. **Assessment:** Right foot fourth/fifth fracture - metatarsal neck and bilateral ankle sprain. **Plan:** Postop shoe applied. Weightbearing as tolerated. Return one week.

11/16/07 - X-rays of Right Foot - Kaiser Permanente - Matthew Tan, M.D. Impression: Fracture of the right fourth and fifth metatarsal bone. Spiral fracture. No significant displacement. Moderate soft tissue swelling.

11/16/07 - X-rays of the Left Ankle - Kaiser Permanente - Matthew Tan, M.D. Impression: 1) No osseous fracture. 2) Status post open reduction/internal fixation of the left distal fibula and the tibia. 3) Severe degenerative joint disease at the left ankle. Severe joint space narrowing at the tibiotalar joint.

11/20/07 - Doctor's First Report of Occupational Injury or Illness - Michael Hadley, M.D. Date of injury 11/10/07. Employer was D'Veal Family & Youth Services. Patient fell onto gravel and fractured right foot to prevent car from rolling into oncoming traffic. Injured right foot. When attempting to get into her moving car, the patient tripped on the ground and fell. She hit her left knee and twisted her left ankle and right foot. She developed pain mostly in the right foot. She went to Kaiser ER and was told she had a fracture of the right foot. She was referred to this examiner. She complained of mild discomfort in the left ankle and left knee. There was significant discomfort in the right foot. She sustained a prior left ankle fracture in 1992. **Diagnoses:** Contusion, left knee. Fracture, right foot. Sprain, left knee. **Treatment Rendered:** Examination. X-rays. Walker boot/cam walker dispensed. Dispensed Motrin 800 mg and extra

strength Tylenol. Referred to orthopedic surgeon. **Work Status:** Placed on modified duty.

11/20/07 - X-rays of the Right Foot / Left Ankle / Left Knee - Health Care Partners - Michael Vo, M.D. Right Foot Impression: 1) Fractures of the fourth and fifth metatarsals. 2) Abnormal report. Preliminary report sent to Dr. Hadley on 11/21/07. **Left Ankle Impression:** Postoperative findings in the distal tibia and fibula. There is significant degenerative narrowing of the ankle mortise. **Left Knee Impression:** 1) Mild osteoarthritis in the left knee. 2) Questionable 0.8 cm loose body.

11/26/07 - Permanent and Stationary Report - Kerlan Jobe Orthopedic Clinic - Ralph Gambardella, M.D. Date of injury was 8/09/07. Patient was initially seen on 9/10/07 for a work injury to the left knee which occurred when she slipped on a piece of cumber and fell. She injured the left ankle and left knee and was under the care of Dr. Jung who had referred the patient for evaluation of the left knee. The patient had been recommended to undergo physical therapy and found improvement in her knee condition. She no longer had any type of significant discomfort in the knee. She would get some aches and minimal irritability. No recurrent swelling but continued to have occasional swelling. Patient felt her knee was improved enough to return back to regular work. In the interim, the patient sustained a new work injury to the right lower extremity that resulted in a fracture to the right foot. She was ambulating with the assistance of a cane and a moon boot. She was being seen separately for her right lower extremity injury. The patient agreed that in the absence of her right foot condition, she would be able to return back to regular work relative to her left knee. Physical examination was performed. **Final Impression:** Underlying degenerative osteoarthritis including patellofemoral arthrosis and mild patellofemoral malalignment, left knee, status post post-traumatic synovitis and pes bursitis, left knee. **Recommendations:** The patient was permanent and stationary for the left knee. **Subjective Factors of Disability:** Occasional minimal pain with activities of daily living increasing to occasional to intermittent, minimal to slight pain with heavier squatting, kneeling, or lifting activities. **Objective Factors of Disability:** X-ray evidence of patellofemoral joint space narrowing and degenerative osteoarthritis joint space narrowing noted radiographically. There were no other objective factors. **Permanent Work**

Restrictions: None indicated. The patient was released to regular work activities effective 11/26/17. **Loss of Pre-Injury Capacity:** None. **Future Medical Care:** Anti-inflammatory medication, physical therapy and/or cortisone injection and/or arthroscopic surgical intervention. **Causation:** Patient' condition was directly related to the work injury. **Apportionment:** There was no apportionment indicated as there was no residual disability. There was definite evidence of pre-existing osteoarthritis. **Impairment Rating:** 7% Lower Extremity Impairment for 1 mm joint space narrowing of the knee. Additional 10% Lower Extremity Impairment added for patellofemoral joint. There was 17% Lower Extremity Impairment which converted to **7% Whole Person Impairment for the left knee.**

11/29/07 - Orthopedic Consultation - Tomas Saucedo, M.D. Date of injury 11/10/07. The patient sustained injury to the right foot. At the time of the injury, she had parked on a gravel road and her car began to roll without her in it. She ran towards the car and got into the car to pull the emergency parking brake and in the process twisted her right foot, sustaining fractures to the fourth and fifth metatarsals, as well as injuring the left knee and left ankle. She was seen at Kaiser and was treated with a cam walker with significant improvement in the right foot. She continued to have left ankle pain and to a lesser extent to the left knee. She had been off work. Past medical history reviewed. **Impression:** 1) Right foot fourth and fifth metatarsal fractures. 2) Left ankle post-traumatic degenerative osteoarthritis. 3) Left knee sprain. **Discussion:** Continue with use of cam walker for the right foot. Continue off work. Continue use of Motrin. X-rays requested to assess healing of the right foot.

12/20/07 - Orthopedic Supplemental Report (PR-2) - Tomas Saucedo, M.D. Patient using cam walker for right foot fractures, with pain steadily improved. Complaints of pain and discomfort in the left knee and left ankle, which was subjectively improved since the last visit. **Impression:** 1) Health right fourth and fifth metatarsal fractures. 2) Left knee sprain. 2) Left ankle sprain. **Discussion:** Patient to continue off work. Encouraged to continue with use of cam walker. A knee immobilizer was to be provided. Weightbearing as tolerated with assistive devices.

12/20/07 - X-rays of the Right Foot - Health Care Partners - Michael Vo, M.D. Impression: Healing fractures of the fourth and fifth metatarsals.

01/17/08 - Orthopedic Supplemental Report (PR-2) - Tomas Saucedo, M.D. Right foot pain was steadily improved. Patient complained of pain in the left knee with swelling and effusion. She complained of left ankle soreness. **Impression:** 1) Health right fourth and fifth metatarsal fractures. 2) Left knee internal derangement. 3) Left ankle sprain. **Discussion:** Right foot fracture appeared to be healing well. Continue conservative measures and use of cam walker. An MRI of the left knee was requested. Patient continued off work. For the left ankle, the patient was to continue aggressive exercises, and use of Tylenol.

01/17/08 - X-rays of the Right Foot - Health Care Partners - Michael Vo, M.D. Impression: 1) No significant interval change. 2) Continued healing of fracture involving fourth and fifth metatarsals.

01/28/08 - DEXA Scan - Kaiser Permanente - Hao Sun, M.D. T-score -0.9.

01/28/08 - Bilateral Screening Mammogram - Kaiser Permanente - Christian Yi, M.D. Impression: Normal study.

02/21/08 - Orthopedic Supplemental Report (PR-2) - Tomas Saucedo, M.D. The patient sustained a right foot fracture of the fourth and fifth metatarsals. She also sustained a left ankle sprain and left knee injury. Left knee pain had progressively worsened and appeared to be the result of favoring the right lower extremity and putting all of her weight on the contralateral extremity, which pain had steadily become worse as a result of the initial injury, as well as the underlying degenerative osteoarthritic changes from which the patient already suffered. **Impression:** 1) Healing right fourth and fifth metatarsal fractures. 2) Left knee internal derangement. **Discussion:** The patient developed increased pain in the left knee as a result of favoring the right lower extremity. She did

have a left knee injury but it was now more painful. An MRI of the left knee was recommended. The right foot appeared to be healing well.

02/21/08 - X-rays of the Right Foot - Health Care Partners - Michael Vo, M.D. Impression: Continued healing of fractures involving the fourth and fifth metatarsals.

03/19/08 - MRI of the Left Knee - Health Care Partners - Anthony Bledin, M.D. MRI was indicated to rule out internal derangement. **Impression:** 1) Tear, posterior horn, medial meniscus (grade III). 2) Early osteoarthritic changes of the medial compartment of the knee joint. 3) Knee joint effusion. **Findings:** Minimal osteoarthritic changes in the knee joint predominantly involving the medial compartment. Fraying and irregularity of the apex of the posterior horn of the medial meniscus. Tear of the posterior horn of the medial meniscus. The body and anterior horn of the medial meniscus appeared normal and the lateral meniscus demonstrated no significant abnormality. Knee joint effusion was present with fluid in the suprapatellar bursa with the volume of the effusion less than 5 cc. No significant popliteal cyst.

03/20/08 - Orthopedic Re-examination - Tomas Saucedo, M.D. The patient had no pain or discomfort in the right foot. She had no significant pain in the left ankle. She complained of left knee pain. MRI of the left knee revealed a tear of the posterior aspect of the medial meniscus and evidence of mild early osteoarthritic degenerative changes of the left knee. **Impression:** 1) Left knee internal derangement with evidence of medial meniscus tear. 2) Right fourth and fifth metatarsal fracture, healed. 3) Left ankle sprain. **Discussion:** Continue off work due to pain in left knee. Authorization requested for left knee surgery.

03/20/08 - X-rays of Right Foot - Health Care Partners - Michael Vo, M.D. Impression: Continued healing of fourth and fifth metatarsal fractures.

04/17/08 - Orthopedic Supplemental Report (PR-2) - Tomas Saucedo, M.D. The patient was treated for a right foot fracture which had completely healed. She had no pain or discomfort. She continued to have left knee pain. She had minimal soreness of the left ankle. Left ankle pain was increasing with prolonged periods of standing. **Impression:** 1) Healed right foot fourth and fifth metatarsal fracture. 2) Left knee internal derangement with evidence of medial meniscus tear. 3) Left ankle postop degenerative osteoarthritic changes with limited range of motion. **Discussion:** An MRI of the left knee revealed a medial meniscus tear. Surgery was scheduled for 4/24/08. The right foot would continue to be treated conservatively. She was to remain off work.

04/24/08 - Operative Report - Plaza Surgical Center - Tomas Saucedo, M.D. **Preoperative Diagnosis:** Left knee internal derangement. **Postoperative Diagnoses:** 1) Evidence of left knee complex tear of the medial and lateral meniscus. 2) Evidence of cartilage tears of the patellofemoral groove, tears of the medial femoral condyle cartilage, lateral femoral condyle cartilage, medial tibial plateau and lateral tibial plateau. **Operation Performed:** 1) Left knee diagnostic and surgical arthroscopy. 2) Left knee partial medial and partial lateral meniscectomy. 3) Left knee abrasive chondroplasty of the patellofemoral groove, medial femoral, medial tibial plateau, lateral femoral and tibial plateau cartilage.

06/06/08 - Orthopedic Supplemental Report (PR-2) - Eastside Orthopedic Medical Associates - Tomas Saucedo, M.D. Significantly improved left knee pain following arthroscopic surgery. Now six weeks status post surgery to the left knee. Physical therapy was of benefit. **Impression:** Status post left knee arthroscopy. **Discussion:** Continue physical therapy and aggressive home exercise program. Continue Vicodin for pain. Continued off work.

06/18/08; 07/16/08 - Physical Therapy Progress Report - Associated Sport Therapy - Signature Illegible. Handwritten notes are mostly illegible. Knee pain rated 2-3/10 as of 7/16/08.

07/30/08 - Progress Notes - Kaiser Permanente - Kelly Ching, M.D. Patient seen for blood pressure. Only eating once per day. Complained of hot flashes x 15 years.

08/28/08 - Orthopedic Supplemental Report - Signature Illegible. Handwritten notes are mostly illegible. Severe electrical type pain LLE. No low back pain. Continue Motrin. Strengthening exercises.

09/05/08 - Orthopedic Supplemental Report - Eastside Orthopedic Medical Associates - Tomas Saucedo, M.D. Patient underwent left knee arthroscopy surgery on 4/24/08 and was placed on aggressive physical therapy, as well as a home exercise program. The patient indicated her pain had improved significantly. She complained of associated pain in the lower back and some radiculopathy of the left lower extremity. **Impression:** 1) Status post left knee arthroscopy. 2) Lumbosacral spine strain. 3) Left lower extremity radiculopathy. **Discussion:** Patient was given work restrictions of no prolonged standing and walking, no squatting, climbing or pivoting activities. Continue strengthening program for the left lower extremity. Ibuprofen for pain. Return in four weeks. A handwritten Orthopedic Supplemental Report from the same date is noted and is illegible.

10/10/08 - Orthopedic Supplemental Report - Signature Illegible. Handwritten notes are mostly illegible. Modified work. Home exercise program. Further treatment was indicated.

11/07/08 - Orthopedic Supplemental Report - Signature Illegible. The patient complained of left knee pain. Rx Motrin 800 mg, Vicodin, Prilosec. Home exercise program. Modified work. Handwritten notes were somewhat illegible.

12/05/08 - Orthopedic Permanent and Stationary Report - Eastside Orthopedic Medical Associates - Tomas Saucedo, M.D. Date of injury 11/10/07. The patient was under the care of this physician for the left knee.

She underwent left knee surgery on "4/24/07." The patient's pain had improved but was not completely resolved. She had some continued mild discomfort in the left knee. Physical examination was performed. **Impression:** 1) Status post left knee arthroscopy with partial meniscectomy. 2) Status post left knee abrasive chondroplasty. **Discussion:** The patient was Permanent and Stationary. **Subjective Factors of Disability:** Intermittent minimal not exceeding that level. **Objective Factors of Disability:** Partial meniscectomy and abrasive chondroplasty with favorable response. **Work Status:** Usual and customary job duties with no restrictions. **Future Medical Care:** Physician care, medications, physical therapy and coverage should an aggravation or recurrence of the same similar symptoms as a result of the initial injury. **Apportionment:** Not indicated. **Vocational Rehabilitation:** Not indicated as the patient was released to her previous occupation. **Impairment Rating:** 1% Whole Person Impairment based on the partial meniscectomy.

01/23/09 - Orthopedic Supplemental Report - Eastside Orthopedic Medical Associates - Tomas Saucedo, M.D. It noted the patient underwent arthroscopic surgery to the knee on 4/24/08 for partial medial and partial lateral meniscectomies with an abrasive chondroplasty of the patellofemoral groove, medial femoral condyle, medial tibial plateau, lateral femoral and lateral tibial plateau. She was considered Permanent and Stationary as of 12/05/08. The patient denied prior injuries to the left knee in her history. She did give a history of prior injury to the left ankle in August 2007 and was off work for 4-5 weeks due to the ankle sprain treated by Dr. Gambardella. She developed pain in the left knee for which Dr. Gambardella did not note an acute traumatic event to the left knee other than pain. Dr. Gambardella awarded the patient 7% Lower Extremity Impairment for the pain based on joint space narrowing of the knee and 10% Lower Extremity Impairment as a result of the patellofemoral joint space narrowing for a total of 17% Lower Extremity Impairment with converted to 7% Whole Person Impairment. It appeared the patient did in fact have a pre-existing underlying degenerative osteoarthritis of the knee with previous pain that had improved or resolved at the time she had a recurrence of the same problem. This examiner apportioned this to at least 50% to the present industrial injury of 11/10/07 and would be apportioned to her prior injury of the left knee as noted by Dr. Gambardella.

03/06/09 - Progress Notes - Kaiser Permanente - Kelly Ching, M.D. Patient seen for help with smoking cessation. Wanted Zyban. Had been disabled due to left knee surgery. Residual left lower extremity swelling. Rx Bupropion, ibuprofen and Lisinopril.

05/01/09 - Bilateral Screening Mammogram - Kaiser Permanente - Morley Slote, M.D. Negative study.

09/04/09 - Orthopedic Re-examination - Eastside Orthopedic Medical Associates - Tomas Saucedo, M.D., Orthopedic Surgeon. Date of injury 11/10/07. Patient last seen 12/05/08 and was considered Permanent and Stationary. In the past week, the patient was getting out of a friend's car and twisted her left knee which caused pain and discomfort. She was concerned about possible re-injury to the left knee and sought medical attention. She denied other injuries or loss of time from work. Physical examination was performed. X-rays taken this date revealed evidence of mild medial joint space narrowing. **Impression:** 1) Left knee re-injury. 2) Left knee evidence of mild degenerative osteoarthritis. **Discussion:** Rx Motrin for pain and inflammation. It appeared this injury was nothing more than a strain to the left knee. She was to continue working.

10/22/09 - Eye Examination - Kaiser Permanente - Anna Montenegro. Patient seen for routine eye examination. History of strabismus.

10/22/09 - Stipulation with Request for Award. This is in relation to the date of injury of 8/09/07. Applicant was Floreen Rooks who was employed by D'Veal Family & Youth Services in Pasadena, California, as a therapist. Date of injury involved the left knee and left ankle. The injury caused temporary disability for the period 8/22/07 through 9/16/07. The injury caused permanent disability of 6% payable in the sum of $4,140. This Stipulation was based on the Permanent and Stationary report of Dr. Ralph Gambardella, dated 11/26/07.

10/22/09 - Stipulation with Request for Award. Case No. ADJ7024643 for the date of injury of 11/10/07. Floreen Rooks was employed by D'Veal Family & Youth Services as a Therapist. This date of injury involved the left knee. The injury caused temporary disability for the period 11/15/07 through 9/14/08 for which indemnity paid at $647.44/week. The injury caused permanent disability of 1% for which indemnity was payable at $230.00/week beginning 9/15/08 in the sum of $690, less credit for such payments previously made. An informal rating had not been previously issued in this case. There was a need for medical treatment. This Stipulation was based on the Permanent and Stationary report of Dr. Tomas Saucedo, dated 12/05/08 and supplemental report dated 1/23/09.

11/09/09 - Progress Note - Kaiser Permanente - Khine Win, M.D. The patient presented with chest pain that began 11/09/09, as well as upper and lower back pain x1 month. Also noted stress at work. Upper and lower back pain worse with going to work. Ankle and knee pain. Neck muscle pain worse and ongoing for past few months. Took ibuprofen 800 mg b.i.d. for ankle and did not help with neck pain. Chest pain was more like soreness, pain with pressing, and no shortness of breath. **Review of Systems:** Positive for myalgias, neck pain, back pain and joint pain. **Assessment:** Myofascial pain syndrome; counseling on smoking cessation; chest wall pain; muscle spasm. **Plan:** Discussed fibromyalgia and vitamin deficiency. Trial Robaxin. Suggested use of Icy Hot. Follow-up with PCP in one week.

8/30/10 - Progress Note - Kaiser Permanente - Sabrina Villalba, M.D. Patient presented for annual physical and blood pressure check. Patient was not taking BP medications and did not like taking meds. Blood pressure this visit was 166/91, weight 217 pounds. **Review of Systems:** Occasional left ankle pain, better with use of ibuprofen. **Assessment/Plan:** Counseling on smoking cessation; essential HTN. Labs ordered. Rx Lisinopril.

01/06/11 - Order Suspending Action. Case No. ADJ7024643; ADJ7024645. Action suspended due to the stipulation not adequately addressing the two injuries, in particular apportionment claimed between the two events, in particular the left ankle and right foot. Dr. Saucedo did not perform an examination or report for all the parts of the body and issue adequate support

to the proposed stipulated awards or be rated by the DEU. Abdominal pain was unsupported by the medical record.

03/17/11 - Orthopedic Agreed Panel QME Evaluation - Thomas W. Fell, Jr., M.D. Date of Injury: 8/09/07 and 11/10/07. Employer: D'Veal Family & Youth Services. **Employment at Time of Incident:** The patient was a 61-year-old female who worked as a family and marriage therapist. She had worked for the above-named employer for three years prior to her injury and continued working at this time. **History of Present Injury:** In August 2007, the patient slipped and fell injuring her left ankle and left knee and received treatment. The patient had a second injury in November 2007 when she was picking up clients at work and noticed the car was rolling. She jumped into the car to pull the brake and fell striking her left knee on the ground and twisting her right foot. She had pain in the left knee and right ankle. She was seen at the Kaiser ER and was told she had two fractures in the right foot, treated with a cam walker. Under the treatment of Dr. Saucedo, the right foot became better but she had continued pain in the left knee. She eventually underwent an MRI of the left knee and surgery, which was of benefit. She continued to have ongoing symptoms in the left knee since the surgery. She was released from care by Dr. Saucedo in approximately 2008. She returned to Dr. Saucedo a couple of months ago due to left knee pain and inability to use the clutch in her car. She was provided a cortisone injection to the knee, which was of significant benefit. She subsequently developed a burn to the skin from the topical used to freeze the knee prior to receiving the injection. She was told by Dr. Saucedo that she had bone-on-bone laterally and would need a total knee replacement in the future. **Prior Injuries:** Left ankle injury, mid-90s, medical and lateral fractures, treated surgically. Pain continued and was worsened by the accident in August 2007. She denied left knee symptoms prior to the injury in August 2007. **Present Complaints:** The right foot was asymptomatic. Left knee and left ankle symptoms occurred at the same time due to prolonged walking, climbing stairs, squatting, and kneeling, with swelling to the knee and followed by the ankle. Ankle pain was medial and lateral. There was diffuse peripatellar pain in the left knee. There was no locking or buckling in the left knee. There was stiffness in the left knee. **Past Medical History:** Two work injuries as noted. Positive for arthritis of the knee and a heart murmur. History of hypertension. Medications included Lisinopril, hydrochlorothiazide, ibuprofen and Vicodin. Surgeries included left knee surgery for the current injury and prior left ankle surgery.

She denied motor vehicle accidents. **Social History:** The patient smoked cigarettes and consumed alcoholic beverages. Medical records were reviewed. **Physical Examination:** 5'6", 213 pounds. Normal gait. Mild swelling in the left knee compared to the right. Multiple healed arthroscopic portals and a 1.5 cm circular lesion over the superior medial aspect of the knee consistent with a skin burn. Tenderness over the anterior medial joint line and anterior lateral joint line with the anterior lateral joint line being more tender. Mild crepitus of the patellofemoral joint and moderate crepitus over the lateral joint. Left knee in valgus compared to the right. Left knee range of motion was 0-130 degrees. Mild swelling of the left ankle medially and laterally with well healed scars and diffuse tenderness medially and laterally. Pain with slight ankle motion with dorsiflexion 0 degrees and plantar flexion 5 degrees. No left ankle instability. Normal right ankle and foot. Right ankle/foot dorsiflexion 15 degrees and plantar flexion 40 degrees without pain. Sensation in the lower extremities intact. Lower Extremity Measurements R/L: Ankles 26.5/29.0 cm, calves 41.0/41.0 cm, knees 41.0 cm/41.5 cm, quadriceps 57.0/56.5 cm. **X-rays:** Radiographs of the left ankle showed plate and screws; deformity of the talar tibial joint with virtual absence of any joint space; old fracture across the talus possibly not healed. Radiographs of the left knee showed arthritis with approximately 2 mm of joint space interval to medial and lateral joint space, with narrowing slightly more lateral than medial, with marginal osteophytes laterally and prominence of the tibial spines. There was very minimal spurring noted on the patellofemoral joint. **Diagnoses:** 1) Sprain/strain of the left knee aggravating degenerative arthritis of the left knee. Status post arthroscopic partial lateral and medial meniscectomies. 2) Sprain of the left ankle temporarily aggravating significant pre-existing arthritis of the left ankle. 3) Fracture of the right foot, fourth and fifth metatarsals, healed. **Discussion:** The patient had done well in regard to her left knee with pre-existing arthritis until she suffered the injury in August 2007 and again in November 2007. She had left ankle pain prior to the two work incidents due to the injury to the left ankle in the mid-90s that required open reduction/internal fixation. She had a temporary increase in left ankle pain due to the work incidents. It was expected that the majority of her symptoms were now residuals of her arthritis given the fact that she had significant limitation of motion of the ankle as an ankle sprain would not cause the type of limitation of motion she had, but instead would cause excessive motion. The slightest motion of the ankle caused pain, with all of the pain coming from the ankle joint. The patient agreed the arthritis of the knee was what was really aggravated by the work incidents, and the left knee "really wasn't

hurting her" and the left ankle had always caused her problems since the prior ankle surgery. The previous right foot fractures of 11/10/07 had healed completely without residuals. It was stated the patient had a flare-up of symptoms that precipitated a lot of her symptoms. An injection calmed the knee down but it remained symptomatic. This examiner stated, "Fortunately, individuals with valgus knees, that is, arthritis in the lateral aspect of the knee can tolerate a lot of arthritis without need for total knee replacement." **Status:** The patient had reached Maximal Medical Improvement. **AMA Impairment:** There was no impairment for the right foot as the fracture was well healed. The left ankle was rated based on the Arthritis Table 17-31 with 30% Lower Extremity Impairment due to 0 mm of joint space. For the left knee, the patient had approximately 2 mm of joint space on the left side with 20% Lower Extremity Impairment based on Table 17-31. The left knee was also rated based on Table 17-33 due to the partial medial and lateral meniscectomies with 10% Lower Extremity Impairment. There was a total of 30% Lower Extremity Impairment for the left knee. ***(This report is incomplete as subsequent pages are missing/not provided and no further information is available.)***

05/14/11 - Eye Exam - Kaiser Permanente - Kris Lum, O.D. The patient was seen for a routine eye examination. Patient did not fill prescription from last visit. **Assessment:** 1) BAL OD, CMA OS c presbyopia. 2) Strabismic amblyopia OD. 3) Anisometropia. 4) Cataracts OU.

08/11/11 - Progress Note - Kaiser Permanente - Kelly Ching, M.D. Patient presented for routine Pap smear. The patient was status post fall after tripping on pavement two days prior. No head trauma. Scrapes over bilateral anterior knees. Pain in knees. Mammogram and routine lab tests were ordered. Recommended rest, ice and NSAIDs for soft tissue trauma due to fall. Continue Lisinopril and ibuprofen.

10/19/11 - Progress Note - Kaiser Permanente - Kelly Ching, M.D. The patient presented with left hand and forearm constant tingling x2 weeks, involving all fingers. She was right-hand dominant. She admitted to leaning and sleeping on hands all the time. **Assessment:** Paresthesias; osteoarthritis; essential HTN; obesity; smoker; menopausal symptoms. **Plan:** Routine

vaccinations given. Rx ibuprofen 800 mg and Lisinopril. Avoid compression of hands at work and during sleep. Smoking cessation. Diet/exercise.

02/09/12 - Minutes of Hearing - Lynn Devine, Workers' Compensation Administrative Law Judge. Case No. ADJ7024643; ADJ7024645. **Comments:** No one able to reach the applicant despite serval calls. Applicant was not present. Applicant was under the impression case was (illegible). Applicant was given one more chance to appear at MSC or matter would be set for trial. MSC set on 3/12/12 at 8:30.

03/05/12 - Compromise & Release. Case No. ADJ7024643; ADJ7024645. Floreen Rooks was employed by D'Veal Family & Youth Services in Pasadena as a Therapist. In regard to ADJ7024643, she claimed a specific injury occurring on 11/10/07 with injury to the right foot and left knee. In regard to ADJ7024645, she claimed a specific injury of 8/09/07 involving the left knee, left ankle and left hip. Temporary disability indemnity paid was $30,885.52 for the period 8/22/07 to 9/14/08. Permanent disability indemnity paid was $16,435.14 for the period 9/19/08 to 2/28/12. Total medical bills paid $20,836.63. The parties agreed to settle the above claims on account of the injuries by the payment sum of $62,000 with $16,435.14 deducted from the settlement amount for permanent disability advances through 2/28/12 and continuing, leaving a balance of $45,564.86. This Compromise & Release included resolution of all issues, all dates of injuries, all body parts indicated in the claim form, including the right foot, left ankle, right ankle, left knee and other body parts mentioned in any medical records. This C&R included all temporary disability, retro TD, permanent disability, retro PD, vocational rehabilitation maintenance allowance, retro VRMA, supplemental job displacement benefit, retro medical benefits, future medical benefits, out of pocket medical expenses, penalties and interest. **Comments:** The injured worker was not receiving benefits at the current time and was currently working full time with D'Veal Family & Youth Services so there was no need for Medicare Set Aside allocation report. Settlement based on Panel QME report of Dr. Thomas Fell, dated 3/17/11.

03/12/12 - Joint Order Approving C&R - Lynn Devine, Workers' Compensation Judge. Case No. ADJ7024643; ADJ7024645. Award was made in favor of Floreen Rooks and against State Compensation Insurance Fund in the sum of $62,000, less permanent disability advances of $16,435.15, leaving a balance payable to the applicant of $45,564.86.

09/27/13 - Eye Examination - Kaiser Permanente - Terre Watson, O.D. Patient seen for routine eye exam. Felt like strabismus OD was increased.

12/16/13 - Call Documentation - Kaiser Permanente - On Call Nurse (RN). Patient called regarding left arm tingling and back pain. Tingling in left arm from the wrist up more than one month. Pain to the left side of the back. Patient referred to appointment center. No action necessary.

12/17/13 - Progress Note - Kaiser Permanente - Kelly Ching, M.D. Patient complained of constant left upper extremity tingling including all fingers x 1 month. Possibly related to how she slept. No numbness. Full range of motion. No weakness indicated. **Assessment:** Left arm paresthesia. **Plan:** Routine labs ordered. Consider steroids if paresthesia persisted. Restart blood pressure medication.

10/29/14 - Call Documentation - Kaiser Permanente. Message to Dr. Watson. Patient stated urgent appointment needed. Patient had problems with lenses and a new vision exam was needed.

11/11/14 - Eye Examination - Kaiser Permanente - Terre Watson, O.D. Patient seen for routine eye examination. Constantly had to remove glasses to see. New prescription given. Right exotropia and amblyopia (longstanding) and dilation discussed.

12/31/14 - Call Documentation - Kaiser Permanente - Elaine Ravare, LVN. Patient called regarding work note for days missed from work, 12/29/14 and 12/30/14. Missed work due to cold symptoms. Appointment given.

12/31/14 - Progress Note - Kaiser Permanente - Jamie McKinney, M.D. Patient presented with work slip 12/29/14 to 12/30/14. Chills x 4 days, rhinorrhea x 4 days. Patient not taking BP medications.

01/09/15 - Progress Note - Kaiser Permanente - Paul Reehal, M.D. Patient presented with cough and URI symptoms x 1 week. Blood pressure noted to be low after starting new medication. **Assessment/Plan:** Cough, URI. Cheratussin AC, saline nasal spray.

01/09/15 - X-ray of Chest - Kaiser Permanente - Fernando Torres, M.D. Negative chest x-ray.

10/02/15 - Eye Exam - Kaiser Permanente - Terre Watson, O.D. Patient seen for routine eye exam.

03/01/16 - Progress Note - Kaiser Permanente - Daniel Lin, D.O. Patient presented with cough x 4 days. Worsening URI symptoms. BP 134/72.

03/08/16 - Progress Note - Kaiser Permanente - Sandra Montes, M.D. Patient presented with cough x2 weeks. Complained of myalgias and headache. Medications prescribed.

04/26/16 - Mammogram / Amendment - Kaiser Permanente - Paul Didomencio, M.D. Additional imaging needed. Cluster of coarse heterogeneous calcifications in the right breast. Letter sent to patient.

10/14/16 - Telephone Appointment Visit - Kaiser Permanente - Kelly Ching, M.D. Patient needed refill of Motrin for ankle pain and swelling x2 weeks. Patient declined meloxicam. *(No further information regarding the ankle was indicated.)*

11/07/16 - Progress Note - Kaiser Permanente - Kevin Bromage, M.D. Patient was sent by dentist for high blood pressure, which was 198/122. Patient indicated she had smoked a cigarette before going into the dentist's office. She stated she was unsure if the BP cuff was the correct size. She was also very anxious regarding dental appointment. She had high blood pressure in the past but no longer needed medication after significant lifestyle changes. Blood pressure came down to normal limits while in urgent care without intervention. On exam, blood pressure was 136/102 and 136/88. **Assessment/Plan:** Elevated BP; vaccination influenza and pneumonia; smoker. Vaccinations given. Smoking cessation, diet and weight loss discussed. Home BP monitoring.

12/09/16 - Telephone Appointment Visit - Kaiser Permanente - Kelly Ching, M.D. Patient called to follow-up on smoking cessation. Smoked ¼ pack per day. Patient to stop on her own. Declined assistance/meds.

01/25/17 - Telephone Appointment Visit - Kaiser Permanente - Kelly Ching, M.D. Patient called and was adamant about needing Motrin refilled for her chronic ankle pain. She had not been seen by this physician in three years. She did not get lab work done as requested. Still smoking 3 cigarettes per day per patient. **Assessment:** Left ankle joint pain; smoker; atherosclerosis of aorta. **Plan:** Patient advised she needed to be seen for evaluation and for lab work. She was instructed to use Tylenol over-the-counter as needed.

01/30/17 - Progress Note - Kaiser Permanente - Kelly Ching, M.D. Patient seen for follow-up. Requested refill of Motrin. Using Motrin twice a week. Blood pressure 143/86. **Assessment:** Osteoarthritis; tobacco smoker; vitamin D deficiency; medication refill; elevated blood pressure reading without HTN

diagnosis; smoking cessation counseling; atherosclerosis of aorta; menopausal symptoms; obesity. **Plan:** Routine screenings and vaccinations indicated. Rx Wellbutrin, vitamin D3, Calcium and ibuprofen 800 mg.

02/09/17 - Eye Examination - Kaiser Permanente - Richard Gin, O.D. The patient was seen for a routine eye examination.

10/05/17 - Nurse Visit - Kaiser Permanente - Lizette Cespeds, LVN. The patient was seen for a routine blood pressure check. Blood pressure 197/89. Weight 203 pounds. Pulse 84.

10/11/17 - Progress Note - Kaiser Permanente - David Shaw, M.D. Patient presented with complaint of dizziness intermittently for the past 2 weeks. She was worried she had a left facial droop and may have had a stroke. **Assessment:** Vertigo. **Plan:** Rx meclizine.

10/23/17 - Progress Note - Kaiser Permanente - David Morris, M.D. The patient was seen for a blood pressure check. Asymptomatic. Blood pressure was 92/57. Started blood pressure medication 10/05/17. Patient advised to hold off on medication for the night and follow-up with titration nurse the following day.

10/23/17 - Nurse Note - Kaiser Permanente - Leilani Rebancos Macaseib, RN. Patient indicated she had upper left shoulder pain since the prior night with pain rated 3-4/10. She was able to speak clearly. No shortness of breath, chest pain, nausea, vomiting or any symptoms. Nurse and M.D. consult.

10/24/17 - Progress Note - Kaiser Permanente - Mi Pham, LVN. Patient was seen for a blood pressure check. Blood pressure was 88/57.

10/24/17 - Mammogram - Kaiser Permanente - Eric Lee, M.D. Incomplete study. Additional views requested. 6 mm area of grouped heterogeneous calcifications in the right breast appeared indeterminate. Possible ultrasound and additional reviews recommended. Letter sent to patient.

11/01/17 - Progress Note - Kaiser Permanente - Kelly Ching, M.D. Patient not feeling well. Intermittent vertigo x3 weeks. Blood pressure 134/69. **Assessment:** Benign paroxysmal positional vertigo; smoker; obesity; atherosclerosis of aorta; vitamin D deficiency; left ankle joint pain. **Plan:** Diclofenac topical gel prescribed to be applied to affected areas.

REVIEW OF DEPOSITION TRANSCRIPT:

10/19/17 - Deposition of Floreen Rooks, Volume I, 77 pages. This deposition transcript in the case Floreen Rooks vs. D'Veal Family and Youth Services is reviewed in its entirety. Only pertinent information is summarized as follows.

Page 5, the applicant was introduced. Her full name was Floreen Sharon Rooks. Rooks was her maiden name. She was previously married and went by her husband's name, Sparks. She was unsure when she went by that name, but it was possibly in 1988. She was married once again after her marriage to Mr. Sparks and went by the name Lespierre for one year when she worked at Cal Tech, possibly in 1999. The rules of the deposition were discussed.

Page 9, her date of birth was 6/20/49. She resided in Pasadena by herself. She had a college degree. She had a Master's Degree in Marriage and Family Child Therapy, which she obtained between 2002 and 2003. She had previously been deposed years ago when she filed a claim after she slipped in a 99 Cents Store on wet floor. She sustained injury to her left leg at that time and stated it was over 30 years ago. She indicated she fully recovered.

Page 12, her current healthcare provider was Medicare, Parts A and B. Her personal medical physician was Dr. Ching through Kaiser in Pasadena. Dr. Ching had been her physician for about the last 10 years. She began working for D'Veal Family Youth Services in December 2004 and last worked on 4/16/16.

She denied subsequent employment. She worked as a Marriage and Family Child Therapist.

Page 14, at the time she last worked for this employer, her supervisor was Rafaela Velgado. She worked five days per week, Monday-Friday, for D'Veal from 9:30 am to 6 p.m. She would perform the intake for new patients. She stated she had many different jobs. As part of her job, she did have to travel. She would often provide therapy at client's homes. Page 20, in the 12 years she worked for D'Veal, she indicated she had concurrent employment at one point for 3-4 months. She did not recall what year that was, but she taught classes at the University of Phoenix in Pasadena. She was asked why she no longer worked for D'Veal Family Youth Services and went on to indicate she really enjoyed her job at D'Veal. She further went on to explain that, "Live was really, really good. I'd go home, be happy. I made a lot of good accomplishments with that job..." She had become a clinical supervisor and everything was going well. She stated people liked her and she was able to purchase a condo. She stated, "I have to admit, everything was fine for a while."

Page 22, she stated she no longer worked there because of stuff that happened to her along the way. She was terminated. Prior to being terminated, she felt like she was really doing a "great job." She went on to state that she felt like she was being discriminated against. It was the counsel's understanding that Ms. Rooks had resigned. She denied any chronic neck, right shoulder or low back pain when she first began working for D'Veal, as well as any chronic pain in her right wrist or left ankle. She denied having chronic pain in her right foot when she began working for D'Veal. She stated she had an accident at her job and injured the left foot. Counsel indicated they were asking about the right foot. She indicated it was not her right foot. She denied claiming that her job with D'Veal caused right foot problems. She was currently treating with Dr. Nissanoff whom she began seeing in June of this year. She claimed to Dr. Nissanoff she had pain in the neck, low back, right shoulder, right upper arm, right hand, right wrist, right thumb, left ankle and right foot. She stated she had more pain in the left foot than in the right foot and thought maybe that was a mistake. She indicated she began to have headaches.

Page 26, her shoulder (unspecified) started hurting; both arms and fingers would become stiff. She would get a lot of "stress" in her lower back. She had difficulty bending down. She noted those were the body parts claimed. In regard to her right leg/right side of her body, she indicated she felt strained due to the left sided leg problems, and caused more pain on the right side. Counsel asked her

about her visit with Dr. Nissanoff on 6/21/17 wherein she reported pain in her "right foot." She indicated it was really her "left foot." She felt the pain her body had shifted. In reference to the stress in her back, she referred to the upper back, then mid-back and low back. She was asked to discuss the problems on the left side that caused her to shift weight to the right side. She further explained she had nuts and bolts in her left ankle and that her left ankle hurts and because of increased stress, she had more stress on the right side of her body. She was asked if the left ankle was related to another incident at work. She claimed it was an injury in 2006 when she worked for D'Veal. She stated she broke her toe in the left foot in two places and ended up having a torn meniscus in the left knee. The problems in her left ankle caused her to put more pressure on the right side.

Page 29, she was asked to clarify what body parts on the right she referred to and indicated, "It's my body, that's how I feel, to be honest..." It was further clarified that she had problems with headaches, both shoulders, both arms, fingers of both hands, entire back, neck and left ankle. She also had problems with both feet, but more on the left. She denied symptoms in any other body parts. She felt that a lot of the stress that occurred was due to harassment by a CEO and caused psychological issues. She felt that she really suffered because of that "...like PTSD symptoms." She was now easily startled and had nightmares for which she had to leave her job at one point for a couple of days before going back to work. She became scared and was afraid sometimes. She indicated that psychologically the incident did a lot to her. Counsel wished to focus on physical body parts.

Page 31, she was asked about her eyes and vision, noting her vision had changed "tremendously" since she began working for D'Veal. She stated it was a couple of years ago that she felt she could no longer drive at night. She felt that her vision changes were due to her work at D'Veal. She was afraid to tell her employer about her vision because she feared losing her job. She saw an eye doctor through Kaiser Permanente. She was asked if all of the claimed body parts were injured due to the repetitive nature of her job duties. She stated, "I am claiming that certain things accumulated over time." She was asked if she felt her job was responsible for her injuries to the above-mentioned body parts to which she indicated, "...I never felt this way physically before this job." She denied having symptoms prior to starting her employment with D'Veal. She was asked about the specific incident when she injured the left foot, broke two toes and tore the left knee meniscus at work in 2006, and was asked if she suffered

any other specific injuries while working at D'Veal. The injury to the left foot and knee was stated to be an "isolated incident." She was asked if she had any other isolated incidents while working at D'Veal. She was asked how the injury to the left foot/knee happened. She stated she was transporting clients to an event.

Page 34, her car was getting ready to roll into the street. She jumped in her car to pull the brake and while doing that she felt her left foot "flipped over" and her knee hit the ground. She denied sustaining any other specific injuries to other body parts. She believed the issues she had with the shoulders, arms, spine, fingers and feet were the result of the physical nature of her job duties and the stress at work.

Page 37, she was asked about her physical job duties. The time she spent in the office at a desk and her time outside of the office would vary on a week-to-week basis. She did use her personal vehicle to visit clients. Items lifted during the course of her day included books and files, which varied in size. She was required to climb stairs at work since the two-story building she worked in did not have an elevator, although her office was on the ground level. She would have to take files upstairs to different departments and would have to climb the stairs. At times, she would ask for help when she needed to take something upstairs. She would have to type notes and reports all the time. She basically typed every day. She was right-handed. It was within the last couple of years of her employment that she first noticed back symptoms. She was not sure if the back pain came on gradually without any known cause.

Page 43, she had problems with bending down which she noticed the last couple of years. She could not take a bath due to inability to bend. She was not able to trace the back pain to any particular event. She felt her neck pain was of gradual insidious onset. She estimated she had neck pain/stiffness for the past two years. She complained about her neck pain to her co-workers between 2014 and 2016. It was during that time she had certain people help her go up and steps. Her shoulder pain developed about the same time as the neck pain. She indicated she was not good with dates and was not really sure when she noticed her fingers becoming stiff. Her thumb, middle and index fingers would lock up and become stiff, and she was not able to move them. She did not know if she had any issues with the last two fingers of her right hand. She also had locking and stiffness in the left hand thumb, middle and index fingers, which had also been going on for several years prior to her termination. She also had issues with her upper arms of gradual onset. She described the symptoms in her upper arm as achy stating, "It aches like hell." The onset of symptoms in her left foot

came on first following the accident in 2006. She was not able to indicate when she began having pain in the right foot. She had left foot pain since the date of injury when she had to jump into a car as it was moving. She was asked if she recalled having any right foot pain prior to the left foot injury and she answered, "Okay...I don't know. To be honest with you, I don't know where this right foot, like that's not my major complaint in my right foot." She was asked if she was claiming it to be work related and she answered, "And I am saying that because of the way -- it's not just my right foot. It's my body on the right side of my body. It's not, like my foot, like, like I know how my left foot feels..." She could not pinpoint exactly where things were hurting in her right foot stating because her "balance is off..." She was asked if it was painful and she responded, "I just want to day that it's, like the right side -- I can't just, like boil it down to, like my right, right." She was asked if her right leg felt off balance and indicated it was not that she was off balance, but had a hard time walking. She indicated she could not do the stuff she used to do before such as dancing. She noted it was even hard for her to walk down the street one block. She had difficulty doing things like before. She was asked if her right leg felt weak.

Page 52, she responded, "That's a good answer." She was informed it was a question and said, "No. I know, but that's a good -- yes, yes." She would have to drive for her job during the day and would use her right leg to push the gas or the brake. She was asked if the driving for work stressed her leg or if she had any muscle sensations when she would drive a lot. She indicated she had not driven in a while, but did have pain in her right foot and again indicated she felt like as if she were off balance sometimes. She felt off balance when she was walking. She also felt off balance in her house and would sometimes lose her balance. She felt off balance when doing activities in both standing and walking. She was asked if she could recall any instances where she actually felt pain in her right leg, and she responded, "See, I don't know why, because to me, like when I take these painkillers, it's, like I feel like I'm getting ready to stumble or something like that. It's because I have this pain in my back. Okay?" She was again asked whether she had ever experienced pain in the right foot while working for D'Veal or now. She responded, "I would have to -- if I said, yes, because of -- because this is what I've learned physically about how when you shift your weight, how things happen and I have to say, yes." She was not sure if her low back pain radiated down into the right leg and indicated she was trying to learn more about how pain circulated. She denied ever fracturing the right foot or undergoing surgery for the right foot. She did have surgery to the left knee after she tore the meniscus in 2006.

Page 55, she did have surgery for her left ankle. The left ankle was injured in 2006. It was in 2006 when the incident occurred with the moving car when she broke two bones in her left foot. The foot was casted at that time. She was asked if when she jumped into the care if she also injured her left ankle and responded, "No. I injured -- okay. For that accident, I injured my two toes in my left foot and my knee. She was again questioned about the surgery to the left ankle and indicated, "That was a total -- that was another accident that I had a long time ago. It had nothing to do with what's going on now." The work-related injury only involved the two toes and the knee and had nothing to do with her ankle. She did have surgery to her left ankle many years prior as an adult before she worked for D'Veal. A recess was taken. The prior ankle surgery was for a broken ankle and a plate and screws were placed. She was asked if the left ankle bothered her since the surgery and she indicated it would become swollen. She currently had difficulty walking without holding onto something. She had a cane with her. She did not use the cane every time she left her house. She used the cane occasionally. She used the cane for balance. She was asked how long she had the cane and responded, "I've had this, actually, I've had this cane and another cane since I have been working at D'Veal, for a while -- I've, I've, yeah." She was not using a cane when she was first hired at D'Veal. She was unable to recall when she started using the cane while working at D'Veal. She began to use the cane to help with her walking. She was asked if she started to use the cane due to the left ankle causing problems with her balance and stated, "It was, I guess, a combination of things, you know, with my accident. I had the accident at the job and I had to use a cane."

Page 59: She was hired at D'Veal in 2004 and her injury was in 2006. She did not use the cane until after the injury in 2006. Since the 2006 accident, she had never been without symptoms in her left ankle. She was unable to recall the surgeon who performed the left knee surgery but thought he was in Monterey Park, Monterey or Montebello, and was covered by work comp. Before she was fired from D'Veal, she did not have any medical treatment for her back. She was asked if between 2004 and April 2016 when she was still employed by D'Veal, if she went to a doctor for treatment of her back, and she responded, "All I could say about that is, like when I would visit my doctor, sometimes I would complain about stress. Okay? And that's all I can say about that." She did not recall ever specifically going to a doctor for back complaints while she was employed by D'Veal. She did not go to a doctor for her neck while employed at D'Veal. She was asked if she saw a doctor for her shoulders while employed at D'Veal, and said, "The only way I could describe, like going to the doctor specifically for my

neck and my shoulders and my back is just complaining about stress and having some days off from that...that's all I can say about that. Like it was all, to me, kind of related, the neck, the shoulder, the back, to me, it was, like related to stress." She did not recall if at the time she complained about stress to the doctors at Kaiser, if she also mentioned to them she had discomfort or pain in her back, neck or shoulders. She confirmed that when she was referring to stress, she was referring to the condition of her body and stated it was all related and that was how she felt about it. She indicated the stress would accumulate in her neck, shoulder and back. She was labeling her symptoms in those particular body parts as stress. In general, she went to the doctor because of the stress and indicated, "...but then the way I see stress is, they were both body parts all connected together." She agreed her stress had manifested in pain in certain body parts. She confirmed she referred to stress as both emotional and physical. She indicated, "And the emotional part comes, the way I see it, is because of the physical stress, because now you are emotional about it; that's just how I see it." She was asked if she ever saw a doctor while employed at D'Veal for issues with the right side of her body. In response she noted the issues with the right side of her body were because of the way she felt on the left side of her body and the back pain. She indicated the pain she felt in her back affected the way she felt on the other side of her body and did not know how to explain it any other way. She confirmed she had not seen a doctor while employed by D'Veal for problems on the right side of her body. She did complain of back pain and did not divide the back and left side and right side when she complained about it.

Page 65: She had complained of back pain to Dr. Nissanoff. She was asked if she complained about her back pain to her regular physician and stated, "Only in terms of stress." She had not highlighted any particular side of her body. She was asked if she ever saw a doctor while employed at D'Veal for her stiffness and locking in her fingers and she responded, "No. I was just told that, you just need to drink more water." She did not know who told her that. She denied ever having surgery on her hands or fingers. She denied ever injuring herself in an automobile accident. She had received a work comp settlement in the past due to the case from 2006. She denied ever receiving any other settlements from any work comp case. In the past 15 years, she denied ever suffering any personal injuries outside of her job. She denied any non-work-related personal injuries. She was asked if before she was fired from D'Veal if she had ever notified her employer of her physical complaints related to her job, including back, neck, eyes, shoulders, hands, fingers and feet, and she responded yes. She reported

it to be a verbal notification. She had complained about her vision and showed the management a letter from her eye doctor and indicated she had complained out loud. She was asked if she had notified management about any of her physical complaints other than her vision and responded, "The only way I can put it, I complained that because of the way I was mistreated, you know, versus how other people were mistreated, how they were treated at my job that, because of those issues, right, it caused me -- all I can say is, it's caused me a lot of, like mental and physical stress." She did complain to Rafaela Velgado. She was not sure of when she gave the doctor's note for her vision issues prior to her being fired, indicating it could have been months before and indicated that was something that could be looked up and was not really sure of the date but knew she had given to her supervisor Rafaela. She was asked if the doctor's note required the employer to make reasonable accommodations and she indicated, "We never got -- that was up to -- it would have been up to them, but it never got to that and that's how I feel I got fired." She was told that was not the question and was again asked if the doctor's note that she gave to her employer required some sort of change in her job because she had an eye issue. She indicated, "The doctor's note was going to be left up to interpretation by my employer. The doctor gave me limitations." She told counsel they would have to look up what the doctor indicated in his note as far as limitations. Counsel told her he was asking her about the limitations and that he did not have to look anything up. She indicated the limitation was no driving at night and apologized to counsel for not understanding what he meant. Her job did require her to sometimes work and drive at night. She was asked if the doctor made any other changes to her job besides not driving and she said no driving on freeways.

Page 73: She was questioned at which point she started experiencing painful symptoms and indicated she had mentioned a "couple of years" with her response indicating it was not from when she left her job, but was "during the course -- like over the years." She stated that she had definitely complained about her pain to her co-workers, indicating the back pain, and not being able to walk up the steps. She estimated it was within a five year range that she would verbally complain to her co-workers about her pain. This concludes the review of the deposition transcript.

IMPRESSION

Cervical spine degenerative arthritis

CERVICAL SPINE DEGENERATIVE ARTHRITIS WITHOUT RADICULAR SYMPTOMS

REPORTED CERVICAL SPINE STRAIN/PAIN

BILATERAL SHOULDER DEGENERATIVE ARTHRITIS RIGHT GREATER THAN LEFT

BILATERAL HAND CMC JOINT MILD DEGENERATIVE ARTHRITIS / NUMBNESS

THORACIC SPINE DEGENERATIVE ARTHRITIS

LUMBAR SPINE DEGENERATIVE ARTHRITIS WITH RADICULAR SYMPTOMS

BILATERAL KNEE DEGENERATIVE ARTHRITIS LEFT GREATER THAN RIGHT

LEFT ANKLE SEVERE DEGENERATIVE ARTHRITIS STATUS POST FRACTURE STATUS POST SURGICAL INTERVENTION AND FIXATION

RIGHT ANKLE MILD DEGENERATIVE CHANGES

STATUS POST RIGHT FOOT METATARSAL FRACTURES

REPORTED STRESS REACTION–STRESS ASSOCIATED PAIN

REPORTED VISUAL CHANGES

DISCUSSION

After review of the records and discussion with the patient I believe she has the above-mentioned diagnoses. Several issues need to be addressed.

The patient makes reference to having a lot of stress and this causing her issues. This is a psychological issue and is deferred to the appropriate specialists. Similarly all issues regarding her visual changes are deferred to the appropriate expert. I'm addressing only the physical orthopedic issues. I do not feel that the patient's exposure to visual changes and or stressful situations have caused any of her physical orthopedic diagnoses.

FURTHER COMMENTS

It is noted that the patient previously had a significant left ankle fracture. This is estimated approximately in 1993 (14 years prior to her 2007 injury per the records). She was treated with surgical intervention. She returned back to work however had developed severe osteoarthritis. This was noted at the time of her 2007 injury by Dr. Gambardella, Dr. Saucedo and ultimately Dr. Fell. The patient at that time also had a foot injury in 2007 with significant limping, gait abnormality, and degenerative arthritis to the left knee. It was felt at that time by several of these doctors that her gait abnormality from her ankle fracture was a contributing factor. Ultimately, she had surgery to her left knee with a meniscectomy and chondroplasty. She was off work for this combination of injuries for greater than a year. She then had a compromise and release including both ankles, her right foot, in her left knee based on Dr. Fell's report (of which I do not have a complete copy). She however received a rather significant settlement amount which appears to have taken into consideration her arthritic issues. Clearly the arthritis and issues to these body parts are preexistent to the reported cumulative trauma.

It is noted that the patient has diffuse arthritis throughout her body. This even in places that are unlikely to develop that, such as her shoulders. The patient's body habitus is noted, which is a significant contributing factor to development of arthritis. The patient's preexistent arthritis, associated limp, and resultant malalignment is also a further contributing factor due to the patient's lower extremities. She was unable to give me a specific mechanism of injury to cause further injury to her bilateral lower extremities or spine at work.

I have reviewed with the patient her job duties and kept trying to identify the physical stressors that she placed on her body on a daily basis. She kept relating that she felt everything was due to a cumulative trauma that had developed with time. She denied any specific injury to the body parts except for her initial ankle fracture and references her fracture that occurred in 2007 to her foot and injury to her ankle and left knee. This is consistent with the deposition.

In reviewing the patient's job duties with the description she provided to me, I was not impressed that this was very physical. The physical activities that were outlined above. These are no greater than those activities of a typical day for most people at home. A formal job description may be helpful to further delineate this. In the face of such diffuse arthritis, and absent a mechanism, it is more likely than not the genetic and habitual factors such as her weight are causes of her problems. Merely her stating that she has pain at work, does not make this a work-related injury. Further, according to the records and deposition, there is no clear documentation that she reported the injury previously.

The job information the patient outlined notes that she does go out the office periodically but on a very limited basis. There is no overwhelmingly repetitive job activity or significant lifting that can account for her issues. For people with arthritis, limited ambulation and sitting job duties such as that described by the patient, ARE the modifications we give.

Consequently, I do not have a mechanism to account for the patient's cervical spine, thoracic spine and lumbar spine arthritis except for those things that are specific to the patient and her personal lifestyle and unrelated to her work related activities. The exception to this, would be the limp that she mentions she developed due to her ankle arthritis. This is subject to the previous compromise and release. Other than this previously settled case I do not recognize a mechanism for her issues to her spine except her body habitus and genetics.

Further, the patient's job duties are not substantial from an ambulatory point of view. The natural history of the patient's ankle arthritis and knee arthritis is one of progression with time. This in fact has occurred. This is subject to her previous injuries. I do not recognize a cumulative trauma or new specific injury to cause these issues. Consequently, care for the patient's bilateral ankles, right foot, and knees should be treated directly as result of her 2007 injury that has been settled by compromise and release.

The patient reports pain into her trapezial areas and shoulders. I was surprised to see significant arthritis on the right glenohumeral joint and some on the left. There is no mechanism to explain this as result of her work-related activities that it been provided to me. I do not recognize her shoulder injuries as result of a cumulative trauma.

The patient does have reported stiffness and numbness in her hands that has been documented in the Kaiser records for a period of time. She has some early degenerative changes to her CMC joint and a history of numbness. It is unclear whether this is radiated from her neck or a localized carpal tunnel finding. The patient states she did do several hours of paperwork in computer work per day. I do believe this is a reasonable mechanism to contribute to both CMC joint arthritis as well as the possibility of carpal tunnel syndrome in her hands. Clinically, at this time, she does not have provocative testing for the carpal tunnel syndrome. If the Trier of Fact feels it is reasonable, I do believe that her job activities could reasonably have contributed to the cause and/or aggravated her symptoms and diagnoses to her bilateral hands on a work-related cumulative trauma basis. Daily activities, and using ambulatory aids may also contribute. Apportionment would be considered.

FURTHER COMMENTS

I do not have a formal job description to review. The information used has been gleaned from the patient as well as from the deposition. I would be happy to review a formal job description if felt indicated The patient repetitively mentioned the cause of her issues as being stress. This is a different issue is deferred to the appropriate psychologist for assessment for somatization. I do not recognize any other physical orthopedic injury on a work related basis except that outlined above.

ADDITIONAL COMMENTS:

Treatment for the hands would include a short course of physical therapy and anti-inflammatory medications. A nerve study may be indicated. Based on her current clinical findings I see no indication for surgery. I see no indication for restrictions beyond that outlined below for her wrist and hands since the onset of her complaints.

WORK RESTRICTIONS

The patient's hands and wrists she should be precluded from very forceful use of the bilateral hands.

For sake of thoroughness:

For the patient's shoulders she should be precluded from repetitive over shoulder activities.

For the patient's spine she should be precluded from very heavy work

For the patient's left lower extremity she should be precluded from prolonged standing and walking, no squatting and kneeling or climbing. (These should have been given... or similar... at the time of her 2007 injury)

VOCATIONAL REHABILITATION

If the above restrictions for the hands cannot be met the patient would be considered a qualified injured worker

IMPAIRMENT

The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition was used. The AMA calculator was used.

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IMPAIRMENT CALCULATION (AMA GUIDES 5th EDITION)

PHYSICAL FINDINGS/IMPAIRMENT CALCULATION

Right Arm

Abnormal Motion						Other Disorders (Tab 16-24/27)	Regional Impairment%	Amputation (Fig 16-2)
(Fig 16-28/31)		Flexion	Extension	Ankylosis	Imp%			
WRIST	Angle	65	60					
	Imp%	(0)	(0)					
		RD	UD	Ankylosis	Imp%			
	Angle	20	40					
	Imp%	(0)	(0)					
Total Impairment % Flex/Ext + RD/UD =								
(Fig 16-34/37)		Flexion	Extension	Ankylosis	Imp%			
ELBOW	Angle							
	Imp%							
		Pronation	Supination	Ankylosis	Imp%			
	Angle							
	Imp%							
Total Impairment % Flex/Ext + Pro/Sup =								
(Fig 16-40/43/46)		Flexion	Extension	Ankylosis	Imp%			
SHOULDER	Angle	150	30		3			
	Imp%	(2)	(1)					
		Adduction	Abduction	Ankylosis	Imp%			
	Angle	30	140		3			
	Imp%	(1)	(2)					
		Int Rot	Ext Rot	Ankylosis	Imp%			
	Angle	40	70		3			
	Imp%	(3)	(0)					
Total Impairment Flex/Ext +Add/Abd + Int Rot + Ext Rot = 9								0
							Imp% =	9

RIGHT UE

Impairment due to Right Hand	0
Impairment due to Right Arm (Shoulder/Elbow/Wrist)	9
Impairment due to Nerve System	0
Impairment due to Strength	0
Impairment due to Vascular System	0
Total Right Side UE Impairment	9

Left Arm

Abnormal Motion	Other Disorders (Tab 16-24/27)	Regional Impairment%	Amputation (Fig 16-2)

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(Fig 16-28/31)		Flexion	Extension	Ankylosis	Imp%			
WRIST	Angle	65	60					
	Imp%	(0)	(0)					
		RD	UD	Ankylosis	Imp%			
	Angle	20	40					
	Imp%	(0)	(0)					
Total Impairment % Flex/Ext + RD/UD =								
(Fig 16-34/37)		Flexion	Extension	Ankylosis	Imp%			
ELBOW	Angle							
	Imp%							
		Pronation	Supination	Ankylosis	Imp%			
	Angle							
	Imp%							
Total Impairment % Flex/Ext + Pro/Sup =								
(Fig 16-40/43/46)		Flexion	Extension	Ankylosis	Imp%			
SHOULDER	Angle	150	40		3			
	Imp%	(2)	(1)					
		Adduction	Abduction	Ankylosis	Imp%			
	Angle	30	150		1			
	Imp%	(0)	(1)					
		Int Rot	Ext Rot	Ankylosis	Imp%			
	Angle	80	80					
	Imp%	(0)	(0)					
Total Impairment Flex/Ext +Add/Abd + Int Rot + Ext Rot = 4								0
							Imp% =	5

LEFT UE

Impairment due to Left Hand	0
Impairment due to Left Arm (Shoulder/Elbow/Wrist)	5
Impairment due to Nerve System	0
Impairment due to Strength	0
Impairment due to Vascular System	0
Total Left Side UE Impairment	5

CERVICAL SPINE (Chapter-15, Table 15-5/P.392):

DRE method was selected.

Cervical Spine DRE is classified as Category II that calculates 6 % Impairment.

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THORACIC SPINE: (Chapter-15, Table 15-4/P.389)

DRE method was selected.

Thoracic Spine DRE is classified as Category I that calculates 0 % Impairment.

LUMBAR SPINE (Chapter-15, Table 15-3/P.384):

DRE method was selected.

Lumbar Spine DRE is classified as Category II that calculates 7 % Impairment.

Right Knee (Range of Motion): (Tables 17-10 and 17-20 to 17-23)

Flexion	Flexion Contracture	Varus	Valgus	Ankylosis	Imp %
110	0				7%

RIGHT LOWER EXTREMITY IMPAIRMENT:

Impairment due to Pelvis	0
Impairment due to Hip	0
Impairment due to Thigh	0
Impairment due to Knee (arthritis 3 mm)	7
Impairment due to Calf	0
Impairment due to Ankle	0
Impairment due to Toe	0
Impairment due to Nervous System	0
Impairment due to Vascular System	0
Total Right LE Impairment	3

Left Knee (Range of Motion): (Tables 17-10 and 17-20 to 17-23)

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Flexion	Flexion Contracture	Varus	Valgus	Ankylosis	Imp %
100	0				28%

LEFT LOWER EXTREMITY IMPAIRMENT:

Impairment due to Pelvis	0
Impairment due to Hip	0
Impairment due to Thigh	0
Impairment due to Knee (arthritis 2 mm and med/lat menisectomy)	28
Impairment due to Calf	0
Impairment due to Ankle (ankle 0 mm arthritis)	30
Impairment due to Toe	0
Impairment due to Nervous System	0
Impairment due to Vascular System	0
Total Left LE Impairment	20

IMPAIRMENT SYSTEM AND RATIONALE Organ System and whole person impairment

All calculations are based on the Guides to the Evaluation of Permanent Impairment, Fifth Edition.

Combined values chart (Page 604) has been used throughout the application to combine impairments wherever necessary, Table 16-1 (digits to hand), Table 16-3 (hand to upper extremity). If both limbs are involved, calculate the whole person impairment for each on a separate chart and combine the percents (Combined values chart)

Body Part or System	Chapter No	Impairment %
Upper Extremity	16	8
Lower Extremity	17	22

Spine	15	13

CALCULATED TOTAL WHOLE PERSON IMPAIRMENT: 38 %.

THIS IS ALL INCLUSIVE OF ALL CLAIMED BODY PARTS. PLEASE SEE DISCUSSION ADDRESSING CAUSATION AND APPORTIONMENT.

CAUSATION

This is addressed above at length

APPORTIONMENT

Based on the information provided to me, absent additional information, patient's shoulders, spine, knees, ankles and feet are 100% apportioned to nonindustrial issues, or are the result of her previous injuries and subsequent compromise and release. I do not recognize a separate specific injury or cumulative trauma injury.

For the hands, if felt work related by the Trier of Fact, I would apportion 70% to her work activities and 30% to her personal non industrial issues.

FUTURE MEDICAL CARE

The patient should have future medical care with an evaluation from an Orthopedic Surgeon, medications, injections, physical therapy, diagnostic studies, and possible surgical intervention.

Thank you for the opportunity to asses this patient. If I can be of further assistance, please contact me.

Time spent with patient face to face: 1.75 hours
Time spent reviewing records: (5 inches and deposition): 6 hours
Report preparation, proof reading and editing: 2.5 hours
Issues of causation and apportionment addressed.
ML 104

DISCLOSURE STATEMENT

Rooks, Floreen
February 28, 2018

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines(Section 507.1 and 5307.6).

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury

I declare under penalty perjury that the information contained in this report and it's attachments, if any, is true and correct to the best of my knowledge and belief, except as to the information that I have indicated I I received from others. As to that information accurately describes the information provided except as noted herein, that I believe is true.

There may or may not be other medical information that is protected by special state and federal laws and cannot be released without the released without the subject's specific written authorization, or pursuant to other procedures established by law.

DATED: 02-28-2018

Gregory T. Heinen, M.D.
Orthopedic Surgeon