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February 13, 2020

AGREED MEDICAL EVALUATION

RE:	Marvetta Johnson
EMPLOYER:	County of Los Angeles/ Probation Department
CLAIM NUMBER:	19-01553-D; 19-02165-D; 20-00359-D
WCAB NUMBER:	Unassigned
EAMS NUMBER:	ADJ12198746; ADJ12198788; ADJ12430393
DATE OF INJURY:	01/25/2019; 03/14/2019; 07/29/2019
ACCOUNT NUMBER:	JOHNM20BW

To Whom It May Concern:

I declare under penalty of perjury that this evaluation warrants billing at the ML104 extraordinary level. This is extraordinary as there are complexity factors. She has had a previous significant injury with overlapping areas and a current history of multiple dates of injury. I have been provided voluminous records. There is a data disc of almost 3000 pages. This did require a 5-1/2-hour timeframe. One hour has been spent for history and clinical examination. Those 2 factors amount to 3 complexity factors. Causation has been addressed, which is a fourth factor. Apportionment has been addressed as well given the earlier overlapping areas of involvement from a prior injury. There are 5 factors. Four are necessary for billing at the extraordinary level. One and one-half hours has been spent in preparation and dictation of this report and discussion. This evaluation, therefore, has required 8 hours, billed accordingly and appropriately as an extraordinary ML104 level evaluation with AME modifier.

This 52-year-old female probation officer for County of Los Angeles/ Probation Department, is seen for an orthopaedic agreed medical evaluation on February 13, 2020. The history is obtained from the patient, as well as from the review of the submitted medical records.

CHIEF COMPLAINT:

Multiple areas.

HISTORY:

She describes an injury that occurred on January 25, 2019. She states that she stepped between 2 minors that were fighting, and was struck by them several times. She developed pain in her left shoulder/ arm, low back and left leg. She reported the injury to her supervisor and was seen at the industrial clinic. Pain medication was prescribed. She received a couple of weeks of physical therapy. She was off work for a couple of weeks "here and there." She then resumed her regular duties.

She continued with pain in her left shoulder/ arm, low back and left leg until March 14, 2019.

On March 14, 2019, she states that while preventing a near fight, she had a contact with one of the minors and developed pain in the left shoulder/ arm, low back and left hip/ leg. She reported the injury to her supervisor and was seen at the industrial clinic at Kaiser. Pain medication was prescribed. She received a couple of weeks of physical therapy, with benefit. She was off work for a couple of weeks. She was then released to return to work full duties.

She returned to work and continued working with pain in these areas until July 29, 2019.

On July 29, 2019, she states that she was assisting a restraint of a combative minor who continued to resist for approximately 30 minutes. After this incident, she noted pain in the left side of her neck, left shoulder/ arm and low back/ leg and left hip. She reported the injury to her supervisor and was seen at Kaiser Workers' Comp. No treatment was given.

She returned to work for a couple of days and then took some time off work.

Due to the persistent pain and problems in these areas, she sought treatment with Doctor Webb.

She received physical therapy with Doctor Webb for some time, with benefit. She believes that Doctor Webb was requesting MRIs, but they have not been authorized.

She remained under the care of Doctor Webb until September or October 2019.

She has not seen any other orthopedic doctors or received any treatment since September or October 2019.

After the industrial injury of July 29, 2019, she was off work for a couple of weeks. She then returned to work full duties and continued working until August 18, 2019, at which time she was placed in a home assignment. She has continued working at this capacity to the present time.

PRESENT COMPLAINTS:

There are left side neck symptoms described as constant throbbing pain. There is no pain radiating down the right arm. There is occasional pain radiating down the left arm to the hand. There is occasional numbness and tingling in the left arm and hand. These complaints tend to be associated with activities such as looking up, reaching overhead, prolonged standing, sitting, lifting, pulling and pushing.

There are left shoulder symptoms described as constant throbbing pain. There is no popping of the left shoulder. These complaints tend to be associated with activities such as reaching overhead and backwards, lying down on the left side of her body, lifting, pushing and pulling.

There are no right shoulder pain or problems at this time.

There are left side low back symptoms described as occasional throbbing pain. There is occasional pain radiating down the left thigh to the knee. There is no numbness or tingling in the left leg. These complaints tend to be associated with activities such as bending, stooping, turning, twisting, stair climbing, standing, walking, sitting, lifting, carrying, pushing and pulling.

There are left hip symptoms described as constant achy to throbbing pain. There is no popping of the left hip. These complaints tend to be associated with activities such as bending, stooping, turning, twisting, lying down on the left side of her body, standing, walking, sitting, lifting, carrying, pushing and pulling.

There are no right hip pain or problems at this time.

MEDICATIONS:

Atenolol, lisinopril/ hydrochlorothiazide, metformin, duloxetine, zolpidem, Humulin.

ALLERGIES:

NONE.

ACTIVITIES OF DAILY LIVING:

She has filled out a pain questionnaire and an activities of daily living questionnaire. She has indicated complaints associated with activities. An effect on activities includes lifting, reaching, pushing, pulling, bending, stooping as well as loading activities. This concerns various areas of involvement. She will limit activities to prevent pain from worsening. There are complaints with activities which include bathing, dressing, showering, and self-hygiene activities. She is not, however, precluded from performing such activities.

PAST MEDICAL HISTORY:

Previous Injuries: In the early 2000s, while working for Boeing, as an instructional mechanic, she injured her neck, right hand and low back due to the repetitive job duties. She underwent right ring finger surgery. She was treated with pain medication and physical therapy. She was off work for a couple of months. She then resumed her regular duties. She states that the pain in her neck, right hand, right ring finger and low back completely subsided.

On July 10, 2009, while working for County of Los Angeles/ Probation Department as a probation officer, she injured her left shoulder. She was treated with pain medication, physical therapy, injections and ultimately underwent left shoulder surgery on August 17, 2011. Postoperatively, physical therapy was provided for some time, with benefit. She was off work for approximately 1 year. She was then released to return to work full duties. She continued working with pain in her left shoulder on an "off and on" basis.

She states that the case was settled, and was awarded future medical care. She has been receiving physical therapy to the left shoulder on an "off and on" basis throughout the years.

Approximately at age 16 or 17, she was involved in a bus accident. She injured her back. She received pain medication and physical therapy. She states her low back condition fully recovered.

She has no history of non-work-related injuries.

Surgeries: Left shoulder surgery on August 17, 2011. Right ring finger surgery in 2011. Gallbladder surgery, right foot surgery. Partial hysterectomy in November 2019.

Medical Problems: Hypertension and diabetes.

JOB DESCRIPTION:

Her job involved working as a probation officer for County of Los Angeles/ Probation Department. She was required to supervise, detain minors, prevent fights and altercations. She described occasional lifting up to 25 pounds, along with occasional bending, stooping, pushing, pulling, squatting, kneeling, climbing and overhead activities. There is frequent standing and walking. She worked her regular duties until the industrial injury of January 25, 2019. She was off work for a couple of weeks. She then resumed her regular duties. She continued working her regular duties until the industrial injury of March 14, 2019. She was then off work for a couple of weeks. She then returned to work her full duties. She continued working at this capacity until June 14, 2019, at which time she was promoted to senior detention officer.

Her duties as a senior detention officer require her to observe the other detention service officers, conduct and instruct the other detention service officers of her duties. She describes occasional lifting up to 10 pounds, along with occasional bending, stooping, pushing, pulling, squatting, kneeling, standing, walking, climbing and overhead activities. She worked at this capacity until August 18, 2019, at which time she was placed on home assignment. She continues working at this capacity to the present time.

PHYSICAL EXAMINATION:

The patient walks with a normal heel-to-toe gait. The patient is able to walk on heels and toes without problems.

The pelvis is level. Trendelenburg sign is negative.

Lumbar Spine Examination

On examination of the lumbar spine, there are left-sided lower back complaints with mobility.

Range of Motion - Lumbar Spine	Right		Left	Normal
Flexion		46		60
Extension		22		25
Deviation	25		25	25

In a sitting position, straight leg raise is negative.

In a supine position, straight leg raise is negative for any elicited lower back pain or nerve root irritability on the right. Straight leg raise left elicits left-sided lower back complaints. There is no radiation. There is no clinical radiculopathy.

Fabere and Lasegue's are negative.

In a prone position, there is no lumbar paraspinal spasm or tenderness. There is no midline spinous process tenderness, posterior iliac spine tenderness, sciatic notch tenderness or posterior thigh tenderness.

Cervical Spine Examination

On examination of the cervical spine, there are left-sided neck complaints with mobility.

Range of Motion - Cervical Spine	Right		Left	Normal
Flexion		50		50
Extension		42		60
Rotation	50		52	80
Lateral flexion	45		45	45

There is no trapezial or interscapular spasm or tenderness. There is no cervical or thoracic paraspinal musculature spasm or tenderness. There is no midline spinous process tenderness noted in the neck and upper back regions. There is no radiculopathy.

Thoracic Spine Examination

Examination of the thoracic spine reveals normal mobility, without complaints.

There is no radiculopathy.

Range of Motion - Thoracic Spine	Right		Left	Normal
Flexion		60		60
Rotation	30		30	30

Shoulder Examination

Examination of the shoulders reveals normal appearance on inspection. There is no evidence of swelling, deformity or atrophy on the right. There are arthroscopic scars of the left shoulder from prior history. There is no swelling or atrophy noted on the left.

There is no tenderness to palpation about the shoulders.

There is no pain or crepitus with mobility of the right shoulder. There are left shoulder complaints with mobility. There is no crepitus with mobility of the left shoulder.

Range of Motion - Shoulders	Right	Left	Normal
Abduction	180	145	180
Forward flexion	180	150	180
Internal rotation	90	50	90
External rotation	90	90	90
Extension	50	50	50
Adduction	50	50	50

There is negative impingement on the right. On the left, impingement testing elicits left shoulder complaints.

There is negative apprehension sign noted.

There is no clinical instability demonstrated.

Normal strength to rotator cuff testing, bilateral.

Hip Examination

Examination of the hips reveals no obvious abnormality to inspection. There are no areas of tenderness to palpation about the right hip. There is left hip greater trochanteric tenderness in the proximal lateral thigh.

Range of motion is noted to be normal and symmetrical with the contralateral side. There is no elicited pain or crepitus with mobility of the right hip. There is pain elicited along the proximal lateral thigh with rotation of the left hip, although mobility is preserved. There is no crepitus with mobility of the left hip.

There is no weakness about the hip.

Range of Motion - Hips	Right	Left	Normal
Flexion	110	110	110
Extension	30	30	30
Internal rotation	35	35	35
External rotation	50	50	50
Abduction	50	50	50
Adduction	30	30	30

Knee Examination

On examination of the knees, there is no obvious swelling or effusion noted. Range of motion of the knees is normal and symmetrical. There is no pain or crepitus with mobility of the knees.

Range of Motion - Knees	Right	Left	Normal
Extension	0	0	0
Flexion	135	135	135

There is no tenderness along the joint lines of either knee.

There is negative Lachman, negative anterior drawer and no collateral instability to varus or valgus stress in full extension or 20 degrees of flexion. There is negative McMurray and negative pivot shift.

Patellofemoral mobility is normal. There are negative patellofemoral inhibition and apprehension signs bilaterally.

Neurovascular Examination

Sensation and motor examination are normal.

Reflexes are intact and symmetrical.

Pulses are normal and symmetrical.

Circumferential Measurements, Upper Extremities	Right	Left
10 cm above the olecranon	30	29
10 cm below the olecranon	28	27

Hand grip using Jamar: The measurements were right 60/65/65 and left 45/55/55. The patient is right handed.

Circumferential Measurements, Lower Extremities	Right	Left
10 cm above the patella	54	54
Maximal calf	37	37

X-RAYS:

No x-rays are obtained; however, there are imaging studies that have obtained.

MRI, cervical spine, September 4, 2020. C2-3 annular fissure, disc deformity 1.9 mm. No stenosis. C3-4 disc abuts anterior cord, mild to moderate spinal canal narrowing. No abnormal cord signal. Bilateral facet arthrosis, disc and facet hypertrophy with mild foraminal narrowing, disc 3.5 mm. C4-5 disc abuts anterior cord, mild to moderate spinal canal narrowing. No abnormal cord signal. Concurrent uncovertebral joint hypertrophy with bilateral facet arthrosis. Disc material and facet hypertrophy cause severe right more than left foraminal narrowing. Compression of right exiting nerve root is seen, annular fissure identified, disc 3.8 mm. C5-6 disc and osteophyte complex noted. Disc material abuts anterior cord. Mild to moderate spinal canal narrowing. No abnormal cord signal. Concurrent bilateral uncovertebral hypertrophy, disc and hypertrophic change with mild foraminal narrowing. Exit nerve roots are normal. Annular fissure is noted with disc deformity,

3.2 mm. C6-7 disc protrusion identified, right facet arthrosis, disc material and facet hypertrophy with moderate right more than left foraminal narrowing. Abutment of right exiting nerve root is seen. Spinal canal patent. Annular fissure identified with disc deformity, 3 mm.

MRI, lumbar spine, September 3, 2020. T12-L1, L1-2 normal. L2-3 mild foraminal narrowing. Spinal canal patent, 2.3 mm disc. L3-4 mild to moderate right more than left foraminal narrowing. Concurrent mild lateral recess stenosis. Spinal canal patent. Abutment of right exiting nerve root. Transitioning nerve roots are normal. Disc deformity, 2.8 mm. L4-5 protrusion, mild to moderate left more than right foraminal narrowing, concurrent moderate bilateral lateral recess stenosis. Spinal canal patent. Abutment of left exiting nerve root. Abutment on transiting nerve root is noted. Disc deformity, 2.7 mm.

Left central protrusion L5-S1. Hypertrophy of left facet. No lateral stenosis. No foraminal narrowing. Annular fissure is seen. Disc 2.1 mm.

RECORD REVIEW:

Claim form dated August 20, 2014 is reviewed, noting cumulative trauma from October 1, 2011 to July 9, 2014 to "psych, head, body SMS," as a result of "stress and strain of job; psyche headaches internal."

Claim form dated May 15, 2019 is reviewed, noting injury on January 25, 2019 to "arm, back, shoulder, leg," as a result of "please note body parts are left arm, low back, left shoulder, left hip, left thigh, left knee breaking up a fight between two female youth."

Claim form dated May 15, 2019 is reviewed, noting injury on March 14, 2019 to "arm, back, shoulder, hips, legs," as a result of "please note body parts are left arm, left shoulder, low back, left hip, left thigh, left leg breaking up a fight between two females engaging in physical altercation."

Claim form dated August 6, 2019 is reviewed, noting injury on July 29, 2019 to "neck, back, shoulder," as a result of "please note body parts are low back, bilateral shoulders restraining combative minor."

March 12, 2007, progress report, Dr. Wendell Osborne, Kaiser Permanente. Current complaints: Right-sided neck pain for

three days; right big toenail pain. Diagnosis: Onychomycosis. Treatment plan: Lamisil; ongoing evaluation. Work status: Not noted.

May 7, 2009, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: "Carpal tunnel syndrome, no pain, no tingling." Diagnosis: Carpal tunnel syndrome. Treatment plan: Ongoing evaluation. Work status: Not noted.

July 12, 2009, progress report, Dr. Ivan Garcia, Kaiser Permanente. Current complaints: "Comes in today with soreness and stiffness of left neck and shoulder pain for two days after having to restrain a detainee while at work. She states that the individual ran into her and cannot remember the exact details … However, states that yesterday and today has increased soreness of left neck and shoulder," denies numbness, tingling, or burning in upper extremities; some mild limitation to range of motion in left shoulder; muscular tenderness in left trapezius with decreased cervical range of motion. Diagnosis: Strain of neck. Treatment plan: Ibuprofen, 600 mg, cyclobenzaprine, 10 mg; ongoing evaluation. Work status: Not noted.

July 14, 2009, progress report, Lois Martindale, NP, Kaiser Permanente. Current complaints: "Patient injured neck and left shoulder July 10, 2009 restraining a minor," with persistent left-sided neck pain and left shoulder pain; decreased cervical range of motion with tenderness to palpation on the left side. Diagnosis: Cervicalgia. Treatment plan: X-ray of cervical spine; ongoing evaluation. Work status: Not noted.

February 1, 2010, initial comprehensive orthopedic evaluation, Dr. Philip Sobol. History: "The patient relates that on July 10, 2009, she was attempting to prevent an altercation between two female minors when one of them ran toward her and collided with her, striking her on her left shoulder. The patient then proceeded to restrain the female minor who collided with her and in doing so, caused her to jerk her upper torso into a flexed position. The patient immediately experienced left shoulder pain and neck pain radiating to her left upper extremity … She was released to return to work at her usual and customary duties and later that day, she began to experience headaches and difficulty sleeping secondary to her pain … On November 25, 2009, the patient was placed on modified duties, requiring her to sit and observe juvenile offenders. It was at this time that the patient began to notice the onset of lower back pain radiating to her left lower extremity and left hip and bilateral

knee pain secondary to her antalgic gait favoring her lower back and left lower extremity." Past medical history: Hypertension; diabetes; cesarean section, 1990; right ring finger release, 2000; breast reduction, 1994; right foot bunionectomy, 1990s, not detailed; work-related injury in 2000 with injury to right ring finger, full recovery; motor vehicle accident, 16 years old with injury to lumbar spine, full recovery. Current complaints: Cervical spine pain with symptoms into left upper extremity, associated with headaches; low back pain with symptoms into left lower extremity; left shoulder pain; left hip pain; bilateral knee pain; difficulty sleeping; decreased cervical lordosis with tenderness to palpation, with cervical muscle spasms and muscle guarding, with some limitation to range of motion; tenderness to palpation with lumbar muscle spasms and guarding, positive straight-leg testing on the left, with some limitation to range of motion; some tenderness to palpation over acromioclavicular joint, supraspinatus joint, posterior musculature and periscapular region, with positive cross-arm and impingement test on the left; tenderness to palpation over left sacroiliac joint, left gluteal muscle and left piriformis muscle, over patellar region and patellar tendon; decreased sensory examination over left lateral arm and forearm in C5 to C6 dermatomal pattern, and over left lateral thigh region in L5 dermatomal pattern. Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity radiculitis and cervicogenic headaches. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis. 3).Left shoulder periscapular strain with supraspinatus tendinitis and acromioclavicular degenerative joint disease, per patient history. 4).Left hip sprain and strain with left sacroiliac joint sprain and strain. 5).Bilateral knee patellar tendinitis. 6).Sleep difficulty, deferred. Treatment plan: Acupuncture therapy twice weekly for three weeks, with aquatic therapy twice weekly for four weeks, pending authorization and consideration; Tylenol with codeine, Anaprox, Dendracin lotion; review of medical and diagnostic records, pending; cervical spine pillow; ongoing evaluation. Causation and apportionment: Disabilities are due to industrial trauma. Work status: Temporarily totally disabled.

March 8, 2010, progress report, Dr. Philip Sobol (handwritten). Current complaints: Illegible. Diagnosis: Illegible. Treatment plan: Aquatic therapy, twice weekly for four weeks, pending consideration; acupuncture therapy twice weekly for four weeks, pending schedule; ongoing evaluation. Work status: Temporarily totally disabled.

March 31, 2010, progress report, Dr. Ronald Woods (handwritten). Current complaints: Illegible. Diagnosis: Illegible. Treatment plan: Additional acupuncture therapy once weekly, and aquatic therapy twice weekly, for four weeks; possible additional chiropractic therapy, as necessary; topical compounds; ongoing evaluation. Work status: Temporarily totally disabled.

April 15, 2010, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: "Carpal tunnel syndrome, feels stable, no pain, no tingling." Diagnosis: Carpal tunnel syndrome. Treatment plan: Ongoing evaluation. Work status: Not noted.

April 28, 2010, progress report, Dr. Ronald Woods (handwritten). Current complaints: Ongoing symptoms with some improvement from aquatic therapy, with persistent spasms in cervical spine and some limitation to range of motion; trapezius spasms; illegible. Diagnosis: Illegible. Treatment plan: Topical compounds; trigger point injection; chiropractic therapy twice weekly for one week; OrthoStim, pending consideration; ongoing evaluation. Work status: Temporarily totally disabled.

May 3, 2010, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: "Carpal tunnel syndrome, feels stable, no pain, no tingling." Diagnosis: Not noted. Treatment plan: Ongoing evaluation. Work status: Not noted.

May 26, 2010, progress report, Dr. Ronald Woods (handwritten). Current complaints: Ongoing symptoms; illegible. Diagnosis: Illegible. Treatment plan: Tylenol with codeine, Anaprox; chiropractic therapy twice weekly for three weeks; aquatic therapy once weekly for four weeks, pending authorization; ongoing evaluation. Work status: Temporarily totally disabled.

June 30, 2010, progress report, Dr. Ronald Woods (handwritten). Current complaints: Ongoing left shoulder pain with limitation to range of motion; illegible. Diagnosis (partial; illegible): 1).Cervical spine sprain and strain with left upper extremity radiculopathy. 2).Lumbar spine sprain and strain with left lower extremity radiculopathy. Treatment plan: Home exercises, continue; possible trigger point injection for left upper trapezius, pending consideration; ongoing evaluation. Work status: Temporarily totally disabled.

August 3, 2010, progress report, Dr. Philip Sobol (handwritten). Current complaints: Illegible. Diagnosis:

Illegible. Treatment plan: Tylenol with codeine; trigger point injection into left upper trapezius; physical therapy twice weekly for four weeks, pending authorization; ongoing evaluation. Work status: Temporarily totally disabled.

August 27, 2010, progress report, Dr. Philip Sobol (handwritten). Current complaints: Illegible. Diagnosis: Illegible. Treatment plan: Chiropractic therapy twice weekly for four weeks, pending authorization; home exercises, continue; ongoing evaluation. Work status: Temporarily totally disabled.

October 1, 2010, progress report, Dr. Philip Sobol (handwritten). Current complaints: Illegible. Diagnosis: Illegible. Treatment plan: Ongoing chiropractic therapy, not detailed, continue until completion; Ativan, 1 mg; pain management consultation, regarding possible cervical epidural steroid injection, pending consideration; lumbar spine MRI, pending authorization; ongoing evaluation. Work status: Temporarily totally disabled.

November 4, 2010, progress report, Dr. Philip Sobol (handwritten). Current complaints: Illegible. Diagnosis: Illegible. Treatment plan: Tylenol with codeine; pain management consultation, pending consideration; MRI for lumbar spine, pending authorization; ongoing evaluation. Work status: Temporarily totally disabled.

June 1, 2011, progress report, Dr. Ronald Woods (handwritten). Current complaints: Illegible. Diagnosis: 1).Lumbar spine sprain and strain, left lower extremity radiculopathy; illegible. 2).Left hip sprain and strain; illegible. 3).Cervical spine sprain and strain, bilateral upper extremity radiculopathy; 2 mm disc bulge C3-C4, 6 mm disc protrusion C5-C6; illegible. 4).Left shoulder strain; illegible. Treatment plan: Tylenol with codeine; illegible. Work status: Temporarily totally disabled for six weeks.

July 11, 2011, progress report, Dr. Philip Sobol (handwritten). Current complaints: Illegible. Diagnosis: 1).Lumbar spine sprain and strain, left lower extremity radiculopathy; illegible. 2).Left hip sprain and strain; illegible. 3).Cervical spine sprain and strain, bilateral upper extremity radiculopathy; 2 mm disc bulge C3-C4, 6 mm disc protrusion C5-C6; illegible. 4).Left shoulder strain; illegible. Treatment plan: Left shoulder surgery with Dr. Kvitne, pending schedule; illegible. Work status: Temporarily totally disabled.

July 27, 2011, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: No active symptoms of carpal tunnel syndrome. Diagnosis: Carpal tunnel syndrome, stable. Treatment plan: Ongoing evaluation. Work status: Not noted.

August 12, 2011, progress report, Dr. Philip Sobol (handwritten). Current complaints: Illegible. Diagnosis: Illegible. Treatment plan: Left shoulder surgery with Dr. Kvitne, pending clearance and schedule; illegible. Work status: Temporarily totally disabled.

August 17, 2011, operative report, Dr. Ronald Kvitne. Preoperative diagnosis: 1).Chronic subacromial impingement syndrome, left shoulder. 2).Degenerative joint disease, severe, left acromioclavicular joint. 3).Degenerative type I superior labrum anteroposterior tear. 4).Partial-thickness bursal-side surface rotator cuff tear. Postoperative diagnosis: 1).Chronic subacromial impingement syndrome, left shoulder. 2).Degenerative joint disease, severe, left acromioclavicular joint. 3).Partial-thickness bursal-side surface rotator cuff tear. Procedure: 1).Arthroscopic subacromial decompression, left shoulder. 2).Arthroscopic distal clavicle resection, Mumford procedure. 3).Extensive debridement partial-thickness bursal-surface rotator cuff tear. 4).Extensive debridement degenerative type I superior labrum anterosuperior tear, left shoulder.

February 20, 2012, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: No active complaints of carpal tunnel syndrome. Diagnosis: Carpal tunnel syndrome, stable. Treatment plan: Ongoing evaluation. Work status: Not noted.

May 17, 2012, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: No active symptoms of carpal tunnel syndrome. Diagnosis: Carpal tunnel syndrome, stable. Treatment plan: Ongoing evaluation. Work status: Not noted.

June 2, 2012, progress report, Carla Lizarraga, NP, Kaiser Permanente. Current complaints: Muscle tension in neck with some tenderness; anxiety. Diagnosis: Anxiety disorder. Treatment plan: Lorazepam, 1 mg; ongoing evaluation. Work status: Not noted.

June 4, 2012, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: No active symptoms of carpal tunnel syndrome. Diagnosis: Carpal tunnel syndrome, stable. Treatment plan: Ongoing ergonomic practices, continue; ongoing

evaluation. Work status: Not noted.

June 21, 2012, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: No active pain from carpal tunnel syndrome. Diagnosis: Carpal tunnel syndrome, stable. Treatment plan: Ongoing evaluation. Work status: Not noted.

August 2, 2012, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: No complaints of carpal tunnel syndrome. Diagnosis: Carpal tunnel syndrome, stable. Treatment plan: Ongoing evaluation. Work status: Not noted.

August 30, 2012, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: No active problems from carpal tunnel syndrome. Diagnosis: Carpal tunnel syndrome, stable. Treatment plan: Ongoing evaluation. Work status: Not noted.

May 3, 2013, progress report, Dr. Ruben Franco, Kaiser Permanente. Current complaints: No symptoms of carpal tunnel syndrome. Diagnosis: Carpal tunnel syndrome, stable. Treatment plan: Ongoing evaluation. Work status: Not noted.

November 11, 2013, progress report, Dr. Yong Ho Lee, DO, Kaiser Permanente. Current complaints: Left foot pain, sharp, with tingling and numbness, with first toe tenderness, "says she woke up with pain and swelling today. No trauma or injury or fall." Diagnosis: Left foot joint pain. Treatment plan: X-ray, "shows mild hallux valgus and soft tissue swelling. No bony erosions"; ibuprofen; ongoing evaluation. Work status: Not noted.

November 11, 2013, x-ray of left toe, Dr. Andrew Wu, Kaiser Permanente. Findings: Mild hallux valgus. Mild soft tissue swelling adjacent to the first metatarsophalangeal joint. External beads over the distal first toe. No acute fracture or destructive bone lesion. No erosion. Impression: Not noted.

July 9, 2014, first report of occupational injury or illness, Dr. Stephen Greene. History: "Patient states 'sustained medical disability work-related 2011.' Return to work subject to harassment, subject to retaliation, harassment, discrimination, write up, isolation weekly"; date of injury is listed as July 9, 2014, while mechanism of injury is not noted. Current complaints: "Migraine headaches; achy and stiffness to neck and shoulder; tension in chest." Diagnosis: Anxiety, stress; not work-related. Treatment plan: "Patient discharged from care. Not industrial in causation." Work status: Full

duty.

August 25, 2014, progress report, Dr. Shaun Reid, Kaiser Permanente. Current complaints: "Here with right wrist pain. She noticed two bumps overlying the joint three days ago and the pain started yesterday, assuming this is a bite but did not see anything bite her, pain started two days ago and then she notes some swelling." Diagnosis: Right wrist joint pain. Treatment plan: Naproxen, 500 mg, hydroxyzine 25 mg; x-ray of right wrist; ongoing evaluation. Work status: Not noted.

August 25, 2014, x-ray of right wrist, Dr. Ryan Downey, Kaiser Permanente. Findings: No acute fracture is identified. The alignment is normal. No significant joint disease is noted. No significant soft tissue abnormality is identified. Impression: As noted.

August 28, 2014, initial comprehensive psychological evaluation, Dr. Seth Hersch, PhD. History: "Ms. Johnson has described how she had a work-related injury leading to a procedure. She returned to work with restrictions. Since returning she says, 'There was harassment and they are trying to get me to demote or retire.' … The applicant states that consequently the harassment became worse … The applicant states she sustained an injury to her left shoulder. She was involved preventing a near fight. She needed surgery in June or July 2011 resulting in restrictions. She says, "This is basically retaliation"; date of injury is listed as July 9, 2014. Past medical history: Work-related left shoulder injury in 2010, "resolved her left shoulder claim"; work-related injury to back and left hand in 2000 "due to continuous repetitive work at Boeing where she was employed as a mechanic. She resolved that claim"; diabetes diagnosed six years ago; breast reduction, 1993; gallstone removal, 2012; hypertension, diagnosed six years ago. Current complaints: Moderately severe and ongoing neck pain; moderately severe and ongoing left shoulder pain; migraine headaches; epigastric pain; depression; sadness; feelings of helplessness and hopelessness; irritability, social withdrawal; sleep disturbance; anxiety. Diagnosis: 1).Axis I: Major depressive disorder, single episode, moderate; insomnia. 2).Axis II: None. 3).Axis III: Persistent neck pain and migraine headaches; ongoing left shoulder pain (moderate to moderately severe), not depicted on the pain drawing; insomnia. 4).Axis IV: Moderate. 5).Axis V: GAF = 57. Treatment plan: Wellbutrin, 100 mg; referral to Dr. Franco for orthopedic evaluation; cognitive behavioral psychotherapy and psychotropic medications. Work status: Not noted.

October 20, 2014, initial consultation in psychology, Dr. David Kauss, PhD. History: "She reports that she enjoyed the nature of her job duties and functions without any particular difficulties until 2009. In 2009, as she was trying to break up a fight between two minors, she injured her left shoulder. She reported the injury but continued to work for four to five months before being placed off work to undergo left shoulder surgery performed by Dr. Kvitne. She was off work for approximately one year. She does report, however, that the AME, Dr. Berryman, released her with permanent restrictions and she believes that she had a permanent disability rating of 42%. She does not believe there was a psychiatric aspect to that claim. She cannot recall any other specifics regarding the settlement of that claim. When she returned to work, Ms. Johnson felt that she was treated in a discriminatory fashion as retaliation for having filed a claim … She filed a grievance and the grievance was ignored … Ms. Johnson reports the onset of psychiatric and physical symptoms in response to work stressors. In December 2012, she experienced the onset of a skin disorder on her face … Ms. Johnson has been receiving treatment from Dr. Sobol, an orthopedic surgeon, and his colleagues, for musculoskeletal injuries. From a physical perspective, Ms. Johnson reports that she was diagnosed with hypertension approximately six years ago. Her blood pressure was controlled with medication … She experiences daily moderate pain in her back that is worse in the morning and with activities including prolonged sitting and standing. She continues to experience tension in her right shoulder and tingling down right arm has started only two or three weeks ago. Headaches persist but have diminished in intensity since she stopped working and only occur now when she talks about her stressful work environment. She is chronically fatigued secondary to difficulty sleeping. From a psychological perspective, Ms. Johnson remains anxious since December 2012. She experiences difficulties falling asleep and staying asleep … Irritability has developed over the last year secondary to work stressors and has diminished since she has been off work. She is tearful when she thinks about her difficulties in the workplace. She reports a diminished libido since July 2014. She experiences difficulties with concentration and memory since July 2014. She has gained 15 pounds since she has been off work," date of injury is listed as July 10, 2009. Past medical history: Hypertension, controlled with medication; headaches. Current complaints: "She experiences daily moderate pain in her back that is worse in the morning and with activities including prolonged sitting and standing. She continues to experience tension in her right shoulder and tingling down right arm has

started only two or three weeks ago. Headaches persist but have diminished in intensity since she stopped working and only occur now when she talks about her stressful work environment. She is chronically fatigued secondary to difficulty sleeping. From a psychological perspective, Ms. Johnson remains anxious since December 2012. She experiences difficulties falling asleep and staying asleep … Irritability has developed over the last year secondary to work stressors and has diminished since she has been off work. She is tearful when she thinks about her difficulties in the workplace. She reports a diminished libido since July 2014. She experiences difficulties with concentration and memory since July 2014. She has gained 15 pounds since she has been off work." Diagnosis: 1).Axis I: Unspecified anxiety disorder; somatic symptom disorder, with predominant pain, persistent, moderate; psychological factors affecting another medical condition (depression and anxiety aggravating headaches, hypertension, diabetes); female sexual interest, arousal disorder. 2).Axis II: Not noted. 3).Axis III: Not noted. 4).Axis IV: Chronic pain and physical limitations; work stressors including discriminatory and retaliatory treatment; death of father and brother, March 2013; out of work status since July 10, 2014. 5).Axis V: GAF = 90, premorbid; 55, current. Treatment plan: Psychotherapy for cognitive behavioral treatment, 12 sessions; ongoing evaluation. Causation and apportionment: Not indicated. Work status: Temporarily totally disabled since July 10, 2014.

October 27, 2014, progress report, Dr. Philip Sobol (handwritten). Current complaints: Low back pain, moderate and persistent, "having good and bad days." Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity radiculitis with 5 to 6 mm disc bulge with stenosis at C4-C5, 2 mm disc bulge at C3-C4, 3 mm disc bulge at C5-C6. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis with 2 mm disc bulge at L4-L5 and multilevel facet osteoarthritis. Treatment plan: Lumbar spine traction and brace, pending consideration of denial; lidocaine; home exercises, continue; "patient not interested at this time in pain management consultation … re-released from care as not interested in invasive treatment at this time." Work status: No lifting of heavy objects; no over-the-shoulder or overhead work on the left.

February 12, 2015, progress report, Dr. Daniel Paveloff (handwritten). Current complaints: Ongoing lumbar spine pain and cervical spine pain; illegible. Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity

radiculitis with 5 to 6 mm disc protrusions and stenosis. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis with 2 mm disc bulge at L4-L5 and multilevel facet osteoarthritis. Treatment plan: Lidocaine patches, Tylenol with codeine; ongoing home exercises, continue; ongoing evaluation. Work status: No lifting of heavy objects; no over-the-shoulder or overhead work on the left.

March 24, 2015, progress report, Dr. Hosam Hosein, DC (handwritten). Current complaints: No change in ongoing cervical spine pain, moderate, with tenderness to paraspinals region, left worse than right, with spasms; ongoing and moderate lumbar spine pain with tenderness to paraspinals, with spasms, left worse than right. Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity radiculitis with 5 to 6 mm disc protrusions and stenosis. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis with 2 mm disc bulge at L4-L5 and multilevel facet osteoarthritis. Treatment plan: Ongoing evaluation. Work status: No lifting of heavy objects; no over-the-shoulder or overhead work on the left.

April 16, 2015, permanent and stationary report in psychology, Dr. David Kauss, PhD. Current complaints: Hypertension; diabetes; headaches; weight gain; anxiety, with some improvement; ongoing depression; cognitive impairment; denies suicidal ideation; poor sleep; irritability; impaired concentration and memory. Diagnosis: 1).Axis: I: Unspecified anxiety disorder; somatic symptom disorder with predominant pain, persistent, moderate; female sexual interest and arousal disorder; psychological factors affecting another medical condition (depression and anxiety aggravating headaches, hypertension, diabetes mellitus, weight gain). 2).Axis: II: Not noted. 3).Axis III: Not noted. 4).Axis IV: Chronic pain and physical limitations; work stressors including discriminatory and retaliatory treatment; death of father, March 2013; death of brother, 2013. 4).Axis V: GAF = 90, premorbid; 57, current. Disability status: Permanent and stationary. Causation and apportionment: Not indicated. Work restrictions: Moderate impairment. Vocational rehabilitation: Not noted. Future treatment plan: Possible access to psychiatric treatment, psychotherapy, psychotropic medications; ongoing orthopedic evaluations; ongoing internal medicine evaluations.

April 27, 2015, progress report, Dr. Ghislaine Rodriguez, DC (handwritten). Current complaints: Low back pain with symptoms

into left lower extremity; illegible. Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity radiculitis with 5 to 6 mm disc protrusions and stenosis. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis with 2 mm disc bulge at L4-L5 and multilevel facet osteoarthritis. Treatment plan: Chiropractic therapy, twice weekly for four weeks; ongoing evaluation. Work status: No lifting of heavy objects; no over-the-shoulder or overhead work on the left.

May 27, 2015, progress report, Dr. Ghislaine Rodriguez, DC (handwritten). Current complaints: Ongoing low back pain, not improved with Tylenol with codeine; illegible. Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity radiculitis with 5 to 6 mm disc protrusions and stenosis. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis with 2 mm disc bulge at L4-L5 and multilevel facet osteoarthritis. Treatment plan: Ongoing evaluation; illegible. Work status: No lifting of heavy objects; no over-the-shoulder or overhead work on the left.

July 2, 2015, progress report, Dr. Daniel Paveloff (handwritten). Current complaints: Lumbar spine pain with spasms, left worse than right, with symptoms into left lower extremity; tenderness in paraspinals region with spasms, left worse than right. Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity radiculitis with 5 to 6 mm disc protrusions and stenosis. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis with 2 mm disc bulge at L4-L5 and multilevel facet osteoarthritis. Treatment plan: Ongoing evaluation. Work status: No prolonged sitting; no over-the-shoulder or overhead work on the left.

August 18, 2015, progress report, Dr. Daniel Paveloff (handwritten). Current complaints: Ongoing low back pain with symptoms into left lower extremity; denies genitourinary symptoms; tenderness to bilateral lumbar paraspinals with spasms, with limitation to range of motion. Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity radiculitis with 5 to 6 mm disc protrusions and stenosis. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis with 2 mm disc bulge at L4-L5 and multilevel facet osteoarthritis. Treatment plan: Ongoing home exercises, continue; referral to Dr. Rosen for pain management consultation, pending authorization; Motrin, tramadol; ongoing evaluation. Work status: Not noted.

September 22, 2015, progress report, Dr. Hosam Hosein, DC (handwritten). Current complaints: Moderate and ongoing lumbar spine pain; tenderness to lumbar paraspinals with spasms, with limitation to range of motion, with some symptoms into left lower extremity. Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity radiculitis with 5 to 6 mm disc protrusions and stenosis. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis with 2 mm disc bulge at L4-L5 and multilevel facet osteoarthritis. Treatment plan: Pain management consultation for lumbar spine, pending schedule; Tylenol with codeine; ongoing evaluation. Work status: Not noted.

October 6, 2015, comprehensive pain management consultation, Dr. Randy Rosen. History: "The patient relates that on July 10, 2009, she was attempting to prevent an altercation between two female minors when one of them ran toward her and collided with her, striking her on her shoulder. The patient then proceeded to restrain the female minor who collided with her and in doing so, caused her to jerk her upper torso into a flexed position. The patient immediately experienced left shoulder pain and neck pain radiating to her left upper extremity … She was released to return to work at her usual and customary duties and later that day, she began to experience headaches and difficulty sleeping secondary to her pain … The patient was subsequently returned to work at her usual and customary duties on August 28, 2009, noting increased neck and left shoulder pain. On November 25, 2009, the patient was placed on modified duties, requiring her to sit and observe juvenile offenders. It was at this time that the patient began to notice the onset of lower back pain radiating to her left lower extremity and left hip and bilateral knee pain secondary to her antalgic gait favoring her lower back and left lower extremity." Past medical history: Left shoulder surgery, not detailed; cesarean section; diabetes; hypertension. Current complaints: Moderately severe low back pain, aching, with symptoms into left hip; no genitourinary complaints; denies depression, anxiety; antalgic gait on the left; diffused tenderness to palpation over left side of lumbar paravertebral musculature, with moderate facet tenderness to palpation over L3 through S1, with limitation to lumbar range of motion. Diagnosis: 1).Lumbar disc disease. 2).Lumbar facet syndrome. 3).Left sacroiliac strain. Treatment plan: Left sacroiliac joint injection, pending authorization; possible left-sided L2-L4 medial branch blocks directed at left L3-L4 and L4-L5 facets, pending consideration; possible updated MRI of lumbar spine, pending; Tylenol with codeine; urine toxicology;

ongoing evaluation. Work status: Deferred.

October 9, 2015, agreed medical examination in psychiatry, Dr. Samuel Miles, PhD. Current complaints: Persistent worry and irritability; anxiety; frustration; occasional depression; difficulty falling asleep daily. Diagnosis: 1).Unspecified anxiety disorder. 2).Psychological factors affecting other medical condition. 3).Major depressive disorder, recurrent, in remission. 4).Headaches. 5).Hypertension. 6).Diabetes. 7).Orthopedic conditions, deferred. Disability status: "She reached a point of maximal medical improvement on April 16, 2015 when she was reevaluated by Dr. Kauss"; GAF = 60, "mild to moderate difficulty in functioning." Causation and apportionment: 20% of permanent disability "due to pre-existing sensitivity reflected in patient's history," remaining 80% due to industrial injuries. Work restrictions: Not indicated psychiatrically. Vocational rehabilitation: Not indicated psychiatrically. Future treatment plan: Possible access to four to six psychoeducational or cognitive behavioral psychotherapeutic sessions, as necessary; "otherwise, no additional psychiatric treatment is indicated on an industrial basis."

November 30, 2015, progress report, Dr. Daniel Paveloff. Current complaints: Constant and moderate low back pain; ongoing neck pain; tenderness to palpation of lumbar spine with some guarding over bilateral paralumbar musculature; positive straight leg raising on the left, negative on the right; neurological examination with intact sensation in right lower extremity; decreased sensation to light touch in left lower extremity. Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity radiculitis with 5 to 6 mm disc protrusions and stenosis. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis with 2 mm disc bulge at L4-L5 and multilevel facet osteoarthritis. Treatment plan: Left sacroiliac joint injection, pending schedule; ongoing evaluation. Work status: No lifting of heavy objects; no over-the-shoulder and overhead work on the left.

January 7, 2016, progress report, Dr. Philip Sobol (handwritten). Current complaints: Illegible. Diagnosis: 1).Cervical musculoligamentous sprain and strain with left upper extremity radiculitis with 5 to 6 mm disc protrusions and stenosis. 2).Lumbar musculoligamentous sprain and strain with left lower extremity radiculitis with 2 mm disc bulge at L4-L5 and multilevel facet osteoarthritis. Treatment plan: Ongoing evaluation, not detailed. Work status: Not noted.

February 5, 2019, first report of occupational injury or illness, Dr. Rohan Kapoor. History: On January 25, 2019, "stepped in between two youth engaging in physical fight. Attempted to separate and I was injured to my left upper arm and left lateral thigh." Past medical history: Not noted. Current complaints: Intermittent mild to moderate left lateral thigh pain with soreness; left upper arm pain with soreness; symptoms without numbness, weakness or radiation of pain. Diagnosis: 1).Left thigh contusion. 2).Left upper arm contusion. Treatment plan: Motrin, 800 mg, Tiger balm, topical compounds; ongoing evaluation. Work status: Full duty.

February 13, 2019, occupational medicine progress report, Dr. Rohan Kapoor. Current complaints: Slight and sharp left lateral thigh pain, mild, occasionally dull, aggravated by activities, localized, denies numbness or weakness of left lower extremity; left upper arm stiffness and soreness, pain mostly resolved. Diagnosis: Left thigh contusion. Treatment plan: Physical therapy twice weekly for three weeks, pending authorization; topical compounds; ongoing evaluation. Work status: Full duty.

March 18, 2019, occupational medicine progress report, Dr. Rohan Kapoor. Current complaints: Intermittent, slight and sharp left lateral thigh pain, occasionally dull, denies numbness, tingling or weakness of left lower extremity. Diagnosis: Left thigh contusion. Treatment plan: Physical therapy twice weekly for three weeks, pending authorization; topical compounds; ongoing evaluation. Work status: Full duty.

A group of patient reports and notes from Kaiser Permanente is reviewed, relating to nervousness, stress, anxiety, adjustment disorder with work inhibition, headache, blister, vaginal irritation, women's health, ear pain, otitis media, onychomycosis, rash, obesity, hypertension, pilonidal cyst with abscess, abscess, wound care, right thumb laceration, vaginitis, gynecology, diabetes mellitus type II, congestion, sore throat, upper respiratory infection, abdominal pain, dyspepsia, constipation, nausea, sinus congestion, bronchitis, optometry, menorrhagia, diarrhea, vomiting, cholelithiasis, symptomatic gallstones, laparoscopic cholecystectomy, gastroenteritis, gastritis, lesions of vulva, allergic rhinitis, canker sore, palpation, cellulitis, spider bite, dizziness, sebaceous cyst, dermatitis, non-orthopedic diagnostic reports and procedures, while some are handwritten and found to be illegible.

Duplicate records previously reviewed are noted.

End of review of submitted medical records.

IMPRESSION:

1. Musculoligamentous strain, cervical spine, with axial residuals.
2. No evidence of cervical radiculopathy.
3. Multilevel disc pathology per cervical MRI.
4. Sprain/ strain, left shoulder, with bursitis/ impingement syndrome.
5. History of previous left shoulder arthroscopic surgery.
6. Musculoligamentous strain, lumbar spine, with axial residuals.
7. No evidence of lumbar radiculopathy.
8. Lumbar disc pathology per MRI.
9. Contusion and sprain/ strain, left hip, with clinical evidence of greater trochanteric bursitis.

DISCUSSION:

This history involves 3 incidents that occurred within 6 months. This occurred while working as a probation officer.

On January 25, 2019, she was injured when she stepped between 2 minors that were fighting. She describes an onset of complaints to the left shoulder, arm, lower back, and left leg. She did go on to receive medical care. I did review documentation with mention of the left upper arm and left lateral thigh. She sustained contusion injuries.

She did return to work with ongoing complaints. On March 14, 2019, she was preventing a fight and had contact with a minor. She re-injured those areas. She did go back to work. She did have treatment. Unfortunately, I do not have any particular specific documentation related to that date of injury.

The third incident occurred months later on July 29, 2019. She was assisting a restraint on a combative minor. This went on for an extended period of time, and as a result, she felt an onset of complaints in her neck, left shoulder, arm and lower back, and left leg and hip. She did report this and was seen at Kaiser. She did see Dr. Webb and had treatment. Unfortunately, I have no records from that incident as well.

She did require further temporary disability. She came back to work until August 2019 when she was placed on a home assignment.

I have received records, but, for the most part, these records relate to her prior history. I did evaluate Marvetta previously and provided the parties an extensive report back in 2011. This concerned injury to overlapping areas. There was cervical involvement with imaging findings. There was left shoulder involvement. In fact, she had surgery.

There was lumbar involvement as well. Those areas showed residuals.

While she had some hip complaints, there had been no findings. This is important in light of this current history.

It is important to note that there were overlapping areas of involvement previously.

By history, she states that the case went on to settle. She was afforded future medical care. Unfortunately, however, I do not have any information concerning any settlement. In the schedule of records from the brief letter that I received, this mentions a compromise and release. I do not have that documentation.

There is obviously apportionment to be noted.

With regards to the cervical spine, she has axial residuals. Previously, a cervical MRI had been positive for pathology at multiple levels.

I obtained an updated MRI. This shows hypertrophic change and various levels of disc pathology causing stenosis.

For the left shoulder, there are some findings. When compared to previous, however, I am not convinced that there is any worsening.

For the lumbar spine, she has axial residuals. An MRI does show discogenic bulging with associated stenosis.

Lastly, there are hip findings with trochanteric bursitis.

While the neck, lower back, and left shoulder clearly overlapped with the previous case, the hip findings are new. I will provide an overall updated analysis to compare with previous.

Apportionment is obviously at issue.

I find the applicant to be permanent and stationary/ MMI.

Subjective residuals related to the cervical spine would be intermittent and slight, reaching slight to moderate intermittently and, at times, moderate.

Objectively, there is restriction of mobility with axial findings. There is no radiculopathy. There is significant disc pathology.

For the left shoulder, this would be intermittent and slight, at times reaching slight to moderate.

Objectively, there is limited mobility with response to maneuvers. There is no weakness.

For the lumbar spine, this would be intermittent and slight, reaching slight to moderate intermittently and, at times, moderate.

Objectively, there is limitation of mobility with axial findings. There are MRI findings to be noted with associated stenosis. There is no significant disc disease, however, such as hypertrophic change.

With regards to limitations, I would suggest that she avoid heavy lifting and repetitive bending and stooping as it relates to the neck and back on a prophylactic basis.

Concerning the left shoulder, this would be intermittent and slight, reaching slight to moderate intermittently.

Objectively, there is limited mobility with response to maneuvers. There is no weakness.

I would preclude her from repetitive overhead activities.

As it relates to the left hip, this would be intermittent and slight, reaching slight to moderate intermittently.

Objectively, she has greater trochanteric bursitis with tenderness and some complaints associated with mobility, although range of motion is preserved.

For the hip, she should avoid repetitive climbing and pivoting activities.

For an AMA Guides analysis, the cervical spine would be rated with a DRE model at 7%.

This is not accurate given the disc pathology, and this is a recurrent history. I did calculate the range of motion model previously. Currently, using table 15-7, this would be category IIc, which is 6% and 3% to the other levels amounting to 9%.

The range of motion is calculated using dual inclinometry with multiple trials. There is ratable impairment in extension at 1% and rotation at 3% for a total of 4% for mobility. There is no neurologic component. The range of motion model for the neck is 13%.

For the lumbar spine, a DRE model was also 7% as a DRE category II.

Given the fact that this is now a recurrent history and there is disc pathology, I am going to utilize the range of motion model to give the most accurate updated impairment.

Using table 15-7, this would be category IIb, which is 5% and 1% to the other level amounting to 6%. The range of motion is calculated using dual inclinometry. Flexion is 2% and extension 2% for a total of 4%. This is 10%. The cervical spine, therefore, would be appropriately rated at 13%, while the lumbar spine is 10%. This is greater than previous, acknowledging that there have been further injuries.

For the left shoulder, this is 2% upper extremity for loss of flexion and 2% in abduction and 2% internal rotation for a total of 6%. There is 10% for the previous acromioclavicular joint resection. This would be a total of 15% upper extremity converting to a 9% whole person impairment. This is less than previous. Based on the analysis, there is no further aggravation with regards to this new history concerning the left shoulder.

Lastly, for the hip, there is trochanteric bursitis, which is rated at 3% using a diagnostic-based estimate from table 17-33. This is valid.

Therefore, the current impairment is 24% whole person. This is made up of the neck, back, and left hip. The left shoulder is

not included as there is no worsening as compared to the previous case and analysis.

She did return to work but is currently on a home assignment.

Future care is indicated to the extent that she requires access to orthopedic followup and further testing if necessary. This may include imaging studies. Physical therapy, medications, and injections may be warranted. There is no indication for any future surgery.

As it relates to causation, this is industrial. I evaluated the applicant previously back in 2011. I found impairments to the neck, back, and left shoulder.

Again, the left shoulder impairment currently is less than previous. I do not believe there has been a further injury to the left shoulder that has resulted in aggravation with additional impairment. Therefore, the left shoulder is pre-existing as it relates to the earlier injury. There was surgery.

The left hip had been mentioned previously; however, there had been no findings. Therefore, I am not apportioning the left hip to the earlier history. There are currently findings of greater trochanteric bursitis. With regards to the left hip, I would apportion to this subsequent history.

There are multiple dates of injury. It is difficult to determine exactly what happened following each of these incidents. There are 3 incidents within 6 months. While this is industrial, I do not believe one could reasonably separate 3 incidents and parcel out contributing factors. Therefore, the left hip would be industrial as it relates to a combination of factors concerning 3 incidents within 6 months.

The neck and back are more complicated. With regards to the neck and back, there was already a discussion regarding contributing factors. That case settled. I do not have information, although there is reference made in the schedule of record that this was a compromise and release. If this was an award, then obviously, I will need to see that information. If this was indeed a compromise and release, then there would be apportionment per Labor Code Section 4663.

For the lumbar spine, there had been some earlier findings. There are further findings currently on the MRI. There are no underlying factors such as degenerative factors per the lumbar

MRI. The minimal spondylolisthesis at L3-4 is incidental. I do not see any loss of disc height or hypertrophic change of significance.

With regards to the lumbar spine, therefore, I would apportion 50% to the earlier history and 50% to this subsequent history of injuries.

For the cervical spine, I had addressed the fact that 15% had related to factors, which pre-existed the incident to include underlying degenerative factors. Eighty-five percent had related to industrial factors. This must now be further apportioned. Of the remaining 85%, 50% would relate to the earlier case as there had already been significant imaging findings. Thirty-five percent would now relate to this subsequent history of injury.

This is complicated. I have tried to sort this out. This is complicated in light of the overlapping history from earlier injury.

I hope this is clear, however, and if the parties need me to address anything else, then please advise.

DISCLOSURE:

During this evaluation, the patient was interviewed by a historian, Maria Ramirez, for an initial history. The entire medical history was reviewed in detail by myself with the patient. Medical records were initially reviewed and summarized by Maria Ramirez. The records were also reviewed by the undersigned in their entirety. The entire physical examination was performed by myself, including various measurements. Assessment was strictly done by the undersigned. The above evaluation was carried out at 2080 Century Park East, Suite 1006, Los Angeles, California. All the dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. Transcription was provided by Athreon Corporation.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by myself and was in compliance with

the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2."

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628 (j)): "I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

In compliance with Labor Code 4906 (g), "I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other considerations, whether in the form of money or otherwise, as compensation or inducement for any referral examination or evaluation."

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

If there are any further questions regarding this, please do not hesitate to contact my office.

Thank you very much for allowing me to participate in the evaluation of this patient.

This report and declaration were signed in the County of Los Angeles on 10/14/2020.

Yours truly,

Jeffrey A. Berman, M.D.
Diplomate, American Board of
Orthopaedic Surgery
Electronically Signed

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CLIU 13% .35% sclera

Cumbar 10% 50-50

Ct shoulder no worse

hip 3%

** PLEASE CIRCLE ONE NUMBER FOR EACH QUESTION DO NOT ADD ANY COMMENTS AND / OR TOTAL SCORES.*

NAME: Johnson Marcella Date: 2·13·20

1. Pain (Self- report of severity)

A. Rate how severe your pain is right now at this moment. (Circle a number)

0 1 2 3 4 5 6 (7) 8 9 10

No pain — Most severe pain can imagine

B. Rate how severe your pain is at its worst. (Circle a number)

0 1 2 3 4 5 6 7 8 9 (10)

None — Excruciating

C. Rate how severe your pain is on the average. (Circle a number)

0 1 2 3 4 5 6 (7) 8 9 10

None — Excruciating

D. Rate how much your pain is aggravated by activity. (Circle a number)

0 1 2 3 4 5 6 7 8 9 (10)

Activity does not Aggravate pain — Excruciating following any activity

E. Rate how frequently you experience pain. (Circle a number)

0 1 2 3 4 5 6 (7) 8 9 10

Rarely — All of the time

2. Activity Limitation or Interference

A. How much does your pain interfere with your ability to walk 1 block? (Circle a number)

0 1 2 3 4 5 6 7 8 (9) 10

Does not restrict ability to walk — Pain Makes it impossible For me to walk

B. How much does your pain prevent you from lifting 10 pounds (A bag of groceries)? (Circle a number)

(0) 1 2 3 4 5 6 7 8 9 10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to sit for ½ hour? (Circle a number)

0 1 2 3 (4) 5 6 7 (8) 9 10

Does not restrict ability to sit for ½ Hour — Impossible to sit for ½ Hour

D. How much does your pain interfere with your ability to stand for ½ hour? (Circle a number)

0 1 2 3 (4) 5 6 7 8 9 10

Pain does not interfere with ability to stand at all — Unable to Stand at all

E. How much does your pain interfere with your ability to get enough sleep? (Circle a number)

0 1 2 3 4 5 6 7 (8) 9 10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to participate in social activities? (Circle a number)

0 1 2 3 4 (5) 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to travel up to 1 hour by car? (Circle a number)

0 1 2 3 (4) 5 6 7 8 9 10

does not interfere with ability to travel 1 hour by car — Completely interferes travel 1 hour by car

H. In general how much does your pain interfere with your daily activities? (Circle a number)

0 1 2 3 4 (5) 6 7 8 9 10

Does not interfere with the daily activities — Completely interferes with my daily activities

I. How much do you limit your activities to prevent your pain from getting worse? (Circle a number)

0 1 2 3 (4) 5 6 7 8 9 10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your relationship with your family / partner / significant others? (Circle a number)

0 1 2 3 (4) 5 6 7 8 9 10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do job around your home? (Circle a number)

0 1 2 3 4 (5) 6 7 8 9 10

Does not interfere — Completely unable to do any job around home

L. How much does your pain interfere with your ability to shower or bathe without help from someone else? (Circle a number)

0 1 2 3 (4) 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to Shower or bathe without help

M. How much does your pain interfere with your ability to write or type? (Circle a number)

(0) 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to dress yourself? (Circle a number)

(0) 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to engage in sexual activities? (Circle a number)

0 1 2 3 4 (5) 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to concentrate? (Circle a number)

0 1 (2) 3 4 5 6 7 8 9 10

Never — All the time

Q. How much does your pain interfere with your ability to see, hear and speak? (Circle a number)

(0) 1 2 3 4 5 6 7 8 9 10

Never — All the time

R. How much does your pain interfere with your ability to grasp and tactile discrimination (sense of touch) (Circle a number)

0 1 2 3 4 5 6 7 8 9 10

Never All the time

3. Individual's report of effect of Pain on Mood

A. Rate your overall mood during the past week. (Circle a number)

0 1 2 3 4 5 6 (7) 8 9 10

Extremely High / Good Extremely Low / bad

B. During the past week, how anxious or worried have you been because of your pain? (Circle a number)

0 1 2 3 4 5 (6) 7 8 9 10

Not at all anxious / worried Extremely anxious / worried

C. During the past week, how depressed have you been because of your pain? (Circle a number)

0 1 2 3 (4) 5 6 7 8 9 10

Not at all depressed Extremely depressed

D. During the past week, how irritable have you been because of your pain? (Circle a number)

0 1 2 3 (4) 5 6 7 8 9 10

Not at all irritable Extremely irritable

E. In general, how anxious / worried are you about performing activities because they might make your pain / symptoms worse?

0 1 2 3 4 5 6 (7) 8 9 10

Not at all anxious / worried Extremely anxious / worried

4. How does your pain level interfere with this activity of daily living

Activity	Example	Rating- Please	Circle	One
Self-Care, Personal Hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating	(Mild- Moderate)	Moderate-Severe	Severe
Communication	Writing, typing, seeing, hearing, speaking	Mild- Moderate	Moderate-Severe	Severe
Physical Activity	Standing, Sitting, reclining, walking, climbing stairs	Mild- Moderate	(Moderate-Severe)	Severe
Sensory Function	Hearing, seeing, tactile feeling, tasting, smelling	Mild- Moderate	Moderate-Severe	Severe
Nonspecialized hand activities	Grasping, lifting, tactile discrimination	Mild- Moderate	Moderate-Severe	Severe
Travel	Riding, driving, flying	(Mild- Moderate)	Moderate-Severe	Severe
Sexual function	Orgasm, ejaculation, lubrication, erection	(Mild- Moderate)	Moderate-Severe	Severe
Sleep	Restful, nocturnal sleep pattern	Mild- Moderate	(Moderate-Severe)	Severe