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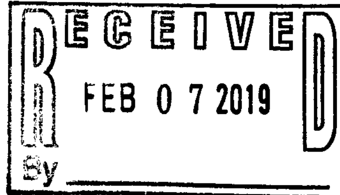


State Compensation Insurance Fund
P.O. Box 65005
Fresno, CA 93650-5005

Philip M. Cohen, Esq.
1550 Hotel Circle North, Suite 170
San Diego, CA 92108

REQUESTED COMPREHENSIVE MEDICAL LEGAL REPORT FORM PRIMARY TREATING PHYSICIAN ML104-92

Re:	**George SooHoo**
Employer:	State of California Department of Corrections
Insurance Carrier:	State Compensation Insurance Fund
Claim Number:	06380832
Date of Injury:	07/06/18
Date of Birth:	11/28/53
Social Security Number	563-78-4407
Date of Exam:	01/04/19
Applicant's Attorney:	Philip M. Cohen, Esq.

OPENING STATEMENT:

I am serving applicant George SooHoo in the capacity of primary treating physician. Pursuant to LC4061.5, the primary treating physician is to opine on all issues necessary to determine an injured worker's eligibility for compensation benefits.

I am presently in receipt of correspondence from Philip M. Cohen, attorney for applicant George SooHoo, dated 01/04/18 (I believe this date to be a typographical error; I believe this date should be 01/04/19). Applicant's attorney apprises the undersigned examiner that this **applicant's claim for industrial injury has been denied.** Applicant's attorney requests that the undersigned examiner address all body parts within my field of expertise. Applicant's attorney apprises the undersigned examiner that since this is a denied claim, it would seem that **all the body parts are contested claims entitling the physicians to write medical-legal reports to attempt to prove or disprove these claims.** Applicant's attorney goes on to state that the physicians issuing these reports should therefore bill these reports as medical legal

reports.

The medical records include a 01/07/19 request from applicant's attorney by way of which **Mr. Cohen requests that the undersigned examiner perform a comprehensive medical legal evaluation of applicant George SooHoo in order to address contested issues relative to this applicant's claim including causation as relates to applicant's entire claim for industrial injury (all body parts), and applicant's need for medical care on an industrial basis.** Applicant's attorney, also by way of his 01/07/17 request, requests that the undersigned examiner address any other contested issues/disputes which currently exist as relates to applicant's claim for industrial injury.

Pursuant to the above described denial of claim, and pursuant to requests put forth by the applicant's attorney, I had an opportunity to perform a comprehensive medical legal evaluation of this applicant in my capacity of primary treating physician in order to put forth a medical legal report to address contested issues relative to this applicant's claim. This medical legal evaluation was performed at 7851 Mission Center Court, Suite 210, CA 92108.

This requested report is a **medical legal report**, not simply a medical report, **since this requested report address a contested issue as defined at CCR 9793.**

CCR9793 (c) states – *"Comprehensive medical legal evaluation means an evaluation of an employee which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (B) is either: (1) performed by a qualified medical evaluator pursuant to subdivision (h) of Section 139.2 of the Labor Code, or (2) performed by a qualified medical evaluator, agreed medical evaluator,* ***or the primary treating physician*** *for the purpose of proving or disproving a contested claim"*.

This report was prepared after a "*comprehensive medical legal evaluation*" as defined at CCR 9793 as an evaluation performed by the primary treating physician for the purpose of proving or disproving a contested claim which results in the preparation of a narrative report and which complies with subpart (g)(1) through (5). This medical legal report does meet the requirements of subpart (g) as it has been prepared at the request of a party for the purpose of proving or disproving this contested claim and addresses the disputed medical facts as set forth herein prior to this physician being notified that this contested issue has been resolved; therefore meeting the definition of a "*medical-legal expense*" set forth in subpart (g).

Failure to reimburse the undersigned examiner for this medical legal report in compliance with LC4622 will result in the filing of a penalty petition.

This **requested report** is appropriately designated as an ML104-92 with 1 hour spent face to face with the applicant; ½ hour spent reviewing medical records; and 4 and ½ hours spent performing research (6 hours spent on a combination of 3 complexity factors). The 4th complexity factor is addressing a contested issue relative to causation of this applicant's neuromusculoskeletal complaints pursuant to a request from this applicant's attorney, noting that this applicant's claim for industrial injury has been denied as industrially compensable. A 5th complexity factor is addressing a contested issue relative to causation of this applicant's sleep disturbance complaint, pursuant to a request from this applicant's

attorney, noting that this complaint (derivative injury) remains denied as industrially compensable. This medical legal report also addresses contested issues relative to this applicant's need for evaluation and treatment on an industrial basis. In addition to spending 6 hours on the first 3 complexity factors, 8 and 1/2 hours was spent in organizing the material into meaningful form, composing thoughts, dictation and editing for a total of 14 and 1/2 hours (**58 units**).

HISTORY OF INJURY – AOE-COE:

George SooHoo is a 65-year-old male who has been employed with the California Department of Corrections as a dentist for approximately 25 years. The applicant reports that during this long tenure of employment with this employer he has worked at multiple locations and facilities. The applicant reports that he has worked at the California Institute for Men (CIM) Facility for approximately the last 10-11 years. The applicant reports that his usual and customary work activities require him to perform dentistry a minimum of 45% of the time, but in actuality he spent 60-70% of the time at work practicing dentistry. Along those lines, the applicant reports that his practice of dentistry includes prolonged standing and prolonged stooping while performing dental procedures. The applicant estimates that he stands 5-6 hours per day while doing dental procedures. The applicant estimates that he sits approximately 2 hours per day while performing dental procedures. The applicant reports that he performed dental procedures 5 days per week through 07/06/18. The applicant reports that he last performed dentistry with this employer on 07/06/18. The applicant reports that he remains employed with the Department of Corrections but he is currently doing audits and peer reviews for 6-7 different Department of Corrections facilities. The applicant reports the development and progressive intensification of musculoskeletal complaints relative to his neck, spine and bilateral upper extremities as a result of his practice of dentistry with the California Department of Corrections through 07/06/18.

The applicant is also reporting additional complaints in relation to the claimed industrial injury which arises out of and through the course of the applicant's employment with the California Department of Corrections. Many of these complaints are beyond my scope of expertise as a doctor of chiropractic. The additional complaints which the applicant is claiming in relation to this industrial injury include injuries to the psyche, cardiovascular system, and ears (hearing loss). I will not be addressing these other complaints which are beyond my scope of expertise other than to request speciality evaluation with appropriate medical specialists as relates to these complaints.

The applicant is also reporting a disruption of his normal sleep cycle as a result of chronic musculoskeletal pain. I will be addressing causation of this complaint as this applicant's primary treating physician to the extent of my expertise, familiarity and experience with respect to derivative sleep disturbance conditions resulting from chronic musculoskeletal pain.

CHIEF COMPLAINTS:

The applicant presented to the undersigned examiner on 01/04/19 with the following subjective complaints: neck pain, headaches, pain and tingling throughout the bilateral upper extremities, tingling within both hands, low back pain, pain throughout the right lower extremity (sciatica), sleep disturbance resulting from chronic musculoskeletal pain.

PAST MEDICAL HISTORY RELATING TO THE INJURY/REVIEW OF RELEVANT MEDICAL RECORDS:

The medical records include a Panel Qualified Medical Evaluation in the Speciality of Internal Medicine from Stewart Lonky, M.D. dated 12/14/18. Dr. Lonky commences his 12/14/18 report with a review of

the history of present illness. Dr. Lonky notes that Dr. SooHoo commenced employment with California Department of Corrections and Rehabilitation as a dentist during January, 1994. Dr. Lonky notes that in 2010 Dr. SooHoo began working at the California Men's Institute in Chino, California as a supervising dentist performing dentistry about 60% of the time with a marked increase within the last 6 months.

Dr. Lonky, at page 5 of his 12/14/18 report, notes that Dr. SooHoo was exposed to substantial stressors during his tenure of employment at California Men's Institute, particularly within the last 5 years. Dr. Lonky reports an incident which occurred at a luncheon when the CEO of the facility struck Dr. SooHoo in the face and apparently laughed about it. Dr. Lonky reports that Dr. SooHoo was very angry and frustrated by this physical assault and the CEO's response to the assault. Dr. Lonky states – *"Dr. SooHoo felt demeaned, unfairly judged by the CEO and physically abused by the CEO"*. Dr. Lonky goes on to describe additional negative experiences with a subsequent CEO at the CIM facility.

Dr. Lonky describes the applicant's present complaints commencing at page 6 of his 12/14/18 report. Dr. Lonky notes that Dr. SooHoo is currently working at Rancho, performing audits.

Dr. Lonky notes the applicant's blood pressure was 180/90 at the time that he was moved to the Regional Facility in Rancho Cucamonga. Dr. Lonky notes that the applicant had been diagnosed with hypertension previously, but it was controlled with medications. Dr. Lonky notes that on 07/12/18 he was evaluated by Dr. Fleming at US HealthWorks pursuant to a referral by his employer, at which time systolic blood pressure was elevated to 170. Dr. Lonky notes that a psychiatric evaluation was recommended.

Dr. Lonky notes that after 07/06/18 the applicant had episodes of being short of breath. He requested a consultation with a physician and he was seen by Jack Kleid, a cardiologist, who recommended a workup which Dr. Lonky states – *"did not materialize"*. Dr. Lonky additionally notes that the applicant presented to Lynne Deboskey, a psychologist, for consultation. Dr. Lonky states – *"He was informed that he could not work at CIM for 60 days"*.

Dr. Lonky notes that the applicant's present complaints include shortness of breath when climbing stairs. Dr. Lonky states this is a relatively new occurrence.

Dr. Lonky notes that that the applicant occasionally feels palpitations, and that the applicant has had a loss of appetite due to stress. Dr. Lonky notes that the applicant has experienced nightmares over the last 2 months, and that the applicant remains stressed and frustrated by an ongoing investigation relative to workplace events including 2 different EEO complaints which were filed against him.

Dr. Lonky, at page 6 of his 12/14/18 report, notes that the applicant was diagnosed with sleep apnea in 2007 and that the applicant had undergone a sleep study at UC Irvine Medical Center in 2000. Dr. Lonky notes that the applicant currently uses a BiPAP sleep apnea machine.

Dr. Lonky, at page 7 of his 12/14/18 report, notes that the applicant has a history of back pain secondary to repetitive and prolonged bending as a dentist.

Dr. Lonky, at page 8 of his 12/14/18 report, states that the applicant denied frequent headaches, dizziness, syncope and seizure.

Dr. Lonky reports his review of records at pages 12-17 of his 12/14/18 report.

Dr. Lonky reports his physical examination findings at pages 18-19 of his 12/14/18 report. Dr. Lonky puts forth diagnostic impressions to include – *"Severe emotional stress associated with marked embarrassment and dressing down in front of subordinates. Depression and anxiety with emotional stress. History of back injury with ongoing back pain. History of well controlled hypertension with loss of control subsequent to emotional stress from events at work as described in the history above. Diabetes mellitus, preexisting with reasonable control at this time. Palpitations with no evidence of arrhythmia on Holter monitoring".*

Dr. Lonky puts forth a discussion and offers his impressions at pages 20-22 of his 12/14/18 report. Dr. Lonky states his opinion that if the applicant's history is accurate, it demonstrates what appears to be some degree of significant difficulty both with subordinates and with supervisory personnel, the etiology of which is not entirely clear since Dr. Lonky does not have all of the personnel records involved with the different workplace events/complaints. Dr. Lonky goes on to state that from an internal medicine perspective however, it is fairly clear that multiple work factors combined with EEO complaints that were filed against the applicant pushed the applicant to a point where he had an apparent acute break from an emotional standpoint.

Dr. Lonky goes on to state – *"There is a significant body of literature that discusses the fact that emotional stress, particularly the kind experienced by Dr. SooHoo, is associated with an acute and perhaps even chronic elevation of catecholamines. The elevation of these endogenous agents is known to be associated with the elevation of blood pressure as well as a lowering of the electrical threshold for arrhythmia development and other cardiovascular complications".* Dr. Lonky goes on to provide studies from the medical literature which support this opinion.

Dr. Lonky continues by stating – *"All of these data have assisted us in understanding how individuals like Mr. SooHoo who may have had very mild hypertension, can have an acute response to a stressful event such as that which occurred when he was escorted off the property and demeaned in front of people who had been both his subordinates and a few of which had been his supervisors over the years. The accusations were an emotionally distressful situation for him and events on July 2018 could be understood as being significantly stressful and capable of increasing the chances of him developing an acute hypertensive response".*

Dr. Lonky, at page 22, goes on to state that he believes that Mr. SooHoo has a personality type that might have a more exaggerated response to emotional stress. Dr. Lonky states – *"It is noteworthy that most if not all his blood pressures subsequent to this event have been out of control from both systolic and diastolic standpoints".* Dr. Lonky then references a study from the medical literature which indicates that acute episodes of hypertension after acute emotional stress frequently dissipate. However, when emotional distress occurs as a result of workplace interactions, such as occurred with Dr. SooHoo, without satisfactory resolution, there can be sustained hypertension. Dr. Lonky is of the opinion that Dr. SooHoo remains in the acute phase of emotional stress relative to the workplace event that occurred with overall poor control of his blood pressure requiring additional medication. Dr. Lonky states – *"At this juncture, it is apparent that even with medical therapy, his blood pressure is not ideally controlled".*

Dr. Lonky concludes his discussion by stating – *"With the history I obtained and notes that I have made, it is reasonably medically probable that the events which surround this termination are true as described, but whether or not any of the accusations, or actions that were started have any basis in fact is not*

known. It is my opinion, at this time that it is reasonably medically probable that the emotional stress that has accompanied this unfortunate series of events has resulted in an acute elevation of blood pressure in Dr. SooHoo. It is not clear whether this will be sustained although it is still present some 5 months post event".

Dr. Lonky puts forth an opinion relative to causation at page 23 of his 12/14/18 report by stating – *"As discussed above, with reasonable medical probability, this gentleman's emotional stress had occurred during the course of his employment as described and particularly with events of 07/20/2018, that these events contributed to his development of a significant worsening of his hypertension such that his blood pressure elevations are sustained at this time".*

Dr. Lonky, also at page 23 of his 12/14/18 report, states that there is an impairment rating according to Table 4-2 within The AMA Guides which would place Dr. SooHoo into a class II impairment level. Dr. Lonky defers his final rating of impairment pending review of the results of a two dimensional echocardiogram.

Dr. Lonky states that apportionment is very important in this case if there is a prior history of hypertension or even elevated blood pressure. Along those lines, Dr. Lonky requests additional medical records that go back to at least 2014 or 2013.

Dr. Lonky recommends keeping the applicant away from his previous place of employment as an extraordinarily important part of his overall management at present. Dr. Lonky additionally states – *"All efforts should be continued to diminish any time constraint or quantitative work overload at this juncture".* Dr. Lonky is of the opinion that the applicant would do well in a structured environment to some degree at this time, particularly at work.

The applicant presented to the undersigned examiner on 01/04/19, at which time I performed a comprehensive evaluation of the applicant on 01/04/19 as relates to the applicant's presenting musculoskeletal complaints which the applicant reports arises out of and through the course of his employment with the California Department of Corrections. Consistent with the denial of this applicant's claim, the 01/04/18 (really 01/14/19) correspondence from the applicant's attorney, and the 01/07/17 request from the applicant's attorney, this requested medical legal report is being put forth in order to address contested issues relative to this applicant's claim for industrial injury.

Applicant George SooHoo is **not** permanent and stationary at present. Mr. SooHoo requires additional treatment to cure and relieve from the effects of the subject industrial injury which has been formally designated with a date of 07/06/18, in spite of the fact that this is not a specific industrial injury, but rather that of a cumulative trauma industrial injury which arises out of and through the course of the applicant's employment with the California Department of Corrections through 07/06/18.

PAST MEDICAL HISTORY:

PREVIOUS ILLNESSES:
Denied.

CURRENT ILLNESSES:
Diabetes mellitus.
Kidney disease.

Hypertension.
Hypercholesterolemia.
Sleep apnea since 2000, currently treated with a BiPAP sleep apnea machine at night.

PREVIOUS INJURIES:
The applicant reports that he is a brigade commander and that he experienced prior episodes of transient low back pain between 2000 and 2013. The applicant reports that these transient episodes of low back pain resulted from lifting soldiers, and also from lifting/carrying large, heavy crates of dental equipment on a simulated battlefield weighing 75-100 pounds. The applicant reports that these prior episodes of low back pain, which resulted from different military exercises, were transient. The applicant reports that these transient episodes of low back pain subsided within days of the military exercises. The applicant reports that he never received treatment for any of these transient episodes of low back pain, nor did he file any claims for any of these transient episodes of low back pain.

The applicant reports that he received injections performed to his left hand at Kaiser about 15 years ago, as well as received injections to his left hand performed at Grossmont approximately 15 years ago.

The applicant reports that he lost his hearing in his left ear about 8 to 10 years ago. The applicant informs me that this is actually very common in dentists due to the high frequency pitch of the dental drills which are utilized. The applicant informs me that he wears hearing aids within both ears. The applicant reports that his left ear hearing loss was settled previously with an award of 10% permanent disability.

SURGERIES:
The applicant had a lipoma removed from his low back about 25 years ago.
The applicant had a benign cyst removed from his neck approximately 2 months ago.

ALLERGIES:
Lisinopril.
Aspirin.
Lipitor.

FAMILY HISTORY:
Non-contributory.

SOCIAL HISTORY:
Non-contributory.

WORK HISTORY:
The patient was employed as a dentist at State of California Department of Corrections at the time of the industrial injury which has been designated to have occurred on 07/06/18.

PHYSICAL EXAMINATION:
Range of motion measurements of the spine were performed as per the protocols established and listed on pages 399-402 of The AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. These protocols require the use of instrumentation, specifically inclinometers, for range of motion measurements of the spine. The patient was properly warmed up as per the AMA protocols and 3 consecutive measurements of each motion were performed. The number recorded is the maximum range of motion

measurement, which the patient was able to achieve during three trials of the specific range of motion. To ensure that the patient performed a full effort during active range of motion, 3 trials were performed and an average was calculated ensuring that the 3 trial measurements were within 5% of the mean if the average range of motion was less than 50°, of if the average range of motion was greater than 50°, then the three consecutive measurements must fall within 10% of the mean. These are the range of motion protocols established upon pages 399 through 402 of the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. Range of motion was measured using dual digital inclinometers.

Range of motion of the cervical spine was as follows:

	Normal	Measurement
Flexion	50°	42°
Extension	60°	37°
Right lateral flexion	45°	35°
Left lateral flexion	45°	32°
Right rotation	80°	64°
Left rotation	80°	61°

Muscular guarding, hypertonicity and trigger points are present throughout the paracervical musculature.

The cervical foraminal compression test is negative.

Jackson's compression test is positive.

The cervical distraction test is positive.

Spurling's tcst is ncgativc bilatcrally.

Range of motion of the lumbar spine is as follows:

	Normal	Measurement
Truc lumbar flexion	60°	49°
True lumbar extension	25°	13°
Lumbar right lateral bending	25°	12°
Lumbar left lateral bending	25°	15°

Digital palpation revealed muscular guarding, hypertonicity and trigger points within the paralumbar musculature.

The sitting straight leg test was negative bilaterally. The supine straight leg test (Lesegue's) was positive on the right at 60 degrees; Lesegue's test was negative on the left. The sciatic stretch (Braggard's) test was positive on the right at 55 degrees; Braggard's test was negative on the left.

The patient is able to perform a toe walk. The patient is able to perform a heel walk.

The patient exhibited a positive Kemp's orthopedic test.

The patient exhibited a positive Milgram's (leg lowering) orthopedic test.

The patient exhibited a positive Minor's orthopedic test.

Range of motion of the right wrist is as follows:

	Normal	**Right**
Flexion	60°	60°
Extension	60°	60°
Radial deviation	20°	20°
Ulnar deviation	30°	30°

Range of motion of the left wrist is as follows:

	Normal	**Left**
Flexion	60°	60°
Extension	60°	60°
Radial deviation	20°	20°
Ulnar deviation	30°	30°

Tinel's sign is positive at both wrists.

Phalen's test is positive for both wrists.

Finkelstein's test is negative bilaterally.

Wartenberg pinwheel testing was normal throughout all sensory dermatomes within the bilateral upper and bilateral lower extremities.

Deep tendon reflexes including the biceps, brachioradialis, triceps, patellar, and Achilles were +2 bilaterally.

DIAGNOSES:

S13.4XXA	Cervical strain.
M53.1	Cervical radiculitis.
S33.5XXA	Lumbar strain.
M54.30	Sciatica-right lower extremity.
G56.00	Probable bilateral carpal tunnel syndrome.
G44.1	Headaches, probable cervicogenic etiology, with probable other contributing factors, possibly hypertensive, possibly stress related, possibly both.

Sleep disturbance resulting from chronic musculoskeletal pain, superimposed upon preexisting sleep apnea, with a possible psychological/emotional contribution as well.

DISCUSSION OF CONTESTED ISSUE RELATIVE TO CAUSATION OF APPLICANT'S MUSCULOSKELETAL COMPLAINTS:

Forensic analysis of this interesting claim results in a supported conclusion that the applicant's musculoskeletal complaints are causally related to his long tenure of practice of dentistry with the California Department of Corrections. The applicant has practiced dentistry with the California Department of Corrections for approximately 25 years at multiple locations and multiple facilities. For approximately the last 10-11 years, the applicant has practiced dentistry at the California Institute for Men (CIM) facility. The applicant reports that 60-70% of his time is spent practicing dentistry. As relates to this time spent practicing dentistry, the applicant reports that he stands 5-6 hours per day and sits approximately 2 hours per day. The applicant performed dentistry with this employer 5 days a week, through 07/06/18.

Clearly obvious, Dr. SooHoo could not have performed dentistry while standing with an erect posture. Dr. SooHoo would have had to bend forward at the waist in order to adopt a forward flexed, stooping posture which would be necessary to facilitate dentistry to a patient seated in a dental chair. This type of flexed forward posture would have subjected the viscoelastic structures of the neck and spine to prolonged static loading, resulting in fatigue and creep deformation, resulting in muscular straining and myofascial irritation.

The human skull weighs 8-10 pounds. Muscular exertion is necessary to maintain the head in an erect posture. Bending the neck forward in order to shift the visual gaze down to the dental patient's mouth would have resulted in prolonged static loading upon the cervical spine from the weight of the skull which would have been coupled with overexertion of the paracervical musculature resulting from the prolonged forward flexed posture of the head and neck. Muscles cannot exert force indefinitely without incurring fatigue. Maintaining the head and neck in a forward flexed posture for a prolonged period of time while performing a dental procedure to a patient would have resulted in muscular fatigue from the sustained muscular exertion necessary to maintain this type of forward flexed static posture of the head and neck.

The same would be true for the lumbar spine. The torso of the body is heavy. Maintaining the torso in a forward flexed erect posture requires muscular exertion from the paralumbar muscles in order to support and counter the weight of the heavy torso which is leaning forward ahead of the center of gravity in this type of position. The prolonged maintenance of this type of forward flexed static posture would require sustained muscular exertional output from the paralumbar musculature; this would have resulted in fatigue, creep deformation and muscular straining.

The medical literature includes a study from M Solomonow, Ph.D., M.D. et al which appeared in Spine 1999; 24(23): 2423-2433. The author reports that repetitive mechanical loading progressively desensitizes receptors in ligaments and viscoelastic structures which support the spine. Fatiguing these receptors results in an exponential decrease in reflexive muscle activity, exposing the spine to possible injury and pain. This study illustrates that spinal ligaments, discs, and other viscoelastic structures become progressively deformed (creep) under repetitive loads, leading to injury.

The medical literature includes a study entitled Working Postures of Dentists and Dental Hygienists. This appeared in J Calif Dent Assoc 2005 Feb; 33(2):133-6. The authors are Marklin RW and Cherney K. This was a joint study conducted by a manufacturer of dental stools in the Midwest of the United States and Marquette University which was undertaken to measure the occupational postures of dentists and dental hygienists. The postures of 10 dentists and 10 dental hygienists were assessed using work

sampling and video techniques. Postural data of the neck, shoulders and lower back were recorded from video and categorized into 30-degree intervals. Each subject's postures were observed while they were treating patients during a 4 hour period, during which 100 observations of postures were recorded at random times. The study data indicate that dentists and dental hygienists flexed their trunk at least 30 degrees more than 50% of the time. The study data indicate that dentist and dental hygienists flexed their neck at least 30 degrees 85% of the time during the 4 hour duration. The study data indicate that these postures were primarily static/fixed. The authors conclude that this data could be utilized to select dental furniture and/or dental devices that promote good body posture in order to reduce the magnitude and duration of deviated joint postures which, in theory, would decrease the risk of musculoskeletal disorders resulting from these static deviated joint postures.

The above study is perfectly on point with respect to the development of a cumulative trauma injuries to the neck and low back resulting from Dr. SooHoo's practice of dentistry with the Department of Corrections. The above study is consistent with the undersigned examiner's explanation of how the magnitude and duration of prolonged fixed/static postures contribute towards musculoskeletal disorders of the neck and low back.

The medical literature includes a study entitled A Systematic Review of Musculoskeletal Disorders Among Dental Professionals. This appeared in Int J Dent Hyg 2009 Aug; 7(3):159-65. The authors are Hayes M, Cockrell D, and Smith DR. The authors report that musculoskeletal problems have become a significant issue for the profession of dentistry and dental hygiene. The authors report that a search of the literature to include all relevant reviews suggests that the prevalence of general musculoskeletal pain ranges between 64% and 93% within the profession of dentistry. The authors report that the most prevalent regions for pain in dentists have been shown to be the back and neck. The authors report that many risk factors accounting for these musculoskeletal symptoms have been identified, including static and awkward posture and work practices. The authors conclude that musculoskeletal problems represent a significant burden for the dental profession.

The medical literature includes a study entitled Lower Back and Neck Pain Among Dentistry Students: A Cross-sectional Study in Dentistry Students in Northern Greece. This appeared in Eur J Orthop Surg Traumatol 2018 Oct; 28(7):1261-1267. The authors are Samoladas E, Barmpagianni C, Papadopoulos DV, and Gelalis ID. The authors start with a background to state that dentistry students and dentists comprise a unique group of professionals whose everyday professional activity requires long hours of standing and working in a position considered unhealthy for the lower back and neck. The objective of this study was to explore the factors involved in the appearance of low back and neck pain in dentistry students, as well as the impact of the pain on the students' professional and everyday activities. A questionnaire was given to all dentistry students of the 4th and 5th year at university in Northern Greece. The results of the study indicate that the dentistry students reported that the most frequent onset of lower back and neck pain was 1 hour after starting to work in a standing position, with the majority of dental students being of the opinion that their working habits were involved in the appearance and the intensity of their neck and low-back pain. The authors conclude that there was a causative relationship between the dentistry students' professional activities and the experienced neck and lower back pain.

The medical literature includes a study entitled Prevalence of Neck and Back Pain Among Dentists and Dental Auxiliaries in Southwestern Nigeria. This appeared in Afr J Med Med Sci 2010 Jun; 39(2):137-42. The authors are Abiodun-Solanke IM, Agbaje JO, Ajayi DM, and Arotiba JT. The authors start with a background to state that dental health workers, like other workers, have occupation related health

problems and hazards which include neck and low back pain. The authors report that previous studies have shown that the prevalence and location of pain may be influenced by posture and work habits. This study included 147 dentists, 37 dental surgeon assistants, 14 dental therapists, and 12 dental technologists. Prevalence of back and neck pain was 88.1% and 81.9% respectively. Prevalence of back pain only was 86.9% in females, and 89.3% in males. The prevalence of neck pain only was 83.2% in males, and 80.6% in females. 88.4% of the dentists within the survey experienced back pain. The authors conclude that the study data indicate that there is a need to address ergonomic issues and change the way dentistry is practiced.

The medical literature includes a study entitled Prevalence of Low Back Pain in Iranian Dentists: An Epidemiological Study. This appeared in Pak J Med Sci 2017 Mar-Apr; 33(2):280-284. The authors are Mohseni-Bandpei MA, Rahmani N, Halimi F, and Farooq MN. The objective of this study was to investigate the prevalence and risk factors associated with low back pain in dentists. Study participants included 300 dentists from Tehran, Iran. Visual analogue scale and Oswestry disability questionnaires were used to determine low back pain intensity and level of functional disability. The authors report that the data indicates that a significant correlation was found between the prevalence of low back pain and the practice of dentistry. The authors conclude that the prevalence of low back pain in dentist appears to be high.

The medical literature includes a study entitled Low Back Pain Prevalence in Healthcare Professionals and Identification of Factors Affecting Low Back Pain. This appeared in J Back Musculoskelet Rehabil 2017; 30(3):451-459. The authors are Çinar-Medeni O, Elbasan B, and Duzgun I. The authors start with a background to state that work related musculoskeletal system diseases are commonly observed among nurses, physiotherapists, dentists and dieticians. The objective of this study was to assess working postures of these healthcare professionals in order to identify whether low back pain is present, and to put forth a correlation between low back pain, working posture and other factors. Study participants included 27 physiotherapists, 34 nurses, 30 dentists and 16 dieticians. Impairment ratings of cases with low back pain were analyzed with The Quebec Back Pain Disability Scale. Working postures were analyzed with the OVAKO Working Posture Analysis System. The study results indicate that low back pain was observed in 70.09% of healthcare professionals. Of the individuals suffering from low back pain, 57.2% were working with a risky posture. Trunk and head posture distribution of individuals with and without low back pain was found as different from each other. Low back pain prevalence of dentists and nurses were higher compared to other groups. The authors conclude that since head-neck and trunk postures are changeable factors that are among the factors affecting low back pain, correcting the working posture of healthcare professionals is important.

The evidence is clear as well as overwhelming. The practice of dentistry requires prolonged static flexed postures of the head and neck. These deviated joint postures which dentist must adopt for hours on end and for up to 5-6 hours per workday, result in overloading upon the viscoelastic structures of the spine, resulting in muscular fatigue and straining, resulting in musculoskeletal injury.

The performance of dentistry 5 days a week over the course of many years resulted in the development and progressive intensification of pain within the cervical and lumbar spinal regions for applicant George SooHoo. It is clearly evident that Dr. SooHoo has sustained an industrially compensable cumulative trauma injury to his neck and low back as a result of his practice of dentistry which he performed with the California Department of Corrections through 07/06/18.

Dr. Soohoo is additionally demonstrating signs and symptoms which are consistent with carpal tunnel syndrome. The medical literature also well documents an association between carpal tunnel syndrome and the practice of dentistry.

The medical literature includes an article entitled Prevalence of Low Back Pain and Carpal Tunnel Syndrome Among Dental Practitioners in Dakshina Kannada and Coorg District. This appeared in Indian J Dent Res 2017 Mar-Apr; 28(2):126-132. The authors are Prasad DA, Appachu D, Kamath V, and Prasad DK. The authors start with a background to state that dental practitioners who usually have to work for long durations in a particular fixed posture are more prone to musculoskeletal disorders, particularly those involving the hand and wrist, and also of the lower back. The objective of this study was to evaluate the prevalence of carpal tunnel syndrome and low back pain among dental practitioners, and to correlate the symptoms with the duration of practice. 100 dental practitioners served as this study's participants. The data indicates that **86% of the total population of dentists practicing for more than five years showed symptoms of carpal tunnel syndrome,** and 54% experienced low back pain. The authors conclude that symptoms of musculoskeletal disorders related to hands, wrists, and low back are widely prevalent among the dentists and that these symptoms/condition severely impact work efficiency.

A dentist utilizes his hands to grip and operate dental tools. The practice of dentistry includes fine and sometimes forceful manipulation of the hands while utilizing tools to perform dental procedures. Utilizing dental instruments requires forceful and controlled exertion across the wrist joint. The dentist is also exposed to vibration from the dental drills utilized during procedures.

The medical literature includes an article entitled The Study of Work Behaviors and Risks for Occupational Overuse Syndrome. This appeared in Hand Surg 2012; 17(2):205-12. The authors are Laoopugsin N and Laoopugsin S. The authors define occupational overuse syndrome to include work-related musculoskeletal disorders resulting from repetitive hand posture and motion. 867 employees in 7 different factories were utilized within this study. Study participants suffered from either trigger fingers, De Quervain's stenosing tenosynovitis, or carpal tunnel syndrome. The authors report that the highest prevalence of these conditions resulted from work patterns where a repetitive workload with a hand in a posture of a contracted grasping position was utilized.

The above study is on point. Once again, Dr. Soohoo would have engaged in repetitive hand postures and motion as well as utilized contracted hand postures while gripping, utilizing and manipulating dental instruments which he used in the dental procedures which he performed for up to 5-6 hours per day, 5 days a week, over the course of many years, through 07/06/18.

The medical literature includes a study entitled Dental Workers, Musculoskeletal Cumulative Trauma, and Carpal Tunnel Syndrome: Who is at Risk? A Pilot Study. This appeared in Int J Occup Saf Ergon 1996 Jan;2(3):218-233. The authors are Rice VJ, Nindi B, and Pentikis JS. This pilot study was conducted at a dental clinic to identify the prevalence of musculoskeletal cumulative trauma disorders, associated symptoms of carpal tunnel syndrome, and practitioners at risk. 45 dental workers participated in this study including dentists, dental hygienists, and dental assistants. The study data indicate that **1 of more symptoms of carpal tunnel were noted by 75.6% of the dental workers,** 11% reported diagnosed carpal tunnel syndrome, and 53% reported back and shoulder pain.

The medical literature includes a study entitled Musculoskeletal Disorders in Dentists. This appeared in NY State Dent J 1998 Apr;64(4):44-8. The authors are Fish DR and Morris-Allen DM. The authors start

with a background to state that occupational injuries involving musculoskeletal tissues are often related to repetitive movements of the upper limbs and prolonged postures such as sitting and standing- activities which are common in dentistry. This study included 1,000 practicing dentists. The data indicates that 29% of study participants reported peripheral neuropathy in the upper limbs or neck. The authors state that since 47% of carpal tunnel syndrome cases in the general population are work related and often associated with repetitive motions, it is reasonable to suspect that dentists may be at risk for this particular disorder.

The medical literature includes a study entitled Carpal Tunnel Syndrome- An Occupational Hazard Facing Dentistry. This appeared in Int Dent 2013 Oct;63(5):230-6. The authors are Abichandani S, Shaikh S, and Nadiger R. The objective of this study was to evaluate the comprehensive medical literature on carpal tunnel syndrome to discover work specific to carpal tunnel syndrome among dentists. A review of the medical literature was undertaken. The authors report that carpal tunnel syndrome is higher in dental professionals. The authors report that abnormal postures, including muscle imbalances, hypomobile joints, nerve compression, and spinal disc herniation or degeneration may result in serious detrimental physiological changes in the body, often resulting in pain, injury or possible neuroskeletal disorders. The authors conclude to state that dentists have an increased risk of carpal tunnel syndrome.

Clearly evident, the dental profession is a physically arduous profession which subjects the body to a multitude of neuromusculoskeletal injuries relative to the neck, spine, shoulders and upper extremities. Considering the consistency between the biomechanics of the applicant's usual and customary work activities with his subjective complaints and objective findings, and also recognizing the association documented within the medical literature relative to these types of work activities inherent within the practice of dentistry in relation to the applicant's musculoskeletal symptoms and conditions, and being aware of the threshold and parameters relative to compensability/causation within the California Workers Compensation System, the undersigned examiner puts forth a supported conclusion to state with reasonable medical probability that the applicant's diagnosed conditions relative to his neck, low back and bilateral upper extremities are causally related to the subject industrial injury which has been designated to occur on 07/06/18. Once again, I find no evidence of a specific industrial injury occurring on or about 07/06/18. Dr. SooHoo has sustained a cumulative trauma industrial injury through his practice of dentistry which he performed with the California Department of Corrections through 07/06/18.

DISCUSSION OF CONTESTED ISSUE RELATIVE TO APPLICANT'S HEADACHE COMPLAINT:

The applicant, by way of a Neck Disability Index (NDI) of 01/04/19 indicated – *"I have moderate headaches which come frequently"*. This reporting from the applicant stands in sharp contrast to the 12/14/18 reporting from panel QME physician Dr. Lonky, who at page 8 of his 12/14/18 report, states that the patient denied frequent headaches, dizziness, syncope or seizure.

Be that as it may, there are many reasons that headaches occur. Headaches may result from cardiovascular conditions such as high blood pressure. Headaches may result from psychological/emotional conditions/complaints such as stress. Headaches may also result from cervical spine dysfunction.

Dr. SooHoo's headache complaint is, in my opinion, at a minimum, at least partially cervicogenic in its etiology. That being the case, the applicant's headache complaint represents a derivate injury in my opinion since the proximate causation relative to this headache complaint is the applicant's cervical spine disorder.

There may be additional contributing factors/causes which also contribute towards Dr. SooHoo's headache complaint. There is no rule which states that a headache can only result from one cause. There could be additional factors (e.g., hypertension, stress) which contribute to Dr. SooHoo's headaches, but if these additional factors are present, that still does not serve to undermine a cervicogenic basis to at least account for some contribution of Dr. SooHoo's headache complaint.

The International Headache Society classifies **cervicogenic headache** as a secondary headache that has its nociceptive source in the neck and is perceived in one or more areas of the head and/or face.

The medical literature includes an article entitled Cervicogenic Headache: Evidence that the Neck is a Pain Generator. This appeared in Headaches 2010, Apr 50(4):699-705. The author is Becker WJ. The author reports that **painful disorders of the neck can give rise to headache**. Clinical studies have shown that pain from cervical spine structures can in fact be referred to the head. Clinical treatment trials involving patients with proven painful disorders of upper cervical zygapophysial joints have shown significant headache relief with treatment directed at cervical pain generators. **The anatomical and physiological mechanisms are such that the referral of pain to the head from the cervical spine is possible.**

The medical literature includes an article entitled Head or Neck Injury Increases the Risk of Chronic Daily Headache: A Population-based Study. This appeared in Neurology 2007 Sep 11; 69(11):1169-77. The authors are Couch JR, Lipton RB, Stewart WF, and Scher AL. The objective of this study was to evaluate the extent to which head and neck injury contributes to chronic daily headache. The authors undertook this study to evaluate the degree to which head injury contributes to chronic daily headache. Study participants included individuals with chronic daily headache for greater than or equal to 180 headaches per year. Headaches suffers were further classified as potentially precipitating injuries if they occurred within 2 years of chronic daily headache onset. The authors note that head injury is associated with headache that remains a problem at 12-24 months post head injury in 20-30% of patients. The authors note that in these types of cases, between 30-50% of individuals manifest with chronic daily headache. The authors report that the study data suggests that head and neck injury accounts for approximately 15% of chronic daily headache cases.

The medical literature includes an article entitled The Effect of Radiofrequency Neurotomy of Lower Cervical Medial Branches on Cervicogenic Headache. This appeared in J Korean Neurosurg Soc 2011 Dec 50(6):507-11. The authors are Park SW, Park YS, Nam TK, and Cho TG. The authors report that lower cervical disorders can play a role in the genesis of headache in addition to the upper cervical disorders, or independently.

The medical literature includes an article entitled Cervicogenic Headache: An Assessment of the Evidence on Clinical Diagnosis, Invasive Tests, and Treatment. This appeared in Lancet Neurol 2009 Oct 8(10):959-68. The authors are Bogduk N and Govind J. The authors report – *"Cervicogenic headache is characterized by pain referred to the head from the cervical spine. The mechanism underlying the pain involves convergence between cervical and trigeminal afferents in the trigeminal cervical nucleus".*

The medical literature includes an article entitled Convergence of Cervical and Trigeminal Sensory Afferents. This appeared in Curr Pain Headache Rep 2003 Oct 7(5):377-83. The authors are Piovesan EJ, Kowacs PA, and Oshinsky ML. The authors report that the trigeminal spinal nucleus, which is located

within the medulla, is a nociceptive structure that exerts fundamental control over input from cervical and trigeminal nociceptors, as well as receives other inputs that participate in head pain control.

Applicant George SooHoo has a painful condition of the neck. The applicant demonstrates an asymmetric loss of cervical spine range of motion resulting from cervical subluxation (misalignment) and muscular imbalance. The applicant additionally has objective findings which include muscular guarding, hypertonicity and trigger points within the cervical spine. The cervical spinal nerve roots innervate the head. The applicant's headache complaint is cervicogenic in its etiology, at least in part.

Inasmuch as the applicant's cervical spine condition results from industrial exposure from his usual and customary work activities which he performed as a dentist with the California Department of Corrections through 07/06/18, and appreciating that a proximate causative factor relative to the applicant's headache complaint is the pain and dysfunction which he has relative to his cervical spine, the applicant's headache complaint is causally related to the subject industrial injury of 07/06/18 which arises out of and through the course of the applicant's employment with the California Department of Corrections.

DISCUSSION OF CONTESTED ISSUE RELATIVE TO CAUSATION OF APPLICANT'S SLEEP DISTURBANCE COMPLAINT:

As stated, applicant George SooHoo has a long history of sleep apnea, dating back to 2000, for which the applicant uses a BiPAP sleep apnea machine while sleeping. Notwithstanding this preexisting, non-industrial sleep apnea, the applicant reports, and the medical literature also supports, that the applicant's chronic musculoskeletal pain complaints within his neck, low back and wrists adversely impact upon his normal sleep cycle.

The threshold for establishing industrial compensability within the California Workers' Compensation System is extremely low. As the parties are aware, work activity need not be the exclusive (100%) causation of symptomatology, need for medical treatment, and/or need for labor disability in order for an injury to be compensable on an industrial basis. In fact, work activity need not even be the predominant (51%) causation of symptomatology, need for medical treatment, and/or need for labor disability in order for an injury to be compensable on an industrial basis. Work activity need merely contribute towards the causation of symptomatology, need for medical treatment, and/or need for labor disability in order for a physical injury to be compensable on an industrial basis (e.g., the so called 1% contribution rule).

The fact that Dr. SooHoo has a preexisting history of sleep apnea only serves to raise the specter of apportionment with respect to his current sleep disturbance complaint. In this particular case, the specter of apportionment relative to the applicant's sleep disturbance complaint is essentially moot.

Apportionment relates to causation of permanent disability. Inasmuch as SB863 precludes the award of permanent disability relative to a sleep disturbance condition, there is nothing to apportion relative to the applicant's sleep disturbance condition since there can be no award of permanent disability relative to this applicant's sleep disturbance condition per SB 863.

Medical treatment is not something that is apportionable. SB863 does not serve to preclude evaluation or treatment of a sleep disturbance condition on an industrial basis.

Inasmuch as the applicant's chronic musculoskeletal pain contributes towards the applicant's current sleep disturbance complaint, and recognizing that the applicant's chronic musculoskeletal pain within his neck,

low back and wrists results from industrial exposure with the Department of Corrections through 07/06/18, the applicant's sleep disturbance complaint represents an industrially compensable derivative injury which is causally related to industrial exposure with the Department of Corrections.

The applicant, as part of his medical legal evaluation of 01/04/19, filled out an ADL worksheet (Table 1-2 from page 4 of the Guides). The applicant specifically circled *"Sleep"* and *"Nocturnal sleep pattern"* on the ADL of 01/04/19 to indicate an adverse impact upon his sleep cycle (resulting from his chronic musculoskeletal pain).

The applicant completed a Revised Oswestry Low Back Pain Disability questionnaire as part of his medical legal evaluation of 01/04/19. Section 7 of the Oswestry relates to sleeping activity. The applicant, on the Oswestry of 01/04/19 stated – ***"Because of pain, my normal night sleep is reduced by** less than one quarter"*. The applicant, also as part of his medical legal evaluation of 01/04/19, completed a Neck Disability Index (NDI) questionnaire. Section 9 of the NDI relates to sleeping activity. The applicant, on the NDI of 01/04/19, stated – *"My sleep is moderately disturbed (2-3 hours sleepiness)"*.

Clearly evident, **the applicant's reporting on the Oswestry and NDI forms of 01/04/19 indicates that in addition to suffering with a preexisting, non-industrial sleep apnea condition, the applicant's chronic pain within his neck and low back adversely impact upon his normal sleep cycle, thus serving to illustrate an additional contributory causative factor relative to the applicant's disturbed sleep cycle.**

The medical literature well documents the association of chronic musculoskeletal pain and derivative sleep disturbance conditions.

The medical literature includes a study entitled – "*Prevalence of Sleep Disturbance and Its Relationship to Pain in Adults with Chronic Pain*". The authors are Tracy Ann Call-Schmidt, M.S.N. and Stephanie J. Richardson, Ph.D., RN. This was published in Pain Management Nursing 4(3):124-133, 2003. This is a descriptive, correlational field study which was performed at an interdisciplinary pain clinic with a sampling of 99 adults. The authors supply the interested readers with a history and review of the current medical literature. The authors report that the literature well documents that sleep disturbance has long been associated with chronic pain. The authors report that as pain intensity increases, sleep becomes more fragmented, and higher pain intensity scores are consistent with higher levels of sleep disturbance. The authors additionally report a bidirectional relationship between chronic pain and sleep to state that pain can interrupt sleep and changing positions to achieve pain relief can also lead to fragmentation of sleep.

The medical literature includes a study entitled Sleep Disturbances in Chronic Pain: Neurobiology, Assessment, and Treatment in Physical Therapist Practice. This appeared in Phys Ther 2018 May 1; 98(5):325-335. The authors are Nijs J, Mairesse O, Neu D, Leysen L, Danneels L, Cagnie B, Meeus M, Moens M, Ickmans K and Goubert D. The authors report that insomnia is highly prevalent in individuals suffering with chronic pain. The authors report that this association between insomnia and chronic pain is closely related to the mechanism of central sensitization, characterized by low grade neural inflammation. The authors also report that this is also commonly associated with stress or anxiety. The authors report that cognitive behavioral therapy for insomnia can be efficacious for improvements in sleep initiation, sleep maintenance, perceived sleep quality, and pain interference with daily functioning in people with chronic pain.

The medical literature includes a study entitled Musculoskeletal Pain and Comorbid Insomnia in Adults; A Population Study of the Prevalence and Impact on Restricted Social Participation. This appeared in BMC Fam Pract 2017 Feb 7; 18(1):17. The authors are Baker S, McBeth J, Chew-Graham CA and Wilkie R. The authors note that comorbidity is common in patients consulting in primary care. The authors report that musculoskeletal pain and insomnia each increase the risk of the other and that the co-occurrences of musculoskeletal pain and insomnia may pose an increased burden on wellbeing. The authors report that this study revealed a significant interaction between pain and delayed sleep onset, difficulty maintaining sleep, early waking, and non-restorative sleep. The authors conclude – *"Pain and insomnia commonly co-occur, resulting in greater impact upon subsequent functional ability. Delayed sleep onset is the insomnia symptom most strongly associated with reduced functional ability"*. The authors recommend – *"clinicians should be aware of the common co-occurrence of insomnia symptoms, inquire about sleep in patients consulting with, and offer interventions that target both sleep and pain"*.

The medical literature includes a study entitled Assessing and Managing Sleep Disturbance with Patients with Chronic Pain. This appeared in Clinical Anesthesiology, 2016 June; 34 (2): 379-93. The authors are Cheatle MD, Foster S, Pinkett A, Lesneski M, Qu D and Dhingra L. The authors report that chronic pain is associated with symptoms that may impair a patient's quality of life, including emotional distress, fatigue, and sleep disturbance. The authors additionally state – *"There is a high prevalence of concomitant pain and sleep disturbance. Studies support the hypothesis that sleep and pain have a bidirectional and reciprocal relationship"*.

The medical literature includes a study entitled Sleep Problems and Pain: A Longitudinal Cohort Study in Emerging Adults. This appeared in Pain 2006 April; 157(4):957-63. The authors are Bonvanic IJ, Oldehinkel AJ, Rosmalen JG, Janssens KA. The authors report that sleep and pain are bidirectional and that sleep problems are associated with chronic pain. The authors conclude by stating that the results of their studies suggest that sleep problems may be an additional target for treatment in patients suffering with musculoskeletal pain complaints.

The medical literature includes a study entitled Myofascial Trigger Points, Pain, Disability and Sleep Quality in Individuals with Mechanical Neck Pain. This appeared in J Manipulative Physiol Ther 2012 Oct; 35(8): 608-13. The authors are Munoz-Munoz S, Munoz-Garcia MT, Alburquerque-Sendin F, Arroyo-Morales M, and Fernandez-de-Las-Penas C. This study investigated the presence of myofascial trigger points, pain intensity, disability, and sleep quality in individuals suffering with mechanical neck pain. The authors report that the referred pain from myofascial trigger points within the neck and shoulder muscles contribute to symptoms in mechanical neck pain, resulting in higher disability and worse sleep quality versus healthy controls. The authors report that sleep quality was associated with pain intensity and disability.

The medical literature includes a study entitled Sleep Quality in Patients with Chronic Low Back Pain: A Cross-sectional Study Assessing Its Relations with Pain, Functional Status and Quality of Life. This appeared in J Back Musculoskelet Rehabil 2015; 28(3):433-41. The authors are Sezgin M, Hasanefendioglu EZ, Sungur MA, Incel NA, Cimen OB, Kanık A, Sahin G. The objective of this study was to investigate sleep quality in patients with chronic low back pain and its relationship with pain, functional status, and health-related quality of life. Study participants included 200 patients with chronic low back pain aged 20-78 years, and 200 sex and age matched pain free healthy controls aged 21-73 years. Physical examination of the lumbar spine was performed and pain was evaluated with the Short Form-McGill Pain Questionnaire, functional capacity with the Functional Rating Index, and health-related

quality of life with the Short Form-36. The Pittsburgh Sleep Quality Index was used to evaluate sleep quality of both groups. The sleep quality was compared between the patients with and without chronic low back pain. Functional status and health related quality of life were also compared between the chronic low back pain and control groups. The authors conclude that the study data indicate that the sleep quality of patients with chronic low back pain was worse compared to healthy controls. The authors report positive associations between sleep quality with pain and functional status and that poor sleep quality had a negative effect on the physical component of quality of life.

The medical literature includes a study entitled The Epidemiology of Back Pain and Its Relationship with Depression, Psychosis, Anxiety, Sleep Disturbances, and Stress Sensitivity: Data from 43 Low and Middle Income Countries. This appeared in Gen Hosp Psychiatry 2016 Nov-Dec ;43:63-70. The authors are Stubbs B, Koyanagi A, Thompson T, Veronese N, Carvalho AF, Solomi M, Mugisha J, Schofield P, Cosco T, Wilson N and Vancampfort D. The aim of this study was to determine the epidemiology of back pain and explore the relationship between back pain and mental health disorders including depression, psychosis, anxiety, sleep disturbance and stress. Data on 190,593 community-dwelling adults from the World Health Survey of 2002-2004 were analyzed. The authors report significant associations between back pain and sleep disturbance were observed. The authors report that associations between back pain and sleep were more pronounced for chronic back pain. The authors conclude that integrated (multidisciplinary) interventions that address back pain and mental health comorbidities (e.g., sleep) might be an important next step to address this considerable burden on society.

The medical literature includes a study entitled Characteristics of Sleep Disturbance in Patients With Carpal Tunnel Syndrome. This appeared in Hand (NY) 2012 Mar; 7(1):55-58. The authors are Patel JN, McCabe SJ, and Myers J. The authors start with a background to state that sleep disturbance is common in carpal tunnel syndrome. This was a case controlled study undertaken to investigate the association between a variety of sleep disturbances and carpal tunnel syndrome. 62 cases were clinically diagnosed with carpal tunnel syndrome and compared against 138 primary care patients without carpal tunnel syndrome. The study results indicate that patients with carpal tunnel syndrome complained of significantly more severe problems with sleep than the control population and had multiple sleep complaints compared to the control group. 63 of the 138 control patients indicated that they had one cause of sleeping disturbance with no control patient choosing more than one. In contrast, in carpal tunnel syndrome patients, 44 of 63 patients (69.8%) indicated they had two or more causes of sleep disturbance. The authors additionally report that the Insomnia Severity Index was significantly higher in carpal tunnel syndrome patients and the impact of sleep disturbance on quality of life was higher with carpal tunnel syndrome patients as well.

The evidence is overwhelming. Chronic musculoskeletal pain adversely affects sleep. Dr. SooHoo's reporting of a negative impact on his sleep cycle as a result of his chronic musculoskeletal pain is consistent with the above references from the medical literature. Inasmuch as a proximate causative factor of the applicant's sleep disturbance is his chronic nusculoskeletal pain, and inasmuch as the applicant's chronic musculoskeletal pain results from the subject industrial injury of 07/06/18, the applicant's sleep disturbance complaint represents a derivative injury which is causally related to the subject industrial injury of 07/06/18 which arises out of and through the course of the applicant's employment with IHSS, in spite of the fact that the applicant has a preexisting non-industrial sleep apnea condition which was diagnosed as far back as 2000, and in spite of the fact that the applicant was, prior to the subject industrial injury of 07/06/18, treating his sleep apnea condition with a BiPAP sleep apnea machine.

PERMANENT AND STATIONARY:
Applicant George SooHoo is **not** permanent and stationary at present. Dr. SooHoo requires additional treatment to cure and relieve from the effects of the subject industrial injury of 07/06/18.

CURRENT TREATMENT NEEDED:
Although I believe that Dr. SooHoo can potentially derive benefit from his neuromusculoskeletal complaints through chiropractic care, I am of the opinion that **chiropractic care is currently contraindicated based on the applicant's current hypertensive state**. Along those lines, regardless of whether or not the applicant's stress related hypertension becomes accepted as an industrially compensable condition, the applicant's hypertension is currently serving as an **impediment** towards treatment of his neuromusculoskeletal complaints. That being the case, treatment of the applicant's hypertension should be provided on an industrial basis such that the applicant's hypertensive state can be brought under control to a manageable level such that chiropractic care is no longer contraindicated.

Clearly obvious, the applicant needs to be under the care of a cardiologist as relates to his hypertensive condition. Applicant's attorney, by way of his letter of 01/04/19, informs me that the applicant is currently under the care of Jack Kleid,M.D., a cardiologist. This is certainly good news.

Applicant's attorney, also by way of his 01/04/19 correspondence, requests that the undersigned examiner refer Mr. SooHoo to Isaac Bakst, M.D., a neurologist who treats and evaluates headaches. I concur with this recommendation and I will be attempting to refer Dr. SooHoo to Dr. Bakst as relates to his headache complaint, especially appreciating that the applicant's headaches appear to be of a multifactorial etiology, most likely resulting from the combination of cervical spine dysfunction, cardiovascular dysfunction (hypertension) and stress.

Applicant's attorney, by way of his 01/04/19 correspondence, requests the undersigned examiner refer Dr. SooHoo to Philip I. Azer, M.D., an ENT specialist, to evaluate the applicant's hearing loss. Inasmuch as hearing loss is well beyond my scope of expertise, I will be happy to attempt to refer the applicant to Dr. Azer along these lines.

The applicant requires electrodiagnostic studies for the upper extremities in order to more fully evaluate his carpal tunnel like symptoms. Based on the applicant's long tenure of practicing dentistry, it is probable that the applicant has carpal tunnel syndrome within both of his wrists; electrodiagnostic studies would confirm this probable diagnosis. I would also recommend electrodiagnostic studies for the lower extremities to more fully evaluate the applicant's right-sided sciatic radiculopathy.

Applicant's attorney, by way of his 01/04/19 correspondence, requests that the undersigned examiner consider a referral to Richard Santore, M.D., a nationally renowned hip expert, as relates to the applicant's right hip if I feel that is necessary. In consulting with the applicant, and examining the applicant, it does not appear that the right hip (acetabular joint) is a current complaint of the applicant. Many people refer to the sacroiliac (SI) joint as the hip. Some people even refer to the SI joint as the rear hip joint. It would be appear, at least at present, that applicant's attorney, in referring to the applicant's right hip by way of his correspondence of 01/04/19, is under the impression that the applicant has a right hip acetabular problem when in fact the applicant, based on my consultation and examination with him, has pain within the right sacroiliac joint resulting from his lumbar spine with pain coursing through the right SI joint along the sciatic nerve through its distribution throughout the right lower extremity. The applicant does not report pain within the right acetabular joint to me. Having stated that, I am not opposed to referring

the applicant for an evaluation with Dr. Santore, especially appreciating that the applicant is 65 years of age and there could be a difficult to detect hip (acetabular) type dysfunction/condition present, especially appreciating the biomechanics of the subject industrial injury which involves prolonged standing with a flexed posture which could serve to subject the right acetabular joint to increased axial loading, which could potentially lead to accelerated degeneration of the right acetabular joint.

Notwithstanding the fact that the applicant has been diagnosed with sleep apnea as far back as 2000 and is currently utilizing a BiPAP machine at night, I would recommend an updated evaluation with a sleep medicine specialist in order to determine whether or not the applicant requires any type of modification with respect to his sleep apnea therapy as a result of additional provocation/aggravation of the applicant's sleep dysfunction as a result of chronic musculoskeletal pain resulting from the subject industrial injury which arises out of and through the course of the applicant's employment with the California Department of Corrections.

I would additionally recommend orthopedic evaluation relative to the applicant's bilateral wrists and hands. In addition to exhibiting significant clinical signs of carpal tunnel syndrome, the applicant reports that his hands and fingers curl up at night; this could reflect an undiagnosed tenosynovitis of the digits which should be evaluated by an upper extremity specialist such as Dori Cage, M.D.

APPORTIONMENT:

Apportionment relates to causation of permanent disability. Inasmuch this applicant is **not** presently permanent and stationary, I am currently unable to opine on the causation of this applicant's permanent disability. Apportionment will be comprehensively addressed upon this applicant attaining a permanent and stationary status.

VOCATIONAL RETRAINING:

This topic will be addressed upon the applicant attaining a permanent and stationary status.

REVIEW OF RECORDS:

Review is made of the examination and treatment records of thc following physicians:
Alexander L. Caligiuri, D.C.
Stewart Lonky, M.D.

BASIS OF OPINIONS:

I have reviewed the patient's objective findings, as well as medical records in my possession. After review of such, it is clear to the undersigned examiner that the opinions expressed in this report are supported by a preponderance of medical evidence. The opinions expressed within this report are based upon consultation and examination of the patient, the patient's response to treatment, review of the available medical records, and clinical experience as an examining and treating physician. I do reserve the right to modify my medical opinions should additional relevant medical information become available.

AFFIDAVIT OF COMPLIANCE:

In compliance with Section 11606 and Labor Code 4628 Rules of Practice and Procedures Manual of the Workers' Compensation Appeals Board, this disclosure is made:

The background information (i.e. occupational history, history of the injury, family history, and past

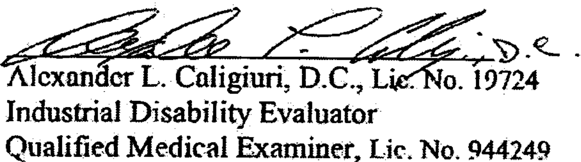
medical history) was obtained by this examiner. I personally reviewed the medical history and the background information with the patient and performed all necessary changes and additions for clarification. I also personally performed a complete chiropractic examination on this patient as described in the physical exam section of this report, except as noted. I personally dictated and edited this report. The report was transcribed by a professional medical transcriptionist, Excellent Transcription Service.

This report is not to be construed as a complete physical examination for general health purposes. Only those symptoms which I believe to have been involved in the injury or might relate to the injury have been addressed. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

As of July 16, 1993, per Labor Code 5703, I declare under penalty of perjury that the attached bills are true and correct, to the best of my knowledge, as the examining and/or treating physician.

Under Labor Code Section 139.3, I have not offered nor been offered or delivered and/or received and/or accepted any consideration in any form for the referral of this patient. I declare under penalty of perjury under the laws of the State of California that the above is true and correct to the best of my knowledge.

Sincerely,



Alexander L. Caligiuri, D.C., Lic. No. 19724
Industrial Disability Evaluator
Qualified Medical Examiner, Lic. No. 944249

ALC/ets

Executed on this 24th day of January, 2019, at San Diego, California, County of San Diego.

STATE COMP INSURANCE
PO BOX 65005

FRESNO, CA 93650

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 06380832

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SOOHOO GEORGE

3. PATIENT'S BIRTH DATE: 11 MM 28 DD 1953 — SEX: M ✓ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): STATE OF CALIFORNIA DEPT CORRECTION

5. PATIENT'S ADDRESS (No., Street): 2506 LIGHTHOUSE LANE

6. PATIENT RELATIONSHIP TO INSURED: Self ✓ Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: CORONADO — STATE: CA

8. RESERVED FOR NUCC USE

CITY — STATE

ZIP CODE: 92625 — TELEPHONE (Include Area Code): (000) 000-0000

ZIP CODE — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES ✓ NO

a. INSURED'S DATE OF BIRTH: 11 MM 28 DD 1953 YY — SEX: M ✓ F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO ✓ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO ✓

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE COMP INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ✓ *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File — DATE 01/25/2019

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 07 06 18 — QUAL. 431

15. OTHER DATE — QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN ALEXANDER CALIGIURI — 17a. — 17b. NPI 1215152509

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO ✓ — $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

A. S13 4XXA (G56 00) B. M53 1 (G44 1) C. S33 5XXA D. M54 30
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01	24	19	01	24	19	11		ML104	92	ABCD EF	3625 00	58		NPI	1215152509
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 352191003 — SSN EIN ✓

26. PATIENT'S ACCOUNT NO.: SOOGE000

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✓ NO

28. TOTAL CHARGE: $ 3625 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature on File — 01/25/19
SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

33. BILLING PROVIDER INFO & PH # ( )
Alexander L Caligiuri DC
7851 Mission Center Ct Ste 210
San Diego CA 92108
a. 1215152509 b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

NUCC Instruction Manual available at: www.nucc.org — *PLEASE PRINT OR TYPE* — CR061653 — APPROVED OMB-0938-1197 FORM 1500 (02-12)

Alexander L. Caligiuri Chiropractic
A Professional Corporation
Qualified Medical Examiner

RECEIVED
BY: E mail

7851 Mission Center Court
Suite 210
San Diego CA 92108
(619)260-1814 Tele
(619)260-1835 Fax

License No. DC19724
QME No. 944249
EIN No. 35-2191003
NPI No. 1215152509

APPLICANT ATTORNEY'S REQUEST FOR COMPREHENSIVE MEDICAL LEGAL EVALUATION AND REPORT FROM PRIMARY TREATING PHYSICIAN

Please complete form and send back to Dr. Caligiuri by fax: (619) 260-1835

Re: Applicant __George Soohoo __

The following contested issues exist at present:

[X] Causation as relates to applicant's entire claim for industrial injury (all body parts). For internal body parts, please see the Dr. Lowsky AME report.

[ ] Causation as relates to some of the claimed body parts as follows: ____________________

[ ] Causation as relates to derivative injuries claimed by applicant as follows: ____________________

[ ] Applicant's need for temporary total disability benefits.

[ ] Applicant's permanent and stationary status.

[ ] Applicant's permanent disability rating.

[ ] Apportionment.

[X] Applicant's need for medical care.

In order to prove the Applicant's claim for compensation benefits, I request that Dr. Caligiuri perform a comprehensive medical legal evaluation in order to address the above described contested issues. If the dispute concerns an opinion of a QME or AME as set forth in a medical-legal report from another physician, I request that the report include a review and analysis of the disputed opinion in order to support and prove the contested medical dispute.

I also request that Dr. Caligiuri provide an opinion of applicant's permanent disability and apportionment of permanent disability if applicant is permanent and stationary at present and a report has not yet been issued on this issue.

I additionally request that Dr. Caligiuri, by way of this comprehensive medical legal report, address any other contested issues/disputes which currently exist as relates to this applicant's claim for industrial injury.

Signature: ____________________ Date: Jan. 7, 2019

Attorney name: Philip M Cohen

* *If necessary please attach separate sheet describing the contested issues to be addressed*

PHILIP M. COHEN*
MARIANNE S. JOHNSON
DEBORAH A. HOLLINGSWORTH*#
MARISA R. QUINZII
*Certified Specialist, Workers' Compensation Law
State Bar of California, Board of Legal Specialization
of- counsel

LAW OFFICES OF
PHILIP M. COHEN
A PROFESSIONAL CORPORATION

1550 HOTEL CIRCLE NORTH, SUITE170
SAN DIEGO, CALIFORNIA 92108

TELEPHONE:
(619) 297-5100

January 4, 2018

Alexander Caligiuri, D.C.
7851 Mission Center Ct.
San Diego, CA 92108

Re: George Soohoo v. State of California Department of Corrections
WCAB No.: ADJ11815610
Claim No.: 06380832

Dear Dr. Caligiuri:

Please be advised that I represent the interests of the above referenced injured worker, George M. Soohoo and we have designated you as the primary treating physician.

This letter will confirm the fact that Mr. Soohoo is claiming injury in the course and scope of employment while working as a supervising dentist for the Department of Corrections, State of California to his psyche, cardiovascular, back, ears, both hands, headaches and right hip.

I would appreciate it if you could address all body parts within your field of expertise hopefully to include the back, both hands and perhaps right hip. If you believe a hip expert consult is necessary I request that you obtain same from Richard Santori, M.D., a nationally renowned hip expert.

Mr. Soohoo has already selected Lawrence Woodburn, Ph.D to treat him for his psyche injuries and Jack Kleid, M.D. as his treating Worker's Compensation cardiologist. Mr. Soohoo believes he has some hearing loss as a result of exposure to noise at work. I would appreciate it if you would consider referring Mr. Soohoo to Philip I. Azer, M.D., ENT specialist to evaluate the hearing claims.

For the headaches, I would appreciate it if you could make a referral to a headache specialist to evaluate the headaches. I would appreciate it if you could refer Mr. Soohoo to Isaac Bakst, M.D., a neurologist who treats and evaluates headaches. Normally Dr. Bakst does not treat Worker's Compensation patients but he will do medical-legal reports and QMEs. Since this is a denied claim, it would seem that all of the body parts claimed would be contested claims entitling the physicians to write medical-legal reports to attempt to prove or disprove these claims and thus, they should be billed as medical-legal. It is my understanding that if defendant will not pay the medical-legal bills of Dr. Bakst then Mr. Soohoo will get them paid and seek reimbursement. Thus, let Dr. Bakst know this if he is hesitant to set up the appointment.

If you have any questions or I can provide you further information, do not hesitate to contact me . I thank you for your courtesy, cooperation and prompt attention to this matter.

Very truly yours,

LAW OFFICES OF PHILIP M. COHEN, A.P.C.

Philip M. Cohen

PMC:je
cc: George Soohoo via email

Patient Name: GEORGE M. SOOHOO Date: 1-4-19

ACTIVITIES OF DAILY LIVING (ADLS)

Please circle all activities which you have difficulty with as a result of your injury

Table 1-2 Activities of Daily Living Commonly Measured in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Scales

Activity	Example
Self-care, personal hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating
Communication	Writing, typing, seeing, hearing, speaking
Physical activity	Standing, sitting, reclining, walking, climbing stairs
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Nonspecialized hand activities	Grasping, lifting, tactile discrimination
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, lubrication, erection
Sleep	Restful nocturnal sleep pattern

FORM C-2. REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: this questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 – Pain intensity
A The pain comes and goes and is very mild
B The pain is mild and does not vary much
C The pain comes and goes and is moderate
D The pain is moderate and does not vary much
E The pain comes and goes and is severe.
F The pain is severe and does not vary much

SECTION 2- Personal Care (Washing, Dressing, etc.)
A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of pain, I am unable to do some washing and dressing without help
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting
A I can lift heavy weights without extra pain
B I can lift heavy weights, but is causes extra pain
C Pain prevents me from lifting heavy weights off the floor
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg, on a table.
E Pain prevents me from lifting heavy weights, but can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weight, at the most.

SECTION 4 – Walking
A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than ½ mile.
D Pain prevents me from walking more than ¼ mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and I have to crawl to the toilet.

SECTION 5 – Sitting
A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than ½ hour.
E Pain prevents me from sitting more than 10 minutes.
F Pain prevents me from sitting at all.

SECTION 6 – Standing
A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than ½ hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing, because it increases the pain right away.

SECTION 7 – Sleeping
A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 – Social life
A My social life is normal and gives me no pain.
B My social life is normal, but increase the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
D Pain has restricted my social life and I do not got out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of pain.

SECTION 9 – Traveling
A I get no pain while traveling
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing degree of pain
A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Comments:____________________

Name GEORGE M. SOOHOO Date 1-4-19 Score________

From Fairbank J, Davies J, et al. The Oswestry Low Back Pain Disability Questionnaire. Physiotherapy 1980;66(18):271-273

FORM C-10. NECK DISABILITY INDEX QUESTIONNAIRE (NDI)

PLEASE READ: this questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 – Pain intensity
A I have no pain at the moment.
B The pain is very mild at the moment
C The pain is moderate at the moment
D The pain is fairly severe at the moment
E The pain is very severe at the moment
F The pain is worst imaginable at the moment

SECTION 2- Personal Care (Washing, Dressing, etc.)
A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain
C It is painful to look after myself and I am slow and careful
D I need some help, but manage most of my personal care
E I need help every day in most aspects of self care
F I do not get dressed, I wash with difficulty and stay in bed

SECTION 3 – Lifting
A I can lift heavy weights without extra pain
B I can lift heavy weights, but is gives extra pain
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights
F I cannot lift or carry anything at all.

SECTION 4 – Reading
A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all

SECTION 5 – Headaches
A I have no headaches at all.
B I have slight headaches which come infrequently
C I have moderate headaches which come infrequently
D I have moderate headaches which come frequently
E I have severe headaches which come frequently
F I have headaches almost all the time

SECTION 6 – Concentration
A I can concentrate fully when I want to with no difficulty
B I can concentrate fully when I want to with slight difficulty
C I have a fair degree of difficulty in concentrating when I want to
D I have a lot of difficulty in concentrating when I want to
E I have a great deal of difficulty in concentrating when I want to
F I cannot concentrate at all

SECTION 7 – Work
A I can do as much work as I want to
B I can only do my usual work, but no more
C I can do most of my usual work, but no more
D I cannot do my usual work
E I can hardly do any work at all
F I cannot do any work at all

SECTION 8 – Driving
A I can drive my car without any neck pain
B I can drive my car as long as I want with slight pain in my neck
C I can drive my car as long as I want with moderate pain in my neck
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 – Sleeping
A I have no trouble sleeping
B My sleep is slightly disturbed (Less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless)
E My sleep is greatly disturbed (3-5 hours sleepless)
F My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10 – Recreation
A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all

Comments:

Name GEORGE M. SOOHOO Age 65 Date 1-4-19 Score

From Vernon H. Mior S. The Neck Disability Index: A study of reliability and validity. J *Manipulative Physiol Ther* 1991;14:409-415.

Upper Extremity Functional Index (UEFI)

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, *do you* or *would you* have any difficulty at all with:

Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Any of your usual work, housework, or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Lifting a bag of groceries to waist level	0	1	2	3	4
4. Lifting a bag of groceries above your head	0	1	2	3	4
5. Grooming your hair	0	1	2	3	4
6. Pushing up on your hands (eg from bathtub or chair)	0	1	2	3	4
7. Preparing food (eg. peeling, cutting)	0	1	2	3	4
8. Driving	0	1	2	3	4
9. Vacuuming, sweeping or raking	0	1	2	3	4
10. Dressing	0	1	2	3	4
11. Doing up buttons	0	1	2	3	4
12. Using tools or appliances	0	1	2	3	4
13. Opening doors	0	1	2	3	4
14. Cleaning	0	1	2	3	4
15. Tying or lacing shoes	0	1	2	3	4
16. Sleeping	0	1	2	3	4
17. Laundering clothes (eg. washing, ironing, folding)	0	1	2	3	4
18. Opening a jar	0	1	2	3	4
19. Throwing a ball	0	1	2	3	4
20. Carrying a small suitcase with your affected limb	0	1	2	3	4
Column Total					

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Minimum Level of Detectable Change (90% Confidence): 9 points SCORE: _____/ 80

Name: GEORGE M. SOOHOO Date: 1-4-19

Patient Name: GEORGE M. SOOHOO Date: 1-4-19

THE EPWORTH SLEEPINESS SCALE

How likely you are to doze off or fall asleep in the following situations, as opposed to just feeling tired? This refers to your usual way of like in recent times. Even if you have not done some of the things listed below, try to work out how they would affect you. Use the following scale to rate each situation listed below:

Scale -			
	0	=	No chance of Dozing
	1	=	Slight chance of Dozing
	2	=	Moderate chance of Dozing
	3	=	High chance of Dozing

Situations:

Sitting & Reading	=	3
Watching T.V.	=	2
Sitting Inactive In A Public Place (e.g. in A theater or meeting)	=	1
As a Passenger In a Car For 1 Hr. With No Break	=	2
Lying Down To Rest in Afternoon	=	3
Sitting & Talking to Someone	=	1
Sitting Quietly After Lunch with no alcohol	=	1
In a Car While stopped For A Few Minutes in Traffic	=	0
Total Score	=	______

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA

COUNTY OF SAN DIEGO

RE: George SooHoo

I, the undersigned declare the following:

I am employed in the County of San Diego, State of California. I am over the age of eighteen years and not a party to the within action. My business address is 7851 Mission Center Court, Ste. 210, San Diego, California 92108.

On *February 4, 2019*, I served the document(s) described as:

- Requested Comprehensive Medical Legal Report Form Primary Treating Physician ML104-92 From Alexander L. Caligiuri, D.C., dated 01/24/19
- HCFA 1500 Billing Claim Form For 01/24/19 Medical Legal Report From Alexander L. Caligiuri, D.C.

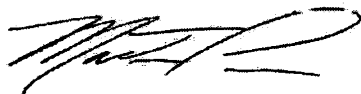
on the interested parties indicated in said action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully pre-paid in the United States mail addressed to the following:

State Compensation Insurance Fund
P.O. Box 65005
Fresno, CA 93650-5005

Philip M. Cohen, Esq.
1550 Hotel Circle North, Suite 170
San Diego, CA 92108

I am familiar with and follow this office's practice of collecting and processing of correspondence for mailing by the United States Postal Service, which practice consists of depositing all out-going correspondence/documents with the United States Postal Service in the ordinary course of business on the same day it is collected and processed.

I declare under penalty of perjury under the laws of the State of California, that the foregoing is true and correct. This declaration was executed on ___*February 4, 2019*______, in San Diego, California.



Martin Torres