ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

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

August 30, 2023

Workers Defenders Law Group
Natalia Foley, ESQ.
751 S. Weir Canyon Road Stuie 157-455
Los Angeles, CA 90048

Re:	Patient:	Smith, Pepper
	SSN:	XXX-XX-XXXX
	EMP:	State of California
	INS:	SCIF
	Claim #:	06758786
	WCAB #:	ADJ16540205
	DOI:	CT: 07/31/2021-07/31/2022

PRIMARY TREATING PHYSICIAN'S MEDICAL LEGAL PERMANENT & STATIONARY EVALUATION ML-201 REPORT

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Medical Legal Permanent & Stationary Evaluation on August 30, 2023, in my office located at 6221 Wilshire Boulevard, Suite 604, Los Angeles, CA 90048. The information contained in this report is derived from a review of the available medical records, as well as the oral history as presented by the patient.

The history and examination were conducted with the assistance of a chaperone by the name of Arlene Vargas.

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

ML-201 – This is a Comprehensive Medical-Legal Evaluation.

Number of pages of records reviewed in preparation of this report =	2024
Subtract 200 pages for MLPRR =	**1824**
Total Billable MLPRR Units=	1824

The patient is being seen today at the request of the applicant attorney for a med legal evaluation as per the enclosed copy of the request.

Labor Code § 4622(a) provides: "For purposes of this article, a medical-legal expense means any costs and expenses incurred by or on behalf of any party . . .which expenses may include X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony . . . for the purpose of proving or disproving a contested claim."

Title 8, California Code of Regulations, § 9793 provides:

(b) "Contested claim" means any of the following:

(1) Where the claims administrator has rejected liability for a claimed benefit. (2) Where the claims administrator has failed to accept liability for a claim and the claim has become presumptively compensable under Section 5402 of the Labor Code. (3) Where the claims administrator has failed to respond to a demand for the payment of compensation after the expiration of any time period fixed by statute for the payment of indemnity benefits, including where the claims administrator has failed to either commence the payment of temporary disability indemnity or issue a notice of delay within 14 days after knowledge of an employee's injury and disability as provided in Section 4650 of the Labor Code. (4) Where the claims administrator has accepted liability for a claim and a disputed medical fact exists.

(c) "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, and which meets the requirements of paragraphs (1) through (5), inclusive, of subdivision (g).**

Please note that its recent en banc decision in *Brower v. David Jones Construction*, 79 Cal. Comp. Cas. 550 (2014), the WCAB stated that a treating physician may properly issue a medical-legal report: (1) if the report is capable of proving or disproving a contested claim; (2) if the cost of the report is reasonably necessary at the time it was incurred; and (3) if the cost of the report is reasonable. **Defendants have denied the Applicant claim, this is a "contested case" within the meaning of Regulation 9793.** This report is in compliance with the requirements of. Labor Code § 4628.

This report and bill should be kept together by the Workers' Compensation carrier for the review company. The claims examiner should forward this report to the defense attorney and nurse case manager. This report serves as a written request for written authorization for today's evaluation/consultation and all additional appropriate treatment. This request is in compliance per AB 775 and with the mandates contained in Reg. 9792.6. Please pay within 60 days to avoid interest and penalties per Labor Code Sections 4603.2 and 5814.

This medical history was obtained with the assistance of medical historian Irma Chavira.

JOB DESCRIPTION:

Ms. Smith was employed by the State of California as a DMV Manager at the time of the injury. She began working for this employer on October 29, 1999. The patient worked full time.

Job activities included supervising, doing transactions, handling customer concerns and complaints, documentation and scheduling new hires, and customer services, working at a desk, using a computer and right handed mouse.

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

The patient is a right-hand dominant female, and she would use the bilateral upper extremities repetitively for simple grasping, power grasping, fine manipulation, keyboarding, writing,

pushing, and pulling, reaching at shoulder level, reaching above shoulder level, and reaching below shoulder level.

The patient worked eight hours per day and five days a week. Normal work hours were 8 a.m. to 5 p.m. Lunch break was 60 minutes. Rest break was 15 minutes. The job involved working 100% indoors.

Prior to her initial evaluation on September 2, 2022, the patient was currently working at her usual and customary job duties with the above employer.

PRIOR WORK HISTORY:

The patient worked for the above employer for 22 and a half years.

HISTORY OF INJURY AND TREATMENT AS PRESENTED BY PATIENT:

CUMULATIVE TRAUMA: 07/31/2021-07/31/2022

The patient states that while working at her usual and customary occupation as a DMV Manager for the State of California, she sustained a work-related injury to her neck, Shoulders, arms, wrist, hand, thumbs, sleep difficulty, and psyche, which the patient developed in the course of employment due to continuous trauma dated July 31, 2021, to July 31, 2022. The patient explains she developed neck pain in March 2020 while working due to an explosion. She received treatment through WC, but her neck progressively worsened due to prolonged posturing while using the monitor and developed worsening left elbow, bilateral thumb and hand pain and numbness due to prolonged keyboarding. The patient explains that on June 2, 2022, she assisted a technician with a customer complaining about making a payment. Ms. Smith and the technician explained that he needed to provide the insurance information, and the customer began to raise his voice. He complained about using the Kiosk and continued to yell. He became more upset and continued to yell, take her picture, and ask for her name. She walked away three times. She noted her manager and admin manager were at her seats watching but did not come to assist her. She became anxious and upset. She threw her hands up and told the customer she could not help him. He continued to yell as she tried to move away from him. She refused to provide him with her last name. He threatened to punch her in her mouth. Her office manager proceeded to assist him in another window, but Ms. Smith felt a lack of concern for her well-being. She experienced a headache and tension in her neck, and the left side of her left shoulder and arm was numbing and tingling. She also experienced aggravated blood pressure at the time of the incident.

On the next day, June 3, 2022, she called her employer and reported the injury. She reported to Kaiser on the job for evaluation. She complained of a headache and numbness in her left shoulder and arm. The doctor told her she would attend to her head and psychological symptoms but needed to report the injury to her insurance carrier (Kaiser), where she had a previous claim. The doctor told her they would not send her to a hostile and stressful environment with headaches and numbness. She was advised to take Ibuprofen. She was taken off work for three weeks.

She returned to work on June 27, 2022, and the numbness and headaches resolved. However, assisting difficult or angry customers triggers her headaches, numbness, and pain. She tries to avoid difficult customers and requests help from her managers. She works with ongoing pain and discomfort.

She has an appointment for a psychological evaluation in September 2022.

In July 2022, she began experiencing abdominal pain. On June 8, 2022, She presented to her PCP by telemedicine. Subsequently, she presented to urgent care for evaluation. A CT scan and an ultrasound were performed. She was told this could be brought on by stress.

Subsequently, she returned to urgent care due to ongoing stomach pain. A colonoscopy was performed on July 25, 2022.

Please note, the patient came under my care on September 2, 2022. Please note, the patient underwent comprehensive course of chiropractic and physiotherapeutic treatment with the undersigned. She reports improvement with the treatment she has received. She is currently receiving acupuncture treatment which is helpful. Please note, the patient was referred to orthopedic spine surgeon, Dr. Edwin Haronian, who prescribed medications and recommended her pain management evaluation and injections to the cervical spine. Please note, the patient came under the care of Dr. Jonathan Kohan as referred by the undersigned, who is an interventional pain management specialist with whom she underwent epidural injections on the 14th of July, which was helpful, and Dr. Kohan is recommending another injection which is being scheduled. The patient does not recall any surgical recommendations. The patient does not recall seeing another specialist in regards to workers' comp case while she underwent treatment with the undersigned. The patient did undergo orthopedic PQME evaluation with Dr. Alexander Christ, which occurred on May 22nd, 2023, as per the patient.

The patient reports she continues working for DMV through the State of California with restrictions as per the undersigned. Please note that significant amount of records have been reviewed. Please refer to review of records section as well as my discussion recommendations section and my opinions as related to the records reviewed. Please note the patient was last seen in my office on July 5th, 2022, which was a follow-up. The patient returns today for a MedLegal evaluation as scheduled by her attorney.

Current Complaints (August 30, 2023):

1. Neck pain with radiation to left shoulder, slight and intermittent.
2. Left shoulder pain, intermittent and slight.
3. Left elbow pain, slight and intermittent.
4. Left wrist and thumb pain with tingling and numbness, intermittent and slight.

5. Right wrist, hand and thumb pain with tingling and numbness of the hand, intermittent and slight.

6. Mid back pain, **resolving**.

7. Anxiety and depression.

8. Hypertension.

9. Abdominal pain.

PAST MEDICAL HISTORY:

Illnesses:

The patient reports a history of intermittent high blood pressure, which she relates was aggravated at the time of the injury.

Injuries:

In March of 2020, while working for the same employer, she suffered an injury to her neck and left shoulder. The patient explains that there is a DWP plant location near her place of employment. There was an explosion, and while she quickly walked over, there was a second explosion. She jerked around to her left side, sustained an injury to her neck and left shoulder, and experienced a severe headache. She was referred for medical care with Kaiser on the Job. Treatment included medicated creams, pain medication, physical therapy, and acupuncture treatment. She does return to the doctor for follow-ups when needed. She continued to have pain in her neck and left shoulder. She has not seen a doctor for about 8 to 9 months.

In 2001, while working for the same employer, she suffered bilateral carpal tunnel syndrome due to cumulative trauma. In 2001 the patient underwent right carpal tunnel surgery, and six months later, she underwent left carpal tunnel surgery. This case was settled with compensation. She relates she fully recovered.

In 2018, the patient was involved in an auto accident when she rear-ended another vehicle. She sustained an injury to her lower back. Treatment included examination, prescribed medication, and physical therapy. She relates she fully recovered.

The patient denied any new injuries.

Allergies:

The patient denied any known allergies.

Medications:

The patient is taking Norco for stomach pain.

Surgeries:

2001: Right carpal tunnel surgery
2001: Left carpal tunnel surgery
1996: Tubal ligation
1999: 2 atopic pregnancies
1999: Removal tube for atopic pregnancy
2017: Hysterectomy
2021: Gallbladder removal surgery

Hospitalization:

The patient denied any hospitalization.

REVIEW OF SYSTEMS:

A review of systems is remarkable for trouble sleeping, muscle or joint pain, stiffness, anxiety, depressed mood, social withdrawal, emotional problems, and stress.

ACTIVITIES OF DAILY LIVING:

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

Travel: As a result of the industrially related injury, the patient states: Difficulty with driving, restful night sleep pattern, and sexual function, with a rating of 3/5.

FAMILY HISTORY:

Mother is deceased and passed away from cancer.

Her Father is deceased and passed away from heart disease.

The patient has two siblings who are alive and in good health. Two siblings passed from drugs and alcohol.

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

SOCIAL HISTORY:

Ms. Smith is a 51-year-old divorced female with four children.

The patient completed some college.

The patient consumes occasional alcohol and does not smoke.

The patient walks and rides her bike for exercise.

The patient does not participate in any sports activities.

The patient has no hobbies.

Physical Evaluation (August 30, 2023) – Positive Findings:

General Appearance:

The patient is a 52-year-old, right-hand dominant female who appeared reported age, and was well-developed, well-nourished, and well-proportioned. The patient appears to be alert, cooperative and oriented x3.

Vital Signs:

Pulse:	75
Blood Pressure:	137/96
Height:	5'3"
Weight:	206

Cervical Spine:

Tenderness was noted over bilateral paravertebral and upper trapezius musculature, greater on the left side. Tenderness was noted over the vertebral regions from C5 through C7 over the bilateral facet joints, greater on the left side.

Left shoulder depression test is positive.

Ranges of motion of the cervical spine were decreased and painful, performed consistently with inclinometer method:

Cervical Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	50	**44**
Extension	60	**40**
Right Lateral Flexion	45	**35**
Left Lateral Flexion	45	**40**
Right Rotation	80	**68**
Left Rotation	80	**70**

Shoulders & Upper Arms:

Right Shoulder:

Deformity, dislocation, edema, swelling, erythema, surgical scars and lacerations are not present upon visual examination of the right shoulder. The shoulder is held in a non-antalgic position.

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

Apprehension, Dugas, Hawkins and empty can test was negative.

Left Shoulder:

Tenderness was noted over the anterior shoulder at insertion of supraspinatus tendon and subacromial and subdeltoid bursa and acromioclavicular joint.

Left Hawkins and empty can tests are positive. Apprehension and Dugas test are negative.

Ranges of motion of the bilateral shoulders were normal without pain.

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

Elbows & Forearms:

Right Elbow:

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

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

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

Left Elbow & Forearm:

Tenderness is noted over the lateral and medial epicondyles.

Left Cozens' and Golfer's tests were positive. Left Tinel's test is negative.

Ranges of motion for the bilateral elbows were normal.

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

Wrists & Hands:

On inspection, surgical scars were noted over the bilateral volar crease and carpal tunnel secondary to carpal tunnel release surgery in about 2001.

Left Wrist & Hand:

Tenderness was noted over the volar crease over the carpal tunnel and carpals as well as over the radial styloid, anatomical snuff box and thenar region.

Left Durkan's test was positive. Finkelstein's test was positive.

Right Wrist:

Positive Durkan's and Finkelstein's test.

Ranges of motion of the right wrist and left wrist were normal **with discomfort at extremes.**

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

Ulnar Deviation	30	30	30
Radial Deviation	20	20	20

Fingers:

Tenderness is noted over the bilateral thumbs at the carpometacarpal and metacarpophalangeal joints.

Bilateral hand digit ranges of motion were grossly within normal limits **with pain during range of motion of the thumbs.**

Grip Strength Testing:

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

Left: 0/0/0
Right: 0/0/0

Motor Testing of the Cervical Spine and Upper Extremities:

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

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

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

Sensory Testing:

C5 *(deltoid)*, C6 *(lateral forearm, thumb & index finger)*, C7 *(middle finger)*, C8 *(little finger & medial forearm)*, and T1 *(medial arm)* dermatomes are intact bilaterally as tested with a Whartenberg's pinwheel.

Upper Extremity Measurements in Centimeters		
Measurements	Left	Right
Biceps	**35**	**35.5**
Forearms	**21**	**20.5**

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

Lower Extremity Measurements Circumferentially & Leg Length in Centimeters		
Measurements (in cm)	Left	Right
Thigh - 10 cm above patella with knee extended	**53**	**53.5**
Calf - at the thickest point	**38.5**	**38.5**
Leg Length - Anterior Superior Iliac Spine To Medial Malleolus	**93**	**93**

Review of records:

Please see addendum 1 section of this report.

Diagnostic Impressions:

1. Cervical myofasciitis, M79.1.
2. Cervical facet-induced versus discogenic pain, multilevel disc protrusions from C2-C3 through C7-T1 with uncovertebral joint hypertrophy and neural foraminal narrowing at multiple levels. Also there was grade I posterolisthesis of C4 on C5 and Modic type 2 endplate degenerative changes at C6-C7 and mild loss of disc height at C5- C6, disc desiccation from C2 through C7 as per MRI dated 10/25/22, M53.82.
3. Cervical radiculitis, rule out, M54.12.
4. Thoracic spine myofasciitis, **resolving,** M79.1.
5. Thoracic facet-induced versus discogenic pain, **resolving,** M54.6.
6. Left shoulder sprain/strain and possible impingement syndrome **as per Dr. Edwin Haronian**, S43.402A/M75.42.
7. Left elbow lateral epicondylitis and brachioradialis tendinitis, M77.12/M75.22.
8. Bilateral thumb de Quervain stenosing tenosynovitis, M65.4.
9. Bilateral carpal tunnel syndrome, G56.03.
10. Status post bilateral tunnel release surgery in 2001 with aggravation.
11. Hypertension, I10.
12. Anxiety and depression, F41.9, F34.1.

13. Gastritis, K29.70.

Discussion and Recommendations:

Please note that the patient's condition has stabilized and reached maximum medical improvement with conservative treatment. This patient's permanent stationary status is unlikely to change without surgical intervention. Please note that significant amount of records were reviewed totaling 2024 pages. The patient has significant records related to multiple internal issues and I defer opinions related to that to appropriate specialists of internist. Please note otherwise the patient's injuries are consistent with the medical records. Please note, this patient did have a prior Workers' Comp case in early 2000s, for which she underwent carpal tunnel release bilaterally. Apportionment is an issue with regards to bilateral carpal tunnel syndrome. Please note the patient did have a specific injury while working for the same employer on April 15, 2020, due to explosion in which she injured her neck and the left arm, shoulder, as well as had significant headaches for which she was treated at the industrial clinic and apportionment is an issues. Please note, the patient did continue working for the same employer with worsening of her condition of the neck and upper extremity. The patient also had an incident on about June 3, 2022, when she suffered significant stress at work and developed worsening neck and left upper extremity pain as well as depression and anxiety. The records reflect the aforementioned. I do not see any other issues in regards to apportionment. Please note that there was an accident in which the patient was involved in, which was an auto accident, when her vehicle was rear-ended in 2018; however, the patient reports that her back was involved and I do not recall reviewing the records to the contrary. Please note, the patient was seen by PQME in the field of orthopedics by the name of Dr. Alexander Christ, who had positive exam findings for cervical spine and upper extremities; however, the patient was given 0% impairment. Please note that I respectfully disagree. This patient does have positive exam findings as well as positive diagnostic studies for which there are impairment ratings as per the AMA guides, fifth edition. Please refer to my impairment section for details.

Please note that I did review of records from a prior injury of April 15, 2020, which was specifically a s permanent and stationary report from treating physician at that time who declared her to have reached maximum medical improvement as of July 12, 2021, with return to full duty and without any impairment from what I recall per records reviewed.

At this time, the patient is **recommended to return to the undersigned on as needed basis.**

The patient is **recommended to continue with the specialist that she is currently treating with as scheduled by the specialist.**

Furthermore, it is **recommended the patient undergo the diagnostics testing as listed below as well as specialty evaluations as listed below.**

Diagnostic studies recommended:

The patient is recommended **upper extremity NCV/EMG study** for further workup of carpal tunnel syndrome and to rule out cervical radiculitis.

Specialty evaluations recommended:

1) The patient is recommended **internal medicine evaluation.**
2) The patient is recommended **psychiatric versus psychological evaluation** for further workup of psych-related complaints.

Medical Causation Regarding AOE/COE:

In my opinion, it is within a reasonable degree of medical probability that the causation of this patient's injuries, resultant conditions, as well as need for treatment with regards to cervical spine, thoracic spine, and bilateral upper extremities are industrially related and secondary to continuous trauma from 07/31/2021 to 07/31/2022 while working for State of California as a DMV Manager.

Please note causation as related to hypertension and gastritis is deferred to appropriate specialist of internist.

Causation as related to psyche is deferred to appropriate specialist of psychiatrist versus psychologist.

Please note that this patient does have prior work-related injury while working for the same employer from March of 2020 to her cervical spine and left shoulder she explains; however, her condition significantly worsened while working due to continue work until present. Apportionment will be an issue and will be discussed when the patient's condition reaches permanent and stationary status. Please note apportionment is also an issue as related to bilateral wrists and hands as this patient did have prior carpal tunnel release surgery due to work-related carpal tunnel syndrome working for same employer.

I concluded my opinion based on this patient's job description, history of injury as reported, medical records (if any provided), as well as the patient's complaints, my physical examination findings and diagnostic impressions, and absent evidence to the contrary.

Permanent and Stationary Status:

The patient's condition has reached permanent and stationary status at this time.

Subjective Factors of Disability:

Please see current complaints section of this report.

Objective Factors of Disability:

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

Work Restriction:

The patient was returned to modified duties. No prolonged posturing. No lifting in excess of 10 pound and furthermore restricted to occasional basis. No repetitive or forceful gripping, grasping, torqueing, pulling or pushing. No prolonged computer work or writing. She must use right epicondylitis brace and bilateral carpal tunnel and thumb splint as needed while working. The patient should be able to rest every 10 minutes of every hour worked as is limited to working 4 hours per day. The patient must work in an ergonomic chair and desk setup. The patient should be able to change positions from sit to stand and stretch as needed based on pain levels. The patient is to work 8 hours per day.

Vocational Rehabilitation Benefits:

In my opinion, the patient is a qualified injured worker if work restrictions cannot be accommodated.

AMA Impairment Analysis:

1. Spine: Cervical spine.
2. Upper Extremity: Bilateral wrist.

Spine:

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

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

Upper Extremity:

1. Right wrist/hand major grip strength impairment is 30% upper extremity impairment by referring table 16-32 and 16-34 on page 509 due to 100% SLI.

2. Left wrist/hand minor grip strength impairment is 30% upper extremity impairment by referring table 16-32 and 16-34 on page 509 due to 100% SLI.
3. Bilateral upper extremity total impairment is 51% by combining right and left upper extremity impairment or 31% whole person impairment by referencing table 16-3 on page 439.

Total Calculated Whole Person Impairment Rating:

Total calculated whole person impairment is 41% by combining 31% upper extremity whole person impairment with 14% spinal impairment

Apportionment to Causation:

Based upon the patient's past medical history and available medical records, I apportion causation with regards to bilateral wrist 50% to prior injury resulting in bilateral carpal tunnel release in early 2000 and 50% to continuous trauma as discussed above. With regards to cervical spine, I apportion causation 100% to continuous trauma as discussed above as the patient returned to full duty without restrictions and was declared MMI on 7/12/2021.

Please note, I reserve the right to change my opinions should additional medical records come forward.

Future Medical Care:

Provisions should be made for further chiropractic, acupuncture, physiotherapy care and treatment, to include both medical and surgical treatment, diagnostic studies of X-rays, MRIs & CT, NCV/EMG, internal medicine consultation, orthopedic consultation, psychiatric, psychological and interventional pain management consultation on an as-needed basis.

Should you have any questions with regard to this report, please contact me at my office.

DISCLOSURE STATEMENT

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

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

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

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

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

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

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

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

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

Sincerely,

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

Signed this 27 day of September, 2023, in Los Angeles, California

Addendum 1 – Review Of records.

Pursuant to Cal Code Regs., Title 8, § 9793(n) the parties attested to **2024** pages being provided for my review which have been received and reviewed by myself in preparation of this report.

A - Review of Legal Records

1) November 04, 2022, Notice of Denial of Claim for Workers' Compensation Benefits, James Kim, Claims Adjuster (State Compensation Insurance Fund): DOI: 07/31/22. After careful consideration of all available information, we have concluded that we cannot pay you workers' compensation benefits. We are denying all liability for your claim of injury because there is insufficient medical evidence available to confirm that your continuous trauma injury to your neck, feet, both legs, lower back, upper extremities, lower extremities, ankles and trunk was caused by employment. We are in the process of obtaining a Panel Qualified Medical Evaluator (QME) list to be issued by the Division of Workers' Compensation – Medical Unit. Upon receipt of this list, your attorney and I will each "strike" a doctor from the three doctor list. The remaining doctor will be utilized as the QME. Your attorney will schedule the QME appointment and will inform me of the date/time of the scheduled appointment. Following your evaluation and upon receipt of the QME report, we will re-assess this determination. If the test results of further investigation change this decision, you will be notified.

2) July 12, 2023, Request for Med-Legal Evaluation, Natalia Foley, Esq. (Workers Defenders Law Group): DOI: CT: 07/31/21 – 07/31/22. Dr. Gofnung agreed to act as the PTP for this client.

   Please be advised that we are in receipt of Panel Qualified Medical Evaluation by Dr. Alexander B. Christ, MD dated 06/20/23. Dr. Christ found applicant to be MMI, with the impairment rating of cervical spine 0% WPI. We objected to the above report.

   We disagree with 0% WPI impairment rating. Please note, that this claim was denied.

   Since the genuine dispute exists as to the nature and the extent of the injury, we request your med legal report to address the issue of causation, mechanism of the injury, impairment rating, apportionment and future medicals. We execute our option to prove our claim in order to receive benefits by requesting Med Legal Evaluation per Lab. Code, § 4620(a). A contested claim exists when the employer knows or reasonably should know that the employee claims entitlement to any benefit arising out of a claimed industrial injury, and the employer fails to accept liability for benefits after the expiration of a reasonable period of time within which to decide if it will contest the claim. [Lab. Code, § 4620(b)], which is the case in this present case.

   Labor Code § 4622(a) provides: "For purposes of this article, a medical-legal expense means any costs and expenses incurred by or on behalf of any party which expenses may

include X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony for the purpose of proving or disproving a contested claim."

Title 8, California Code of Regulations, § 9793 provides:

(b) "Contested claim" means any of the following:
(1) Where the claims administrator has rejected liability for a claimed benefit.

(2) Where the claims administrator has failed to accept liability for a claim and the claim has become presumptively compensable under Section 5402 of the Labor Code.

(3) Where the claims administrator has failed to respond to a demand for the payment of compensation after the expiration of any time period fixed by statute for the payment of indemnity benefits, including where the claims administrator has failed to either commence the payment of temporary disability indemnity or issue a notice of delay within 14 days after knowledge of an employee's injury and disability as provided in Section 4650 of the Labor Code.

(4) Where the claims administrator has accepted liability for a claim and a disputed medical fact exists.

(c) "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, and which meets the requirements of paragraphs (1) through (5), inclusive, of subdivision (g).

Please note that its recent en banc decision in *Brower v. David Jones Construction*, 79 Cal. Comp. Cas. 550 (2014), the WCAB stated that a treating physician may properly issue a medical-legal report: (1) if the report is capable of proving or disproving a contested claim; (2) if the cost of the report is reasonably necessary at the time it was incurred; and (3) if the cost of the report is reasonable.

Since Defendants have denied/delayed the Applicant claim, this is a "contested case" within the meaning of Regulation 9793. Therefore, I am requesting that you perform a Comprehensive Medical-Legal Evaluation ("CMLE") and prepare a report

addressing the issue of whether the injuries claimed by the Applicant in this case are industrially-related to assist me in proving the compensability of the Applicant's claim.

Please ensure that your CMLE Report complies with the requirements of Labor Code § 4628, which provides:

(a) Except as provided in subdivision (c), no person, other than the physician who signs the medical-legal report, except a nurse performing those functions routinely performed by a nurse, such as taking blood pressure, shall examine the injured employee or participate in the non-clerical preparation of the report, including all of the following:

(1) Taking a complete history.
(2) Reviewing and summarizing prior medical records.
(3) Composing and drafting the conclusions of the report.

(b) The report shall disclose the date when and location where the evaluation was performed; that the physician or physicians signing the report actually performed the evaluation; whether the evaluation performed and the time spent performing the evaluation was in compliance with the guidelines established by the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 and shall disclose the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than its clerical preparation. If the report discloses that the evaluation performed or the time spent performing the evaluation was not in compliance with the guidelines established by the administrative director, the report shall explain, in detail, any variance and the reason or reasons therefor.

(c) If the initial outline of a patient's history or excerpting of prior medical records is not done by the physician, the physician shall review the excerpts and the entire outline and shall make additional inquiries and examinations as are necessary and appropriate to identify and determine the relevant medical issues.

(d) No amount may be charged in excess of the direct charges for the physician's professional services and the reasonable costs of laboratory examinations, diagnostic studies, and other medical tests, and reasonable costs of clerical expense necessary to producing the report. Direct charges for the physician's professional services shall include reasonable overhead expense.

(e) Failure to comply with the requirements of this section shall make the report inadmissible as evidence and shall eliminate any liability for payment of any medical-legal expense incurred in connection with the report.

(j) The report shall contain a declaration by the physician signing the report, under penalty of perjury, stating:

"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." The foregoing declaration shall be dated and signed by the reporting physician and shall indicate the county wherein it was signed.

3) July 12, 2023, Attestation Pursuant to Cal Code Regs., Title 8, § 9793 (n), Natalia Foley, Esq. (Workers Defenders Law Group): DOI: 07/31/21 – 07/31/22. I declare that the total page count of the documents provide to the physician is **2024**.

4) August 10, 2022, Application for Adjudication of Claim: DOI: CT: 07/31/21 – 07/31/22. Employer: State of California Betty T Yee State Controller. Body Parts Injured: Trunk – Use for side; multiple parts any combination of above parts. Neck. Back – including back muscles, spine and spinal cord. Upper Extremities – Multiple parts any combination of above parts. Lower Extremities – Multiple parts any combination of above parts. Description of Injury: Stress and strain due to repetitive movement over period of time, injured trunk, neck, lower back, upper extremities and lower extremities.

July 31, 2022, DWC-1: DOI: CT: 07/31/21 – 07/31/22. Description of Injury: Stress and strain due to repetitive movement over period of time, injured left hand, neck, arm, wrist, gastro reflux.

B - Review of Diagnostic Studies

1) January 04, 2008, Ultrasound of the Pelvis, Merrick Tobin Schneider, MD: Impression: 1) 11 cm uterus with some areas of altered echo texture. The endometrium is 1.3 cm. 2) 3.4 cm cyst seen in a 4.6 cm right ovary. 3) Multiple cysts evident in the cervix.

2) May 03, 2013, Bilateral Screening Mammogram, Vijay Rao, MD: Impression: There is no mammographic evidence of malignancy.

3) June 16, 2013, Ultrasound of the Pelvis, Transabdominal and Transvaginal, Dimple Bhasin, MD: Impression: Fibroid, which appears submucosal. Right ovarian cyst (s). Free fluid in the cul-de-sac.

4) August 26, 2013, X-Ray of the Right Knee, Christopher Hsu, MD: Impression: No acute fracture is identified. The alignment is normal. No significant joint disease is noted. No significant soft tissue abnormality is identified.

5) March 30, 2014, X-Ray of the Chest, Ata Rezvanpour, MD: Impression: The lungs are clear. No pleural effusions are seen. The cardio mediastinal silhouette is normal.

6) March 03, 2015, Ultrasound of the Pelvis, Transabdominal and Transvaginal, Andrew Berger, MD: Impression: Fibroid uterus

7) May 21, 2015, Bilateral Digital Screening Mammogram, Vijay Aroor Rao, MD: Impression: Negative. There is no mammographic evidence of malignancy.

8) July 30, 2015, X-Ray of the Right Femur, Monica Almanza, MD: Impression: There is ample soft tissue. No acute fracture is identified. The alignment is normal. No significant joint disease is noted. No significant soft tissue abnormality is identified.

9) September 24, 2015, X-Ray of the Chest, Gary Radner, MD: Impression: There is relatively shallow inspiratory volume and evaluation of lung bases is limited by patient's large body habitus. There is no definite evidence of pneumonia. No pleural effusion or pneumothorax are seen. Heart size appears within normal limits for an AP portable projection.

10) October 07, 2015, Sleep Study, Arash Kharestan, MD: Impression: Normal sleep study with no evidence of sleep related breathing disorder.

11) April 06, 2016, CT of the Head without Contrast, Edward Helmer, MD: Impression: Normal study.

12) October 04, 2016, MRI of the Pelvis with Contrast, Joon Dokko, MD: Impression: Fibroid uterus.

13) October 04, 2016, Bilateral Digital Screening Mammogram, Mojgan Khalpari, MD: Impression: Negative. There is no mammographic evidence of malignancy.

14) November 02, 2017, X-Ray of the Right Knee, Daryl Chen, MD: Impression: No fracture is identified. Specific attention to the patella demonstrates no obvious fracture. Minimal-mild lateral femoropatellar joint space narrowing.

15) May 31, 2018, Bilateral Digital Screening Mammogram, Tina Lynelle Hardley, MD: Impression: Negative. There is no mammographic evidence of malignancy.

16) August 09, 2018, Bilateral Digital Screening Mammogram, Tina Lynelle Hardley, MD: Impression: Negative. There is no mammographic evidence of malignancy.

17) September 16, 2019, Bilateral Digital Screening Mammogram, Khalpari Mojgan, DO: Impression: Benign. There is no mammographic evidence of malignancy.

18) September 10, 2020, CT of the Abdomen and Pelvis with Contrast, Vijay Aroor Rao, MD: Impression: There appear to be multiple gallstones. Recommend right upper quadrant ultrasound to evaluate. 3.7 cm cystic structure within the ovary. Recommend pelvic ultrasound to evaluate if this represents a benign follicular cyst or a more aggressive lesion. Post hysterectomy. Very mild aortic atherosclerosis.

19) September 19, 2020, Ultrasound of the Abdomen, Ramzi Issam Azzam, MD: Impression: Cholelithiasis with gallbladder sludge.

20) September *21*, 2020, Ultrasound of the transabdominal and transvaginal pelvis, Ramzi Issam Azzam, MD: Impression: 1) Status post hysterectomy. 2) Left ovary was not visualized. 3) The ovary is enlarged containing a complete cyst measuring 4x3x2.5 cm with single internal septation corresponding with the finding on CT imaging from 09/10/20. Consider follow-up ultrasound imaging in 6-12 weeks to assess for stability/resolution.

21) August 19, 2021, X-Ray of the Chest, Ata Daniel Rezvanpour, MD: Impression: The lungs are clear. No pleural effusions are seen. The cardio mediastinal silhouette is normal. There is no pneumothorax.

22) October 09, 2021, Bilateral Digital Screening Mammogram, Vijay Aroor Rao, MD: Impression: Incomplete: Needs additional imaging evaluation. The mass in the right breast at 12 o'clock middle depth appears indeterminate. An ultrasound is ordered. The mass in the right breast at 11 o'clock middle depth appears indeterminate. An ultrasound is ordered.

23) October 18, 2021, Ultrasound of the Right Breast, Nishant Mukesh Gandhi, MD: Impression: Benign. There is no sonographic evidence of malignancy. The 9 mm cluster of oval cysts in the right breast at 12 o'clock middle depth appears benign. The 3 mm oval simple cyst in the right breast at 11 o'clock posterior depth appears benign.

24) December 30, 2021, X-Ray of the Left Hand, Monica Yolanda Almanza, MD: Impression: Minimally displaced fracture, middle phalanx, third digit with minimal associated soft tissue swelling. The alignment is normal. No significant joint disease is noted. No significant soft tissue abnormality is identified.

25) January 25, 2022, X-Ray of the Left Hand, Annie Lee, MD: Impression: Healing mildly displaced oblique third middle phalangeal shaft fracture shows unchanged alignment and position.

26) June *28*, 2022, CT of the Abdomen and Pelvis without Contrast, Joon Dokko, MD, Kaiser Permanente: Impression: Colonic diverticulosis without acute diverticulitis. No CT evidence of acute appendicitis. 3.2 cm right ovarian cysts.

27) June 28, 2022, Ultrasound of the Abdomen, Joon Dokko, MD: Impression: Unremarkable exam. S/P Cholecystectomy.

28) June 28, 2022, CT of the Abdomen and Pelvis without no contrast. Joon Dokko, MD: Impression: Colonic diverticulosis without acute diverticulitis. No CT evidence of acute appendicitis. 3.2 cm right ovarian cyst.

29) October 25, 2022, MRI of the Cervical Spine, Andrew Thierry, MD (Expert MRI): Impression: 1) Grade 1 posterior listhesis of C4 on C5. 2) Straightening of the cervical lordosis. 3) Modic type II endplate degenerative changes seen at the apposing endplates of C6-C7. 4) Mild loss of vertebral body height of C5 and C6. 5) Varying degrees of disc desiccation involving C2-C3 down through C6-C7. Moderate associated loss of disc height seen at C5-C6 and C6-C7. 6) C2-C3: A disc protrusion is identified. Disc deformity measures 2.0 mm. 7) C3-C4: A disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord and causes mild spinal canal narrowing. There is no abnormal signal within the spinal cord at this level. Annular fissure is identified. Disc deformity measure 2.6 mm. 8) C4-C5: A disc protrusion is identified. Annular fissure is identified. Disc deformity measures 2-3 mm. 9) C5-C6: A disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord and causes mild spinal canal narrowing. There is subtle increased signal within the spinal cord at this level which may reflect myelopathy in a proper clinical setting. Concurrent right uncovertebral joint hypertrophy is seen. Disc material and uncovertebral joint hypertrophy cause moderate right neural foraminal narrowing. Associated abutment on right exiting nerve root is seen. Annular fissure is identified. Disc deformity measures 2.7 mm. 10) C6-C7: A disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord and causes mild spinal canal narrowing. There is subtle increased signal within the spinal cord at this level which may reflect myelopathy in a proper clinical setting. Concurrent right uncovertebral joint hypertrophy is seen. Disc material and uncovertebral joint hypertrophy cause moderate right neural foraminal narrowing. Disc deformity measures 3.1 mm. 11) C7-T1: A disc protrusion is identified. Disc deformity measures 1.8 mm.

C - Review of all Other Records

1) I reviewed the entire medical file with all pertinent patient information. I have reviewed my initial history, examination and medical file.

2) November 05, 2012, Progress Notes, Jose Cervantes, MD (Family Medicine): HPI: She presents with groin pain on the left side for 1 week. Complain of on/off groin pain for 1 week. She states with certain positions she will pain in the left groin area. Physical Examination: Musculoskeletal: Tight hip flexors bilaterally. Was able to ambulate and twisted the hip and leg in several directions to try to replicate pain, but was not able to. Assessment: Groin pain. Plan: Lab studies were ordered. Heat, massage, trial of NSAIDs were advised. Naproxen (Naprosyn) 500 mg were prescribed. If worsens or fails to improve, needs to see them ASAP.

3) August 26, 2013, Progress Notes, John Miguel, MD (Family Medicine): Subjective: She is a 42-year-old female who sustained a right knee injury 2 days ago. Mechanism of injury:

Fall onto right knee. Immediate symptom: Immediate pain. Symptoms have been constant since that time. Prior history of related problems: No prior problems with this area in the past. Assessment: Knee sprain. Plan: Rest the injured area as much as practical, apply ice packs, and elevate the injured limb, compressive bandage. NSAIDs.

4) November 11, 2013, Progress Notes, Jerusha Emily Stahl, MD (Internal Medicine): Chief Complaint: Patient presents with abdominal pain – patient fell last 10/21/13. Subjective: She complained of abdominal pain. 3 weeks ago she was at a street fair and slipped – hit the pavement on her belly – "like a belly flop" got up, was doing ok, a little sore the next day. Then 3 days later had large bruise on lower left abdomen. All last week had cramping in her stomach – upper left abdomen – started later, coming and going, but stayed all last week. A little bit better today. Bruising is gone. Pain is after eating – her mother had pancreatic cancer so that worries hear. Hasn't looked for a pattern to see what foods make it worse. Objectives: BP: 120/73. Height: 5'3". Weight: 108.047 kg. BMI: 42.21 kg/m2. Assessment/Plan: 1) Abdominal pain: Lab studies were ordered. 2) Vaccine refused by patient: Flu. 3) Health checkup adult: Lab studies were ordered. 4) Ingrown Nail: Referral to podiatry. 5) Skin tag: Removal, fibrocutaneous skin tags, 1 to 15.

5) November 19, 2013, Progress Notes, Chad Hiroshi Kurokawa, DPM (Podiatry): Chief Complaint: Ingrown nail big toe. HPI: She's concerned with painful right hallux ingrown toenail. She has some problem before. Pain with palpation. Irritating in shoe gear. Drainage noted. Erythema noted. Previous treatment – self debridement. Physical Exam: Dermatologic: Right hallux nail plate is incurvated, (medial) border, thickened/mycotic (yes), c-shaped (yes), tenderness to palpation, granular tissue, drainage, surrounding erythema, and edema. Painful – mild. Impression: Ingrown nail. Plan: Medial border big toe, right foot, PNA (partial nail avulsion) with risks discussed in detail.

6) December 04, 2013, Visit Note, Chad Hiroshi Kurokawa, DPM (Podiatry): HPI: She is here for follow-up for removal ingrown toenail on the big toe(s) of the right foot. She is doing well and has no complaints. She has been soaking the foot as instructed and notes minimal drainage. Objective: Vascular: CFT of the operative toe(s) is normal. DP/PT of the operative foot is 2/3. Assessment: Status post phenol matrixectomy of the Medial border of the right big toe nail(s). Plan: 1) Patient to continue soaks until the drainage stops. 2) Patient given shoe gear and activity recommendation. 3) RTC as needed.

7) March 30, 2014, ED Notes, Christian Werner Zimmermann, MD (Emergency Medicine): HPI: She presents with chest pain. Patient with history of obesity comes in with chest pain that began while she was watching TV this evening at 11:30 pm. Pain left parasternal, sharp, lasted 1 minute, P/S 7/10 then relaxed and then 5 minutes later came on again for 1 minute. Objectives: BP: 135/84. Height: 5'3". Weight: 103.42 kg. BMI: 40.4 kg/m2. Review of Systems: Cardiovascular: Chest pain. Physical Exam: Pulmonary/Chest: She exhibits tenderness. Minimal TTP. Assessment/Plan: 1) Chest Pain – rule out ACS (acute coronary syndrome). Labs were ordered. EKG were ordered.

8) October 15, 2014, Visit Note, Geoffrey Alan Yeo, DO (Ophthalmology): Chief Complaint: Last night the patient was cooking (turkey chop) and hot oil splashed in (OD); no problems on left. Last night flushed eye and used cold compress. Currently feels some mile FBS and sees little haze coming and going. Assessment/Plan: Eye exam, screening for eye disorder. Bilateral punctate keratitis: Artificial tears QID for comfort, cold compress as needed. RTC in 1-2years or as needed.

9) October 27, 2014, Visit Note, Melanie Samantha Dewar, MD (Internal Medicine): Subjective: She complains of congestion, sneezing and left sinus pain for 2 days. Mild cough. Objective: Nose is congested. Left maxillary sinus with TTP. Assessment: Viral upper respiratory illness with sinus infection, likely viral. Plan: Symptomatic therapy suggested: Push fluids, decongestants, rest and return office visit as needed if symptoms persist or worsen. Lack of antibiotic effectiveness discussed with her. Call or return to clinic as needed if these symptoms worsen or fail to improve as anticipated. Return if no improvement in 5-7 days, then consider antibiotics.

10) December 22, 2014, Visit Note, Aik Armenovich Gazarian, MD (Family Medicine): Subjective: He complains of congestion, sore throat, nasal blockage and productive cough for 15 days. Objective: Nose is congested. Assessment: Viral upper respiratory illness. Plan: Symptomatic treatment. Symptomatic therapy suggested: Push fluids, rest and return office visit as needed if symptoms persist or worsen. Lack of antibiotic effectiveness discusses with her. Call or return to clinic as needed if these symptoms worsen or fail to improve as anticipated.

11) June 25, 2015, Visit Note, Janina Hanushka Cervera, MD (Internal Medicine): HPI: She complains of 4 days sore throat, headache, body aches, next day little better but then productive cough. Didn't go to work 1 day prior to arrival, but then today hot/cold cough. Review of Systems: Constitutional: Positive for chills, malaise/fatigue and diaphoresis. HENT: Positive for congestion, ear pain and sore throat. Respiratory: Positive for cough. Musculoskeletal: Positive for myalgias and joint pain. Neurological Positive for headaches. Height: 5'3". Weight: 237 lbs. BMI: 41.99 kg.m2. Assessment/Plan: Viral URI: Robitussin, Tessalon Perles, Humidifier and Ibuprofen.

12) July 29, 2015, Telephone Appointment Visit, Jerusha Emily Stahl, MD (Internal Medicine): Chief Complaint: Pain. HPI: Last week leaned against something and felt pain in her right thigh. Look at it, no lump/bruise, shrugged it off – continued to hurt all night, then later that night her upper arm was hurting. Still hurting at night, feels heavy when she lifts it – falls asleep at times. If hits her leg feels a heated sensation that lasts 15-20 minute. Assessment: Myalgia: Unclear without seeing patient, will come in tomorrow for evaluation.

13) July 30, 2015, Progress Notes, Jerusha Emily Stahl, MD (Internal Medicine): Chief Complaint: Leg pain. Arm pain. Subjective: She is here for pain in right upper thigh, feels bruised but no bruise. Hurts when something hits her leg, doesn't hurt to walk. Left shoulder/upper arm feels heavy, not really painful. Objective: Height: 5'3". Weight:

106.3 kg. BMI: 41.52 kg/m2. Assessment/Plan: Right thigh pain: Lab studies were ordered. X-ray of the right femur were ordered. Anemia: Lab studies were ordered.

14) September 24, 2015, ED Notes, Charles Fidel Schmitz, MD (Emergency Medicine): Arrival Time: 18:33. Chief Complaint: Chest pain x 1 hr. HPI: She presents with chest pain x 1 hr. She just stood up at work and had a sudden sharp chest pain that lasted for a few seconds. She had some residual mid chest soreness. Pain did not radiate. Patient is a frequent snoring, wakes up tried even though she goes to bed early. Review of Systems: Cardiovascular: Chest pain. Physical Exam: Obese. Diagnostic Studies: ECG: Nsr with no st or t wave changes that would be consistent with ischemia. Chest x-ray: Normal chest x-ray without infiltrate, mass, pneumothorax or effusion. Normal mediastinum width with a sharp aortic knob. No acute findings (preliminary reading). Visit Diagnoses: Chest pain. Snoring. Fatigue. Plan: Labs were ordered. 08:27: PM patient with no symptoms. Chest pain is atypical, short duration, sharp, no associated symptoms. Discussed with patient the need for weight loss/exercise. Referral for sleep study.

15) September 28, 2015, Progress Notes, Carol Joy Williams Cotton, MD (Obstetrics and Gynecology): Chief Complaint: Fibroids. Physical exam, gynecologic. HPI: She is here to discuss heavy painful periods and to check on fibroids. Assessment: Dysmenorrhea. Uterine Fibroids. Plan: Naproxen (Naprosyn) 500 mg and Levonorgestrel-Ethinyl Estradiol (Levora-28) 0.15-0.33 mg were prescribed. Options to manage periods discussed with patient. Will try to oral contraceptive cycling and continuous options discussed with patient. Diagnoses: Chest pain, primary encounter diagnosis. Snoring. Fatigue. Plan: Discussed with the patient the need for weight loss/exercise. Referral for sleep study.

16) December 17, 2015, Progress Notes, Michael Shekfai Fan, MD (Internal Medicine): HPI: She presents with cough: Cough with mucus for 2 days, had a "violent cough that feels like a knot around stomach area." Unable to sleep at night due to cough. Sore throat: Sore throat for 3 days. Headache: Headache for 2 days. 4 days of sore throat, productive cough – greenish phlegm, nasal congestion. Took OTC meds. Assessment/Plan: Cough: Azithromycin 500 mg and Cheratussin AC 10-100mg/5ml oral liquid were prescribed. Sudafed as needed.

17) February 27, 2016, Visit Notes, Young Il Kim, MD (Family Medicine): Chief Complaint: Pelvic pain. HPI: She is a 43-year-old female with a past medical history of severe obesity who presents for pelvic pain. She thinks that the pain may related to fibroid that was noted on the ultrasound in 2013. She has been experiencing it for 7-8 years now. It has worsened recently. She states she feels like pressure and cramping. The pain is associated with menstrual cycles. She has tried Ibuprofen and Midol without significant relief (not taken regularly however). Menstrual cycles are regularly timed every 28 days and lasts between 7-10 days. Gyne Review of Systems: The current method of family planning is tubal ligation. Last Pap smear: 10/15/12; 09/04/09; 12/04/07. Last Mammogram Test: 10/05/12. Assessment/Plan: Female pelvic pain. Dysmenorrhea: NuvaRing 0.12-0.015 MG/24 hr. vaginal ring. Ultrasound of the pelvis, transabdominal and transvaginal,

complete were ordered. Ibuprofen 800 mg were prescribed. Vaccination for Influenza: Flu vaccine administered.

18) April 06, 2016, ED Notes, Lisa Martine Sanders, MD (Emergency Medicine): HPI: She presents with headache. Around 10:30 am, she developed a headache on the back of his head. Felt sharp and was strong. She felt shaky and dizzy. She doesn't normally get headaches. Sat down and had some celery and water. She was picked up by her husband at work and now she feels like symptoms are mostly gone. She also mentions that she has a heavy period right now and wondering if this has contributed to headache. Review of Systems: Neurological: Dizziness and headaches. Impression: Headache. Anemia. Plan: CT of the head without contrast were done and reviewed. Follow-up with Dr. Jerusha Emily Stahl. Given strict headache precautions.

19) June 06, 2016, Progress Notes, Carol Joy Williams Cotton, MD (Obstetrics and Gynecology): Chief Complaint: Physical exam, gynecologic. HPI: She is here to discuss heavy periods that still come despite taking the birth control pills which were prescribed continuously. Patient however actually did not take the pills correctly to skip periods. Although she did not take the placebo pills she did not start the new pill back and thus still had heavy cycles. Objective: BP: 126/73. Height: 5'3". Weight: 106 kg. BMI: 41.41kg/m2. Assessment: Routine gyn exam including cervical pap (primary encounter diagnosis). Screening for HPV. Abnormal perimenopausal bleeding. Screening for breast cancer. Plan: Mammogram bilateral screening sequential were ordered. HPV Test were ordered. Levonorgestrel-Ethinylestradiol (Levora-28) 0.15-0.03 mg were prescribed. Surgical pathology were ordered. Gyn cytology were ordered. Endometrial biopsy were done. Follow-up in 3-4 months.

20) August 22, 2016, Visit Note, Daniel Vargas, PA (Family Medicine): Chief Complaint: Laceration of finger: Right index, small laceration with no bleeding during screening. Subjective: She presents with superficial open wound to right index finger since this afternoon. She states at work in the DMV, as passing paper to customer, service dog bit her. Patient cleaned wound right away. Review of Systems: Skin: Open wound: Right index finger. Physical Exam: Musculoskeletal: Right Hand: She exhibits tenderness and laceration. Assessment: Cause of injury, dog bite, initial encounter. Open wound of right index finger, initial encounter. Plan: Amoxicillin-Pot Clavulanate (Augmentin) 875-125 mg were prescribed. Follow-up with OHS.

21) August 25, 2016, Visit Note, Carol Joy Williams Cotton, MD (Obstetrics & Gynecology): Chief Complaint: Physical exam, gynecologic. HPI: She is still having episodes of heavy bleeding despite the oral contraceptive use continuous. She has not yet completely ready for surgery and would like to try Mirena IUD. She has a friend who likes it. Objective: Height: 5'3". Weight: 104 kg. BMI: 40.63kg/m2. Assessment: Weight loss counseling. IUD Insertion. Presence of IUD. Uterine Fibroids. Menorrhagia. Plan: MRI of the pelvis without/with contrast were ordered. Mammogram bilateral screening sequential were ordered. Referral health education (Weight Management). Levonorgestrel (Mirena) 20 mcg/24 hr. (5 years) UTRN IUD. Naproxen (Naprosyn) 500 mg were ordered.

22) August 26, 2016, Progress Notes/Doctor's First Report of Occupational Injury or Illness, Emily Thuan Nguyen, MD (Family Medicine): Mechanism of Injury: Puncture or laceration. She reports reaching over for a customer's form when a service dog bit her right index finger. Injury Date: 08/22/16. Chief Complaint: Finger pain. Subjective Complaints: Treatment History for this Injury: She states her symptoms started immediately. She was initially seen for the injury at Kaiser Urgent Care. Current Complaints Today: Upper Extremities: Right index finger. Right Index Finger: Quality: Dull. Timing: Intermittent. Duration: 4 days. Relieving Factors: NSAIDs. Regarding patient complaints: RHD. Right index finger with superficial laceration – 1 centimeter long. Work Status before this visit: Full duty. Objective Findings: BP: 136/77. Physical Examination: Right Hand: Right index finger medial aspect of distal phalanx with superficial laceration – 1 centimeter in length. Diagnosis: Cause of injury, dog bite, initial encounter. Plan: Complete course of Augmentin two times a day for 7 days. Ibuprofen and cool compression as needed for pain. No follow-up indicated. Discharged to pre-injury work status.

23) October 06, 2016, Progress Notes, Jerusha Emily Stahl, MD (Internal Medicine): Chief Complaint: Physical exam, annual. Arm pain – left upper. Subjective: She is here for physical exam. She complains of arm pain – left upper arm. Bothers her at night, bad during the night and sore when she wakes up – better during the day – sometimes pain goes up into her neck and other times in her hand – for the past weeks – taking Advil for pain and occasional *T#4* that her daughter had – also feels a heaviness. Physical Exam: Left shoulder positive impingement sign. Assessment/Plan: Routine Adult Health Check-up Exam, primary encounter diagnosis: Lab studies were ordered. Vaccination for Influenza: Flu vaccine were given. Left Rotator Cuff Syndrome: Exercises given. Ibuprofen 800 mg were prescribed.

24) March 27, 2017, Progress Notes, Elisa Danielle Lansdowne, MD (Obstetrics & Gynecology): History: She was referred by Dr. Williams for 4.5 cm submucous fibroid and menorrhagia. Considering hysteroscopic resection. Her fibroid is on the large size to be successfully removed with this procedure and it is possible it could take 2 procedures to remove the entire fibroid even using the XL device due to reaching the fluid deficit before the entire fibroid is resected. Easy recover with this compared to hysterectomy. However, still could have inadequate bleeding and require additional surgery before menopause. If she prefers the procedure that will absolutely solve her problem and never have bleeding again, that would be hysterectomy instead. Plan diagnostic hysteroscopy to identify fibroid, then hysteroscopic resection. Risks include infection, bleeding, pain, damage to bowel, bladder, nerves, vessels, possible blood transfusion, anesthetic reaction, blood clots, or death. Hysteroscopy may also cause fluid overload or uterine perforation. If perforation is suspected, laparoscopy may be performed to evaluate for possible bleeding, damage to surrounding structures, or to repair of uterus. Most perforations are small, do not require intervention, and heal without subsequent consequence. If the fibroid does not appear to be intracavitary on hysteroscopy, there is a possibility that we do only a Dilation and Curettage and terminate the procedure. The indications, risks, and benefits of total

laparoscopic hysterectomy were discussed with the patient, including the risk of infection, bleeding, pain, damage to bowel, bladder, ureters, nerves, vessels, possible blood transfusion, anesthetic reaction, blood clots, or death. They discussed the risks and benefits of removing her ovaries, including the loss of hormone production and menopause and possible risks of hormone replacement therapy (increased risk of blood clots or stroke, decreased risk of hot flashes, osteoporosis, colon cancer, no increased risk of breast cancer with estrogen replacement alone), and the benefits of decreased risk of ovarian cancer by 98%.

They discussed removing both fallopian tubes as this has been shown to reduce the risk of ovarian cancer in the future. They also discussed the risks and benefits of maintaining her ovaries, including natural hormone production for a few more years (including testosterone production) and research studies indicate benefit to keeping the ovaries if hysterectomy is performed in women up to age 65 years. Plan ovarian preservation given age. They also discussed the possibility of an exploratory laparotomy if we were unable to complete the surgery laparoscopically for any reason. Recommend removing the cervix unless there is extensive scarring of bladder to cervix making the surgical risk of removing the cervix outweigh the benefits of potentially avoiding abdominal morcellation and no future pap tests. Approximately 5% of women will have cyclic bleeding after supracervical hysterectomy, which may be bothersome enough to require future removal. If bladder or ureteral damage is suspected, cystoscopy may be performed. Patient prefers to try hysteroscopic resection first. Dr. Lansdowne does not think that she will have a better chance at removing the entire fibroid in the OR v. The office. Patient prefers office procedure. Reviewed expectations for office procedure, including picking up pain medications prior to surgery, signing consent form on arrival, taking oral pain medications, Toradol shot, paracervical block, expectations for discomfort during procedure, time required, ride required due to sedation, and recovery time. Can have up to 3 days off work for mild cramping. Will call patient with pathology results a few days after surgery when available. Questions answered. Medications verified to pharmacy of patient's choice to pick up before procedure date.

25) June 21, 2017, Office Hysteroscopy Procedure Report, Elisa Danielle Lansdowne, MD (Obstetrics & Gynecology): Procedure Performed: Hysteroscopy using MyoSure device.

26) August 02, 2017, H&P Notes, Elisa Danielle Lansdowne, MD (Obstetrics & Gynecology): Chief Complaint: Patient education pre-operative. HPI: She is a 46-year-old G8P4044 with history of fibroid uterus and menorrhagia status post attempted in office resection of a 4 cm submucous fibroid. Part of the fibroid was removed, but not the entire fibroid. She was offered repeat attempt in office of in OR to resect fibroid or hysterectomy for definitive intervention. Here for Pre-op evaluation for total laparoscopic hysterectomy. Assessment/Plan: Surgical procedure: Total laparoscopic hysterectomy, bilateral salpingectomy, and cystoscopy.

27) August 17, 2017, Operative Note, Elisa Danielle Lansdowne, MD (Obstetrics & Gynecology): Pre-Op Diagnosis: Uterine fibroids. Post-Op Diagnosis: Uterine fibroids.

Procedures: Abdominal hysterectomy laparoscopic. Salpingectomy laparoscopic (Left). Cystoscopy. Intra-abdominal lysis of adhesions laparoscopic.

28) August 17, 2017, Discharge Summary Note for Sameday Gyn Surgery, Nathan Riley, MD (Obstetrics & Gynecology): Date of Admission: 08/17/17. Date of Discharge: 08/17/17. Pre-Op Diagnosis: Uterine Fibroids. Procedures Performed: Abdominal hysterectomy laparoscopic. Salpingectomy laparoscopic (Left). Cystoscopy. Intra-abdominal lysis of adhesions laparoscopic. Hospital Course: The patient was admitted on 08/17/2017 for same day gyn surgery. Procedures listed above. No complications. EBL 75 ml. She was discharged home same day in stable condition per PACU protocol. Current Discharge Medication List: Instructed to stop taking Medroxyprogesterone (DEPO-PROVERA) 150 mg/ml IM Susp., and to continue hydrocodone-acetaminophen (Norco) 5-325 mg, Ibuprofen (Motrin) 800 mg, Simethicone (Mylicon) 80 mg, and Docusate Sodium (Colace) 100 mg.

29) September 15, 2017, Progress Notes, Elisa Danielle Lansdowne, MD (Obstetrics & Gynecology): HPI: Status post total laparoscopic hysterectomy 4 weeks ago. No problems. Very happy. Past Medical History: Iron deficiency anemia – 10/13/16. Severe obesity – 04/11/06. Uterine fibroids – 08/25/16. Vitamin D deficiency – 03/30/11. Assessment/Plan: Aftercare for gynecological surgery. History of total hysterectomy, no vaginal pap smear required. Severe obesity, BMI 40-44.9: Doing well. Return as needed.

30) November 02, 2017, Progress Notes, Clare Tuite, PA: Chief Complaint: Fall – She states she fell outside on concrete 2 days ago. Pain in right knee, thigh, and arm since fall. She fell 2 days ago. Hit right knee scraped it. Feels sore all over. Objective: BP: 130/77. Height: 5'3". Weight: 107.5 kg. BMI: 41.98 kg/m2. Physical Examination: Musculoskeletal: Right Knee: She exhibits decreased range of motion and bony tenderness. Tenderness found. Abrasion to right patella. Assessment: Cause of injury, fall, initial encounter. Declines influenza vaccination. Right knee joint pain. Arthritis of right knee. Plan: X-ray of the right knee were ordered. Hydrocodone-Acetaminophen (Norco) 5-325mg were prescribed. Ice compress advised. Advil advised. Rest.

31) November 16, 2017, Progress Notes, Analiza Lontok Sanchez, DO (Family Medicine): Chief Complaint: Flu-Like symptoms: Fever, cough, congestion, right ear pain for 2 days. HPI: She complains of moderate URI symptoms which include nasal congestion, sore throat, and cough. Symptoms started 2 days ago. She felt she had fever yesterday which resolved. Review of Systems: HENT: Positive for congestion, ear pain and sore throat. Respiratory: Positive for cough. Physical Exam: Nose: Mucosal edema and rhinorrhea present. Assessment: URI (Upper respiratory infection). Vaccination for influenza. Plan: Vaccine Influenza were administered. Codeine-Guaifenesin 10-100 mg/5 ml were prescribed. Lab studies were ordered.

32) November 24, 2017, Progress Notes/Telephone Appointment Visit, Olivera Cuk, MD (Internal Medicine): Reason for TAV: Sinus congestion. HPI: She has congestion and cough for last 2 weeks, seen in the office and Cheratussin was prescribed which helped

with cough. Last few days patient has lot of sinus pressure, congestion and greenish nasal secretion. Assessment: Sinusitis. Plan: Codeine-Guaifenesin 10-100mg/5ml and Azithromycin (Zithromax) 250 mg were prescribed.

33) February 06, 2018, Progress Notes, Patricia Ann Custodio Kai, NP: Chief Complaint: URI (upper respiratory infection) symptoms for 5 days. HPI: She reports coughing and runny nose for 5 days. Feels left ear is congested and on and off chills. Positive head pressure around nose and eyebrows. Review of Systems: Constitutional: Positive for chills, fever and malaise/fatigue. HENT: Positive for congestion, ear pain and sore throat. Respiratory: Positive for cough. Neurological: Positive for headaches. Objective: BP: 143/77. Height: 5'3". Weight: 109.8kg. BMI: 42.87kg/m2. Physical Exam: Left Ear: There is drainage (yellow push) and tenderness. Thick frothy postnasal drip seen. Nonproductive cough during exam. Assessment: Left otitis media. Acute frontal sinusitis. Cough. Plan: Amoxicillin 500 mg, Codeine-Guaifenesin (Cheratussin AC) 10-100 mg/5ml and Acetaminophen (Tylenol) 1000 mg were prescribed.

34) May 31, 2018, Progress Notes, Jerusha Emily Stahl, MD (Internal Medicine): Chief Complaint: Physical examination. HPI: She had hysterectomy last summer – best thing she had ever done – very happy. Up 20 lbs. since her surgery. She feels it a lot more now, feels uncomfortable, clothes don't fit. Bad habits, husband is off work now so she is eating more with him at home. Started walking last week. She stopped drinking soda. Does drink juice – apple juice, grapefruit juice, pineapple juice. Eats out during the day, at home at night. Doesn't always eat lunch. Snacking – eating nuts instead of cookies/cakes. Starbucks every morning – Grande latte (not nonfat). She went to an outside bariatric surgeon. Breasts are very uncomfortable when sleeping- trying to sleep on her back. More back pain in general. Having chest pains – shocking pain, quick sharp pains. White stye in her eye in the past month – doesn't bother her. Ears bother her. Redness to her cheeks and some acne. Objective: Height: 5'3". Weight: 115.2 kg. BMI: 44.99 kg/m2. Assessment/Plan: Routine adult health checkup exam, primary encounter. Screening: Lab studies were ordered. Screening Mammogram for Breast Cancer: Mammogram bilateral screening were ordered. Severe Obesity: Discussed weight loss, ***healthy balance class,*** medications as an option. She would like to go to their pre-op for bariatric surgery orientation and will look into healthy balance. Dr. Stahl advised could have her seen for consult in bariatric med clinic if she wants in the future. Referral health education. Rosacea: Metronidazole (Metrogel) 0.75% gel were prescribed.

35) October 01, 2018, Progress Notes, Rola Nabil Magid, MD (Internal Medicine): Chief Complaint: Vaginal Problem – x 3 days with irritation and abdominal discomfort. Flu Shot – declined. HPI: She states that when wiping has had vaginal irritation for 3-4 days. Review of Systems: Genitourinary: Vaginal Irritation. Objective: BP: 131/77. Height: 5'3". Weight: 107.8 kg. BMI: 42.10kg/m2. Physical Exam: Genitourinary: Creamy curdy acrid white and vaginal discharge found. Assessment: Vaginal irritation. Vaccination for influenza. Vaginal discharge. Plan: Fluconazole (Diflucan) 150 mg were prescribed. Lab studies were ordered. Metronidazole (Vandazole) 0.75% gel were prescribed.

36) January 07, 2019, Progress Notes, Diane Marie Ferguson, MD (Internal Medicine): Chief Complaints: She presents with candidiasis of vagina: repeated. HPI: She is here for third yeast infection since 10/01/18 at which time there is a positive Wet Mount with yeast. She has not been sexually active since September 2018 so without new exposures. She does goes to the gym but showers immediately afterwards. She has been washing her vaginal area with soap. She is s/p total hysterectomy but reports no vaginal dryness. Review of Systems: Genitourinary: Vaginal itching without discharge. Physical Exam: Genitourinary: Vaginal discharge found. Comments: Surgical absent ovaries, cervix and uterus. Assessment/Plan: Vaginitis: Lab studies were ordered. Discontinue soap in area. Miconazole nitrate 2% vaginal cream were prescribed.

37) August 15, 2019, Progress Notes, Kaneesha Juanetta Williams, NP (Obstetrics & Gynecology): Chief Complaint: Vaginal discharge – x 1 day. Subjective: She complains of increased vaginal discharge and vaginal itchiness since yesterday. Reports history of recurrent yeast infections. Objective: Yeast- positive. Assessment/Plan: 1) Candida vulvovaginitis: Lab studies were ordered. Fluconazole 150 mg were prescribed. 2) Vaginitis. 3) Vaginal discharge. 4) Screening Mammogram for Breast Cancer: Mammogram bilateral screening were ordered.

38) January 01, 2020, Progress Notes, Wonjae Chung, MD (Family Medicine): Chief Complaint: URI symptoms for 1 week. HPI: She complains of nasal congestion with sinus pain, post nasal drip for 2 weeks. Intermittent headaches and cough started 1 week ago. Symptoms worse since last night with nasal congestion, body aches and diarrhea. Has upper teeth pain since this morning. Positive history of asthma. She took Dayquil this morning which did not help. Review of Systems: Gastrointestinal: Positive for vomiting (after coughing x3). Physical Exam: Nose: Mucosal edema present. Right sinus exhibits maxillary sinus tenderness. Left sinus exhibits maxillary sinus tenderness. Mouth/Throat: Positive postnasal drip. Assessment/Plan: Sinusitis: Azithromycin (Zithromax) 500 mg were prescribed. Sodium Bicarbonate-Sodium Chloride (Neilmed sinus rinse complete) were prescribed. Fluticasone (Flonase allergy relief) 50mcg/actuation nasal spray solution were prescribed. Benzonatate (Tessalon Perles) 100 mg were prescribed. Lab studies were done. Increase fluids. Continue follow-up with PCP for chronic conditions.

39) January 28, 2020, Progress Notes, Julie Berman, DO: Chief Complaint: Cough for 2 weeks. HPI: She was seen in Urgent Care on 01/01/20. Sinusitis treated with Azithro Max. Influenza negative. She reports cough since diagnosed with sinusitis infection. Reports thick mucus (secretions) – post nasal drip. Watery, itchy eyes. Has coughing fits during the day. Using Flonase – improves cough. Shortness of breath during cough. Used Tessalon Perles – 1 time last week. Has been using sinus rinse for the last 2 weeks. Overall feeling better, but still with cough. Objectives: BP: 149/94. Height: 5'3". Weight: 101.3 kg. BMI: 39.56kg/m2. Review of Systems: Constitutional: Positive for malaise/fatigue. HENT: Positive for congestion. Physical Exam: Nose: Mucosal edema and rhinorrhea present. Mouth/Throat: Posterior oropharyngeal erythema present. Assessment/Plan: Post viral cough: Albuterol (Ventolin HFA) 90 mcg/actuation inhaler were prescribed.

HFAA, Guaifenesin (Mucinex) 600 mg were prescribed. Cetirizine 10 mg were prescribed. Post-Nasal Drip: Cetirizine 10 mg were prescribed. Continue Flonase and sinus rinse. Return to office if develop pain, fever or worsening symptoms. Vaccination for Influenza.

40) March 19, 2020, Progress Notes/Telephone Appointment Visit, Jerusha Emily Stahl, MD (Internal Medicine): Reason for TAV: Follow-up routine. HPI: Patient is doing well. Last visit was 2 years ago. She had a bad flu in January. She had lost 30 lbs; current weight 221 lbs at home. Diet changes, avoiding sugar, eating less. Had gone to class for Bari surgery and then mad diet changes. On vacation now – works at DMV – when she gets back will see if closed. Assessment: Screening. Plan: Lab studies were ordered.

41) April 02, 2020, Progress Notes/Telephone Appointment Visit, Rina Joshi Dave, MD (Family Practice): Reason for TAV: Follow-up routine. HPI: She has history of severe obesity. Noted abdominal pain to lower belly 3 days ago, increased belching and gas. Today she is experiencing epigastric pain, no history of GERD. She took NSAIDs recently due to toothache. P/S 6/10. Assessment/Plan: GERD: Omeprazole (Prilosec) 20 mg and Famotidine (Pepcid) 20 mg were prescribed. Advised to follow-up with PCP is symptoms worsen.

42) April 15, 2020, Progress Notes/Telephone Appointment Visit, Ruth Teshawork Getachew, MD (Family Practice): Reason for TAV: Neck pain. HPI: On 04/10/20, she was running to the window when she saw an explosion, she made an immediately turned around when she heard the explosion. Later on noticed headache, that has since resolved. But patient also had some neck discomfort that improved with NSAIDs and heating pad that evening but continues to have persistent discomfort in left side of neck/shoulder and bottom of her head. This morning noticed some tingling in the left side. Assessment/Plan: Neck muscle strain, initial encounter: Massages and stretches slowly as tolerated, warm patches as needed for pain, NSAIDs as needed for pain. Cyclobenzaprine (Flexeril) 10 mg were prescribed if symptoms not improved with NSAIDs.

43) May 01, 2020, Progress Notes/Doctor's First Report of Occupation Injury of Illness, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaints: Neck and Shoulder pain. Subjective Complaints: She is a 48-year-old female who has worked as a manager I for state of California for the past. Does mostly admin work. Mechanism of Injury: She states she was injured when says injured several areas: Due to moving towards window and turning due to a "startled by loud sound from explosion near the worksite." Current Complaints: Complain of left neck pain and discomfort and left shoulder pain. Diagnoses: Neck muscle strain, initial encounter. Headache. Left shoulder joint pain. Left arm pain. Plan: Referral to physical/occupational therapy for 1-2 times per week for 6 weeks. Acetaminophen 500 mg were prescribed. Diclofenac Sodium (Voltaren) 1% Top Gel were prescribed. Full duty. Anticipate MMI in the next 3-4 months.

44) May 26, 2020, Progress Notes, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaints: Work related injury: Head injury; Neck injury; Arm injury and Shoulder injury. Subjective Complaint: She complains of left neck pain and discomfort

and left shoulder pain and discomfort. Feels better. Has *occ* headache with left upper back muscle tightness. Started physical therapy, completed 4/6 sessions, helpful, doing HEP (home exercise program). Doing full duty. Diagnoses: Neck muscle strain, initial encounter. Headache. Left shoulder joint pain. Left arm pain. Plan: Discontinue Flexeril. Methocarbamol (Robaxin) 500 mg were prescribed.

45) June 23, 2020, Progress Notes, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaint: Work related injury: Head injury; Neck injury; Arm injury and Shoulder injury. Subjective Complaint: She complains of left neck pain. Rates as better than before. Physical therapy very helpful, has about 4 more sessions. Doing full duty. . Diagnoses: Neck muscle strain, initial encounter. Headache. Left shoulder joint pain. Left arm pain. Plan: Fully Duty. Best estimated time to MMI is approximately 2-3 months.

46) July 17, 2020, Progress Notes/Telephone Appointment Visit, Sharon Gabrielle Hartmans, MD (Family Practice): Reason for TAV: Pelvic pain. HPI: Patient with belching and gas two nights ago. She drank ginger ale and went to sleep but was uncomfortable. Woke up and pelvic area was sore. Walking she feels the pain. Every time she ate, the pain was worse. Feels it when she has a bowel movement or urinates. Had a full hysterectomy. Has been constipated a few days ago. Assessment: Left lower abdominal pain. Plan: Suspicious for diverticulitis. No prior history of such. Recommend in person evaluation.

47) July 17, 2020, Progress Notes, Ann Lee Pham, DO (Family Medicine): Chief Complaint: Pelvic pain for 3 days. HPI: 3 days ago she ate a chicken salad (half at work and half at home). Started to develop belching and gas. Started to have pain in her pelvic area with urination and defecation. Even taking steps are painful. Took Ibuprofen last night but still woke up with discomfort. Had a total hysterectomy. Scared to eat because it makes her gassier. Physical Exam: Abdominal: There is tenderness. Epigastric tenderness. Suprapubic tenderness. Assessment/Plan: UTI (urinary tract infection): Estradiol 0.01% (0.1 mg/gram) vaginal cream were prescribed. Nitrofurantoin monohydrate 100 mg were prescribed. Lab studies were ordered. Gastritis: Omeprazole 20 mg were prescribed.

48) August 04, 2020, Progress Notes, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaint: Work related injury: Head injury; Neck injury; Arm injury and Shoulder injury. Subjective Complaint: She complains of left sided neck pain. Feels better. Completed 3/6 physical therapy sessions, helpful, says had muscle that was sore in left side of neck improve with manual physical therapy with last provider. Doing full duty. Diagnoses: Neck muscle strain, initial encounter. Headache. Left shoulder joint pain. Left arm pain. Plan: Improving with physical therapy. Not yet at MMI. Full duty.

49) August 06, 2020, Progress Notes, Garrick Chak, MD (Ophthalmology): Chief Complaint: Narrow glaucoma evaluation for both eyes. Acute decreased vision left eye for less than 1 year. HPI: She is sent for consultation by outside optometry for evaluation of narrow glaucoma evaluation for both eyes. Acute decreased vision left eye for less than 1 year. Unable to dilate outside due to narrow angles. Assessment/Plan: 1) Narrow angles occludable both eyes: Ok for dilation. 2) CHRPE (congenital hypertrophy of the retinal

pigment epithelium) left eye superiorly: Benign. 3) Macular atrophy inferiorly left eye: Refer to retina consultation. Follow-up retina in 2-3 weeks HVF (Humphrey visual field) 10-2 + optos Autofluorescence. Follow-up 1yr optical coherence tomography nerve + gonioscopy.

50) August 27 2020, Progress Notes, Vikram Suresh Makhijani, DO (Ophthalmology): Chief Complaint: Eye examination – 2-3 weeks HVF 10-2 + optos Autofluorescence. HPI: She is referred by Dr. Chak for retinal atrophy left eye. Feels left eye slightly weaker, otherwise no noticeable symptom. Assessment/Plan: 1) Inferior macular atrophy left eye: Can obtain FA (fluorescein angiography). 2) Narrow angels both eyes: Non occludable per Dr. Chak. 3) CHRPE Left Eye: No suspicious features. Follow-up with FA (transit left).

51) September 16, 2020, Progress Notes, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaint: Work related injury: Head injury; Neck injury; Arm injury and Shoulder injury. Subjective Complaint: She complains left sided neck pain. Feels better. Completed 6/6 physical therapy sessions, helpful, says had muscle that was sore in left side of neck improve with manual physical therapy with last provider. Full duty. Diagnoses: Neck muscle strain, subsequent encounter. Left shoulder joint pain. Left arm pain. Myofascial pain syndrome. Neck muscle strain, initial encounter. Headache. Plan: Additional physical therapy for 1-2 times for 3 weeks were ordered. Acetaminophen (Tylenol) 500 mg were prescribed. Improving with physical therapy, will request more. Not yet at MMI. Full duty. Best estimated time to MMI is approximately 2-3 months.

52) Page 1065-1068. October 03, 2020, Progress Notes, Vikram Suresh Makhijani, DO (Ophthalmology): Chief Complaint: Follow-Up exam – with FA (transit left). HPI: She is here for improving vision left eye. Assessment/Plan: 1) Inferior macular atrophy left eye: FA normal flow. . 2) Narrow angels both eyes: Non occludable per Dr. Chak. 3) CHRPE Left Eye: No suspicious features. Follow-up as previously directed (Dr. Chak 1yr optical coherence tomography nerve + gonio).

53) October 05, 2020, Progress Notes, Charles Ronald Plehn, MD (General Surgery): Chief Complaint: Consultation – Dr. Jerusha Stahl: symptomatic gallstones. Cholelithiasis. Referred by Dr. Jerusha Emily Stahl. HPI: Notes epigastric right upper quadrant pain 3 months duration. Previously prescribed for gastroesophageal reflux disease with Pepcid without much improvement. Food makes it worse especially right fatty foods. She presents with history of intermittent epigastric and right upper quadrant pain. Associated symptoms: Feeling fullness. Frequency of symptoms: Several/week to almost daily. Currently asymptomatic. Fatty food intolerance: Yes as above. Assessment: Symptomatic cholelithiasis. Plan: Schedule surgery – Lap Chole.

54) October 12, 2020, Progress Notes, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaint: Work related injury: Head injury; Neck injury; Arm injury and Shoulder injury. Subjective Complaint: She complains left sided neck pain. Feels better with physical therapy overall. Having more pain in neck muscles however this morning after completing physical therapy this morning. Completed 6/6 and 1/6 of additional physical

therapy sessions, helpful. Doing full duty. Diagnoses: Neck muscle strain, subsequent encounter. Left shoulder joint pain. Left arm pain. Myofascial pain syndrome. Plan: Improving with Physical therapy, will request more. Not yet at MMI. Full duty. Best estimated time to MMI is approximately 2-3 months.

55) October 20, 2020, H&P Notes, Charles Ronald Plehn, MD (General Surgery): Chief Complaint: Pre-operative exam – needs flu vaccine. Procedure: Lap Chole. HPI: Notes epigastric right upper quadrant pain 3 months duration. Previously prescribed for gastroesophageal reflux disease with Pepcid without much improvement. Food makes it worse especially right fatty foods. She presents with history of intermittent epigastric and right upper quadrant pain. Associated symptoms: Feeling fullness. Frequency of symptoms: Several/week to almost daily. Currently asymptomatic. Assessment: Symptomatic cholelithiasis. Plan: Lap cholelithiasis.

56) November 03, 2020, Operative Note, Charles Ronald Plehn, MD (General Surgery): Pre-Op Diagnosis: Cholelithiasis. Post-Op Diagnosis: Cholelithiasis. Procedures: Cholecystectomy laparoscopic. Findings: Gallbladder: Cholelithiasis, thick walled, extensive omental adhesions, empyema. Large stone impacted at neck of gallbladder. Acute Cholecystitis: No, severe scarring with thick wall consistent with chronic cholecystitis. Adhesions: Omentum to gallbladder only. Ducts: Appear normal sized. The remainder of the abdominal findings were unremarkable with a grossly normal appearing liver, stomach, pyloroduodenal sweep. The visualized portions of the small bowel and colon appeared normal.

57) November 03, 2020, Discharge Summary Note, Jessica Wu, MD (Family Medicine): Date of Admission: 11/03/20. Date of Discharge: 11/03/20. Diagnosis: Cholelithiasis. Procedures: Laparoscopic cholecystectomy. Plan: Ibuprofen (Advil/Motrin IB) 200 mg, Oxycodone (Roxicodone) 5mg and Amoxicillin-Pot Clavulanate (Augmentin) 500-125 mg were prescribed. Continue Acetaminophen (Tylenol) 500 mg, Omeprazole (Prilosec) 20 mg, Methocarbamol (Robaxin) 500 mg and Diclofenac Sodium (Voltaren) 1% top gel. Encourage walking or regular exercise. No heavy lifting. No strenuous exercise.

58) November 11, 2020, Progress Notes, Charles Ronald Plehn, MD (General Surgery): Chief Complaint: Follow-up call regarding cholecystectomy laparoscopic on 11/03/20 (Colorectal Kit) FOBT ordered and addressed. Post-Operative Exam. HPI: Routine postop telephone appointment visit. Complaints: Sore especially early post-op, now improved, bruising at umbilicus. Constipated first 3 days now resolved. Pain: Yes as above. Assessment: Doing well. Pathology results discussed with patient. Questions answered. Plan: Follow-up as needed. Wound care & activity discussed. Return to work: Scheduled for tomorrow.

59) December 11, 2020, Progress Notes, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaint: Work related injury: Head injury; Neck injury; Arm injury and Shoulder injury. Subjective Complaint: She complains left sided neck and shoulder pain. Feels better with physical therapy overall, requesting renewal. Doing full duty.

Diagnoses: Neck muscle strain, subsequent encounter. Left shoulder joint pain. Left arm pain. Myofascial pain syndrome. Neck muscle strain, initial encounter. Headache. Plan: Additional physical therapy for 1-2 times a week for 3 weeks. Acetaminophen 500mg were prescribed. Not yet at MMI.

60) February 18, 2021, Progress Notes, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaint: Work related injury: Head injury; Neck injury; Arm injury and Shoulder injury. Subjective Complaint: She complains left sided neck and shoulder pain. Feels better, doing PT. Requesting renewal. Doing full duty. Diagnoses: Neck muscle strain, subsequent encounter. Left shoulder joint pain. Left arm pain. Myofascial pain syndrome. Neck muscle strain, initial encounter. Headache. Plan: Additional physical therapy for 1-2 times a week for 3 weeks. Pain medications as needed. Full duty. Best estimated time to MMI is approximately 2 months. Work Status: Concurrent Treatment: PT/OT. Full work today. The patient has a follow-up appointment on 03/25/21 at 2:40pm.

61) March 25, 2021, Progress Notes, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaint: Work related injury: Head injury; Neck injury; Arm injury and Shoulder injury. Subjective Complaint: She complains left sided neck and shoulder pain. P/S 8-9/10 intermittent. Less frequent. Feels better, doing physical therapy, completed 12/12, very helpful. Last RFA denied. Doing full duty. Physical Exam: Shoulder Exam: Palpation: Tender left trapezius. Diagnoses: Neck muscle strain, subsequent encounter. Left shoulder joint pain. Myofascial pain syndrome. Plan: Referred for Acupuncture for 1-2 times a week for 3 weeks. Pain medications as needed. Full duty. Best estimated time to MMI is approximately 2 months.

62) May 24, 2021, Progress Notes, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaint: Work related injury: Head injury; Neck injury; Arm injury and Shoulder injury. Subjective Complaint: She complains left sided neck and shoulder pain. P/S 5/10 intermittent. Feels better, doing physical therapy, completed 11/12, very helpful. Requesting renewal. Doing full duty. Diagnoses: Neck muscle strain, subsequent encounter. Left shoulder joint pain. Left arm pain. Myofascial pain syndrome. Plan: Additional physical therapy 1-2 times per week for 3 weeks. Acetaminophen 500 mg were prescribed. Diclofenac Sodium (Voltaren) 1% Top Gel were prescribed. Full duty.

63) July 12, 2021, Progress Notes, Bhavesh Robert Pandya, MD (Occupational Medicine): Chief Complaint: Work related injury: Head injury; Neck injury; Arm injury and Shoulder injury. Physical Exam: Cervical/Thoracic Spine Exam: Palpation: Tender cervical paraspinals left periscapular/trapezius muscles. Shoulder Exam: Palpation: Tender left periscapular muscles/left mid trapezius. Diagnoses: Neck muscle strain, subsequent encounter. Left shoulder joint pain. Left arm pain. Myofascial pain syndrome. Causation: Based on Dr. Pandya's opinion, the industrial injury dated 04/10/20 resulted in the above diagnoses within reasonable medical probability. No other factors of causation appear to be present in this case based on information that this examiner have available at the time of this report. Permanent and Stationary: She is considered permanent and stationary as

of 07/12/21. Future Medical Treatment: If the patient experiences a flare-up or exacerbation of the industrial condition she may return for medical evaluation approximately 4-6 times per year and treatment with simple analgesics or other pain medication as appropriate and brief referrals to physical therapy or acupuncture for a total of 12-18 visits per year. If the industrial condition fails to improve with the above suggested treatments, the patient may need further medical work up and/or referral to specialist. Anticipate possible need future medical care over the next 5 years. Work Status: Working full duty.

64) July 12, 2021, Progress Notes, Raymond Moallemi, MD (Family Medicine): Chief Complaint: Left leg pain. HPI: She is 50-years-old female with leg pain yesterday, pain 8/10, no fall/injury/trauma recalled, now pain radiated to upper back thigh. Advil did not help, no recent travelling, not taking OCP, no recent surgery. Review of Systems: Musculoskeletal: Positive for joint pain (Left leg pain). Physical Exam: Musculoskeletal: Left Knee: Tenderness present. Assessment/Plan: Left leg pain, primary encounter: Naproxen 500 mg and Diclofenac Sodium 1% top gel were prescribed. Return to clinic or emergency room if not better or worsening. Follow-up with primary doctor in 2-3 days. Have enough rest.

65) August 18, 2021, ED Notes, Zachary Scott Wilson, MD (Emergency Medicine): Chief Complaint: Arm pain. HPI: She presents with 1 day of left arm pain. Review of Systems: Musculoskeletal: Positive for arthralgias. Physical Exam: Musculoskeletal: Mild tenderness to palpation of left biceps. Impression: Left arm pain. Plan: X-ray of the chest were ordered. Lab studies were ordered. Discharge home. Follow-up with PMD. Continue Naproxen 500mg.

66) September 07, 2021, Progress Notes, Jerusha Emily Stahl, MD (Internal Medicine): Chief Complaint: Physical examination. Varicose veins. Subjective: She complains of varicose veins – around knee on right side. Gallstones found a year ago – had gallbladder out last November. Stomach feeling bloated a lot. Not sure if it varies with things she is eating. BM are normal, may go day without and more bloating comes. Watching coffee intake – this week was having a lot of cold brew which did normalize her BM some. If she goes out and has worse eating over the weekend she pays for it. Trying to cook more, plans to go back to keto diet, which diet – more protein and less starch. Staying away from bread and potatoes – had been eating a lot of those. Left ear earache – coming and going the past 6 weeks. Uses Q-tips regularly. Feels like a flutter in her chest, like electric shock very quickly, maybe twice per month. Mostly when she lays down to relax. Exercise – just bought a bike, will be riding with her friend. Though about Bariatric surgery – did classed, had a lot of reflux at that time and didn't want. Objective: BP: 127/84. Height: 5'3". Weight: 103.7 kg. BMI: 40.50kg/m2. Assessment/Plan: 1) Routing adult health checkup exam. 2) Screening. 3) Varicose veins of right leg: Referral vascular surgery. 4) Dermatitis: Triamcinolone acetonide 0.1% top cream were prescribed. 5) Severe Obesity: Referral internal medicine. 6) Vaccination for Influenza: Influenza vaccine was administered.

67) Page 1336-1337, September 27, 2021, Progress Notes, Mark Paul Mueller, MD (Vascular Surgery): HPI: The patient states, "Some right-medial calf soreness; I think is related to varicose veins." Physical Exam: Right-leg scattered varicose veins 2-3 mm knee area. Assessment/Plan: Mildly symptomatic varicose veins: Compression stockings, as tolerated. Follow-up as needed..

68) December 29, 2021, Progress Notes/Video Appointment Visit (VAV), Amanda Velazquez, MD (Obesity Medicine Specialist): Reason for VAV: Bariatric obesity program. Chief Complaint: Weight management. HPI: Duration: Years suffering with weight problem and struggling to lose weight. ROS related: Weight is impacting mobility. Weight is impacting mood. Objective: Height: 5'3". Weight: 100.5 kg. BMI: 39.25kg/m2. Assessment: Obesity, counselling. Obesity, BMI 39-39.9. Plan: Diet/exercise/weight loss counselling. AVS printed with education on this. Reviewed risk and benefits of medication(s) prescribed.

69) December 29, 2021, ED Notes, Keith Dellagrotta, MD (Emergency Medicine): Chief Complaint: Finger problem and assault and battery. HPI: She presents to the Emergency Department complaining of left hand pain after involved in altercation with neighbor. Got into fist fight and now had pain to left middle finger with swelling. Abrasions to face but no other injuries. Did not lose consciousness. Physical Exam: Musculoskeletal: Pain and swelling to left middle finger. Assessment: Left finger fracture, initial encounter. Plan: X-ray of the left hand were ordered and reviewed. Discharge home. Follow-up with PCP. Advised OTC analgesics for pain.

70) January 03, 2022, Progress Notes/Telephone Appointment Visit, Gene Leonard Oppenheim, MD 9Family Medicine): Reason for TAV: Finger fracture and medication request. HPI: She is seen last 12/29/21 in the ED with fractures of two finger. Presently with splint and a buddy tape for two fingers. Still with pain. Using Tylenol three times a day and a Naprosyn 500 once or twice a day. Has been worse due to "hitting" the area accidentally. Still black/blue. Assessment: Left finger fracture rout subsequent (primary encounter diagnosis). Pain. Plan: Instructed to take Naprosyn one pill twice a day next 3-5 days with APA 325 2 four times per day. BTW (back to work) note written. Call or return clinic as needed of symptoms worsen or fail to improve as anticipated.

71) January 07, 2022, Orthopedic Progress Notes, Jason Aquino Buranday, PA: DOI: 12/29/21. Subjective: She is here for initial orthopedic evaluation of left small and middle finger injuries that occurred on 12/29/21. She was involved in an altercation and injured her left hand. She was seen in the ED and found to have finger fractures and sent to Ortho Fracture clinic. Has been wearing finger splint to middle finger and buddy taping her small and ring finger. Objective: TTP: Left small and middle fingers with localized swelling. ROM: Limited flexion at SF and MF DIPJs and PIPJs. Diagnostic Studies: Buranday PA reviewed the x-ray of the left hand dated 12/29/21. Assessment: Closed left small finger and middle finger, middle phalanx fractures. Plan: 1) Buddy tape SF and finger; splint MF in extension x 2 weeks – specific instructions given. 2) No sports/strenuous activity until cleared. 3) OTC pain meds as needed – Discontinue if GI upset. Tramadol was

prescribed. 4) Rest, ice, compression, elevation as needed for swelling and pain. 5) Follow-up in 2 weeks.

72) January 25, 2022, Office Visit in Orthopedic, Jason Aquino Buranday, PA: Subjective: She returns today for follow-up. Left middle and small finger fractures that occurred on 12/29/21. She reports the fingers are doing better. No new injury, but is constantly bumping her middle finger. Wears the finger splint to the middle finger and buddy tapes small finger. Objective: TTP: Mild left small and middle fingers with localized swelling. ROM: Limited flexion at SF and MF DIPJs and PIPJs. Diagnostic Studies: Dr. Buranday reviewed the x-ray of the left hand dated 01/25/22. Plan: 1) Offered hand surgical consultation for finger due to slight shortening of MF fracture, but patient declined. Discussed the likelihood of chronic mallet; deformity which may not cause functional deficits. She will think about it and let Dr. Buranday knows in the next week if she wants to speak to a surgeon. 2) OT referral for finger range of motion and ADLs. 3) OTC pain meds as needed – Discontinue if GI upset. Tramadol was prescribed. 4) Activity modification. 5) Follow-up as needed.

73) Page 1425-1427. February 23, 2022, Progress Notes, Aarti Chaitanya Maskeri, MD (Internal Medicine): Chief Complaint: Left hand pain. Subjective: She states that she fractured her left 3rd and 5th digits on December 2021, has been following with ortho and OT. States she was given a splint initially, then later splint was removed. She was following with OT who made a small cast for her fingers, but felt the cast was causing pain, so removed it. Able to move/flex, but feels pain not improving. Objective: BP: 150/92. Height: 5'3". Weight: 98 kg. BMI: 38.26kg/m2. Musculoskeletal: Left hand: 4/5 grip strength. Assessment/Plant: Left little finger middle phalanx fractures, ***nondisplaced, routine healing,*** subsequent encounter. Left middle finger middle phalanx fracture, ***displaced, routine healing***, subsequent encounter: Follow-up with ortho; has Tramadol at home to use as needed. Elevated BP reading without hypertension diagnosis: Recommend dash diet/exercise/stress reduction; follow-up in 2 weeks.

74) April 21, 2022, OT Treatment Summary, Stacy Yoenhee Chun, OT: The patient attended occupational therapy session from 02/01/22 through 04/21/22. Diagnoses: Left little finger middle phalanx fracture, ***nondisplaced, routine healing***; Left middle finger middle phalanx fractures, ***displaced, routine healing***; orthopedic after care.

75) June 03, 2022, Doctor's First Report of Occupational Injury or Illness/Visit Note, Aliss Markosian, DO (Occupational Medicine): DOI: 06/02/22. Chief Complaint: Head injury and stress. Mechanism of Injury: A customer was yelling and screaming threats to the patient in the lobby taking pictures, no management assistance. She felt tense and stressed and got an instant headache. She reports pre-existing neck, left shoulder and arm pain flared up as a result. Subjective Complaints: She states her symptoms started immediately. She was initially seen for the injury by this provider. Current Complaint: She is a 51-year-old who works as a manager comes in 06/03/22 complaining of work stress. Duration: Since date of injury. Location: Same as above. Quality: Anxious, depressed, difficulty of sleeping, headache. Severity: Severe. Timing: Constant. Context: Injured at work –

Yes. She is reporting a stress claim. Reports stress from work as a result of above. She is reporting the following symptoms as above. She reports family/friend support at home. Reported pre-existing claim for head, neck, left shoulder and arm under 2020 claim. She was doing well until stressed and all symptoms flared up. Past Medical History: Prior Non-Work Related: History of anxiety attack due to stress, never needed to seek treatment for it. Objective Findings: Vital Signs: BP: 138/76. Physical Examination: Tenderness to palpation cervical spine paraspinals, trapezius and periscapular muscles. Diagnoses: Occupational problems or work circumstances. Myofascial pain syndrome. Plan: Refer to Psych. Activity Restrictions: TTD. Return to care as needed. Follow-up with Dr. Pandya under 2020 claim for flare up of symptoms. Off work due to stress per patient report.

76) June 03, 2022, Work Status Report, Aliss Markosian, DO (Occupational Medicine): DOI: 06/02/22. Off-Work: This patient is placed off work from 06/03/22 through 06/24/22.

77) June 18, 2022, Progress Notes, Armen Arshakyan, MD (Internal Medicine): Chief Complaint: She is here with complain of throat and ear ach. Left sided. Assessment/Plan: Throat Pain (primary encounter diagnosis): Lab studies were ordered. Flonase allergy relief 50 mcg/actuation nasal spray solution. Left Otalgia: Ibuprofen (Motrin) 600 mg were prescribed.

78) June 28, 2022, Progress Notes, Daniel Lin, DO (Family Medicine): Chief Complaint: Abdominal or stomach bloating. X1 day – patient with stomach cramping. HPI: She is here for one day of acute left upper abdominal pain and cramping. Pain is constant. She state she had similar episode a month ago which lasted a day. History of cholecystectomy in 2020. Medications: Ibuprofen (Motrin) 800 mg. Hydrocodone-Acetaminophen (Norco) 5-325 mg. Flonase Allergy Relief 50 mcg/actuation Nasal Spray Solution. Triamcinolone Acetonide (Kenalog) 0.1% Top Cream. Review of Systems: Constitutional: Positive for activity change. Gastrointestinal: Positive for abdominal pain. Objective: BP: 137/83. Height: 5'3". Weight: 99.8kg. BMI: 38.97kg/m2. Physical Exam: Abdominal: There is abdominal tenderness in the left upper quadrant. Assessment: Left upper quadrant pain. Plan: Lab Studies were ordered and reviewed. Ibuprofen 800 mg and Hydrocodone-Acetaminophen (Norco) 5-325mg. CT of the abdomen and pelvis were ordered. Recommend: Rest. Warm packs to abdomen.

79) June 30, 2022, ED Notes, Sushil Kumar Jain, MD (Emergency Medicine): Chief Complaint: Referral and diagnostic imaging results. HPI: She is a 51-year-old with unremarkable presents to the emergency department with left upper quadrant abdominal pain. Patient with 3 days of LUQ abdominal pain, dull burning, possibly worse after foot. Seen in 2 days ago with negative CT of the abdomen pelvis and right upper quadrant ultrasound, labs unremarkable. She had received a CT and ultrasound while in Urgent Care and was supposed to come to the ED for result but patient based understood and went home. She came back today for her results. Continues to have pain. Past Medical History: Severe obesity, BMI 40-44.9 – 04/11/06. Vitamin D deficiency – 03/30/11. Uterine Fibroids – 08/25/16. Iron deficiency anemia – 10/13/16. Review of Systems:

Gastrointestinal: Positive for abdominal pain. Objective: Vital Signs: BP: 148/91. Physical Examination: Constitutional: Mild distress due to pain. Abdominal: There is abdominal tenderness. Epigastric tenderness. Assessment: Epigastric abdominal pain. Plan: Discharge home. Follow-up with outpatient physician(s). Alum-Mag Hydroxide-Simethicone (Mylanta/Maalox) 200-220-20mg/5ml and Famotidine (Pepcid) 20 mg were prescribed.

80) July 12, 2022, Progress Notes, Amir Taymoor Ekanej, MD (Gastroenterology): Chief Complaint: Consultation. HPI: She was referred to the GI clinic for evaluation of abdominal pain. Location: Left upper quadrant. Duration: One month. Pattern: Episodic. Bowel Habits: Irregular. Stools both soft and hard. GERD symptoms but infrequent. Impression: Irritable bowel syndrome. GERD-symptoms infrequent. On Pepcid. Plan: Colonoscopy. Citrucel daily. IBgard (Peppermint oil) twice daily. Identify food triggers.

81) July 25, 2022, Progress Notes, Amir Taymoor Ekanej, MD (Gastroenterology): Indication: She is here for colonoscopy. Physical Exam: BP: 137/81. Weight: 97.5 kg. BMI: 38.09 kg/m2. Abdomen: Positive bowel sounds. Plan: Proceed with procedure.

82) July 25, 2022, Procedure Note, Amir Taymoor Ekanej, MD (Gastroenterology): Pre-Procedure Diagnosis: Colonoscopy. Post-Procedures Diagnoses: Abdominal pain. Procedures: Colonoscopy, diagnostic flexible. Findings: Rectum: Internal hemorrhoids. Sigmoid colon through cecum: Normal.

83) August 10, 2022, Progress Notes/Telephone Appointment Visit, Patricia Mayorquin, MD (Internal Medicine): Reason for TAV: Hemorrhoids and proactive call – pre-visit prep. HPI: She is having intermittent abdominal cramping, bloating, and loose stools/constipation for a few months. She had recent colonoscopy showed small internal hemorrhoids. Diagnosed with IBS. Told not sure of diet to help. Assessment: Irritable bowel syndrome. GERD. Plan: Referral nutrition counselling.

84) August 17, 2022, Progress Notes/Telephone Appointment Visit, Christopher Katsura, MD (Family Practice): Reason for TAV: Cough. HPI: Two weeks since COVID. Still having dry cough. But sometimes gets brown phlegm like today. Diagnoses: Cough, unspecified. Plan: Azithromycin (Zithromax) 250 mg and Fluticasone (Flovent HFA) 44 mcg/actuation Inhaler HFAA.

85) September 02, 2022, Primary Treating Physician's Initial Evaluation Report and Request for Authorization, Eric Gofnung, DC (Chiropractic Specialty): DOI: CT: 07/31/21 – 07/31/22. Reviewed but not summarized.

86) December 02, 2022, Chiropractic Treatment Summary, Eric Gofnung, DC: The patient attended chiropractic treatment sessions from 11/04/22 through 12/02/22.

87) December 21, 2022, Initial Orthopedic Evaluation and Request for Authorization of a Secondary Physician, Nicholas Cascone, PA-C/Edwin Haronian, MD: DOI: 07/31/21;

CT: 07/31/21-07/31/22. History of Injury: This is a 51-year-old right-hand dominant female who sustained industrial injuries on CT: 07/31/21 to 07/31/22, while working as a DMV Manager for State of California Department of Motor Vehicles. The patient states on a cumulative trauma during her employment, she gradually developed the onset of pain to her neck, shoulders, arms, wrists, hands and thumbs which she attributes to her work duties consisting of: working eight hours per day, five days per week, supervising, hiring, terminating and assigning job duties to employees, assisting the public, processing driver's license, registrations and IDs, operating a computer, typing, entering data, processing paperwork, making vehicle inspections and taking and making phone calls. The precise activities required entailed prolonged standing and walking, as well as continuous fine maneuvering of her hands and fingers, and repetitive bending, twisting, turning, forceful pulling and pushing, forceful gripping and grasping, lifting and carrying 5 pounds, torquing, reaching to all levels. She also developed psychological distress, anxiety and insomnia attributed to her painful injuries, responsibility, pressured, hostile and stressful work environment. The patient states that in March 2020, she walked over to the DWP plant location after an explosion occurred. Suddenly a second explosion occurred, and she was jerked to her left side, developed pain to her neck and left shoulder and headaches. She received treatment at Kaiser on the Job consisting of: office visits, prescriptions for pain medication and medicated ointments, physical therapy and acupuncture treatments. She was eventually released from medical care and returned to work on full duty. While working full duty and the pain in her neck and left shoulder persisted.

She then also developed pain in her right shoulder, elbows, wrists, hands, thumbs and fingers while doing her repetitive job duties noted above. The patient states on 06/02/22, she assisted a technician-Ms. Smith with a customer who was raising his voice complaining about making a payment on a Kiosk They told him he needed proof of insurance and got more upset, took her picture and asked for her name. She informs she had to walk away from the situation three times because he continued to yell at her. They informed the office manager and administrative manager, but they did not get up from their seats to help. She began to feel anxious and upset. She threw her hands up and told the customer she could not help him. He continued to yell at her. She tried to move away from him and refused to give him her last name. He then threatened to punch her in the mouth. Her office manager finally got up and assisted him in another window. By then she developed a severe headache, tension in her neck and numbness and tingling in her left shoulder and arm, along with elevated blood pressure. On 06/03/22, she called her employer to report her injury and was referred to Kaiser on the Job where she was examined and advised to take ibuprofen. She was placed on TTD for three weeks. She was informed she would only be seen for her headaches and psychological symptoms. She was advised to inform the W/C insurance carrier about her physical injuries to be referred for medical care either through her prior claim or file a new claim. She informs that by the end of June 2022 the numbness in her left arm and headaches subsided but feared returning to work as working in the stressful work environment flared up her symptoms. She informs that following the incident on 06/02/22, she also developed abdominal pain and gastritis which she attributes to her psychological distress.

On 06/08/22, she sought medical care with her PCP through telemedicine. She was only examined. Due to her ongoing symptoms she went to an urgent care clinic twice for her abdominal pain. She underwent a CT scan and ultrasound of her abdomen. She was told her symptoms may be stress related. On 07/25/22, she underwent a colonoscopy. In September 2022, she was referred with a psychologist, but it was canceled as she was given the wrong date and time. The psychologist then changed the date again without informing her. She has not been rescheduled since then. On 09/02/22, she was sent with PTP, Dr. Eric Gofnung, DC. She was examined and was given work restrictions not accommodated by her employer and was placed on TTD. She was given bilateral wrists and thumb spica braces. She underwent intervals of physiotherapy, chiropractic treatments once per week for six weeks at a time which provided temporary pain relief. She is pending to undergo an Open MRI study of her cervical spine and x-rays of her neck, left elbow, wrists and hands. She is also pending to undergo EMG/NCV studies of her upper extremities. On 10/24/22, she was referred to Jonathan Kohan, M.D., a pain management specialist who evaluated her, prescribed Ibuprofen cream, a muscle relaxant, a pain medication and a tens unit. She presents to my office today for a comprehensive orthopedic evaluation. Job Description: The patient began employment as a DMV Manager for State of California Department of Motor Vehicles since 1999. She worked eight hours per day, five days per week. Her job duties at the time of injury included: supervising, hiring, terminating and assigning job duties to employees, assisting the public, processing driver's license, registrations and I.D.'s, operating a computer, typing, entering data, processing paperwork, making vehicle inspections and taking and making phone calls. The precise activities required entailed prolonged standing and walking, as well as continuous fine maneuvering of her hands and fingers, and repetitive bending, twisting, turning, forceful pulling and pushing, forceful gripping and grasping, lifting and carrying 5 pounds, torquing, reaching to all levels.

Current Work Status: The patient is currently not working. Her last day at work was in August 2022. Present Complaints: 1) Neck: The patient presents today with complaints of intermittent pain in the neck with pain, numbness and tingling radiating into her arms. She has occasional headaches, which she associates with her neck pain. She has stiffness in the neck and her pain is aggravated when she tilts her head up and down or moves her head from side to side. Her pain increases with prolonged sitting, standing, walking, and with bending of her neck and turning of her head. She has difficulty sleeping and awakens with pain and discomfort. Her pain level varies throughout the day depending on activities. Pain medication provide her pain improvement, but she remains symptomatic. 2) Bilateral Shoulders: The patient has complaints of intermittent pain in her shoulders. She complains of stiffness to her shoulders. Her pain increases with reaching, pushing, pulling, and with any lifting. Lifting her upper extremity above shoulder level also increases her pain. Her pain level varies throughout the day depending on activities. She has difficulty sleeping and awakens with pain and discomfort. Rest and pain medication provide her pain improvement, but she remains symptomatic. 3) Bilateral Elbows: The patient has complaints of frequent bilateral elbows pain. Her pain increases with gripping, grasping, flexing/extending, rotating, and repetitive hand and finger movements. She has difficulty sleeping and awakens with pain and discomfort. Her pain level varies throughout the day

depending on activities. Physical therapy, acupuncture treatments, and pain medication provide her pain improvement, but she remains symptomatic. 4) Bilateral Hands/Wrists: The patient has complaints of intermittent right hand and wrist pain and constant left hand and wrist pain, at times becoming achy and sharp at times.

She has numbness and tingling in her hands as well as weakness that causes her to drop objects. Her pain increases with gripping, grasping, flexing/extending, rotating, and repetitive hand and finger movements. She has difficulty sleeping and awakens with pain and discomfort. Her pain level varies throughout the day depending on activities. Physical therapy, acupuncture treatments, and pain medication provide her pain improvement, but she remains symptomatic. Medical History: The patient has a history of gastrointestinal problems and elevated blood pressure due to her stress and pain. Surgeries: The patient underwent the following surgeries: 1) Bilateral Wrists CTR Surgeries-2001 each surgery occurring six months apart. 2) Tubal Ligation-1996. 3) D&C and Fallopian tube removal for two ectopic pregnancies. 4) Hysterectomy. 5) Cholecystectomy. Injuries: The patient states in March 2020 she suffered a work injury to her neck and left shoulder, along with headaches with the same employer. She received medical care, treatment and recovered. The patient states in 2018 she suffered a motor vehicle accident with injuries to her lower back. She received medical care, treatment and recovered. She filed a PI claim which settled. The patient states in 2001 she suffered cumulative trauma work injuries to her wrists and hands with the same employer. She underwent bilateral wrists CTR surgeries and recovered. She filed a W/C claim which settled. Medications: The patient is currently taking Ibuprofen cream, a muscle relaxant, a pain medication. ADLs: ADLs were reviewed. Physical Examination: Height: 5'3". Weight: 213 lbs. Cervical Spine Examination: There is spasm and tenderness over the paravertebral musculature. Cervical spine range of motion is restricted. Sensory Testing: C6 (Lateral forearm, thumb, index) and C7 (Middle finger): Decreased with pain on the left. Hoffman testing was positive on the left.

Shoulder Examination: Left shoulder range of motion is restricted. Tenderness was noted over the left acromioclavicular joint. Impingement and Hawkins sign were positive on the left. Elbow Examination: Tenderness was noted over the left lateral (tennis) epicondyle. Wrist and Hands Examination: There was tenderness over the left distal radius. Tinel testing was positive on the left. Phalen and reverse Phalen (praying position) testing were positive on the left. Two-point discrimination was greater than 6mm on the left. Diagnoses: Cervical radiculopathy. Bilateral shoulder impingement. Bilateral elbow tendonitis/bursitis. Bilateral wrist tendonitis/bursitis. Discussion: All conditions, risk, benefits and alternatives were discussed with the patient and the patient verbalized understanding. They request that all prior medical records and diagnostic studies be forwarded to our attention, so they may avoid duplication in testing and treatment. In particular all MRI investigations are needed in order to make the surgical recommendations which have been requested. Apparently their history is in error and neurodiagnostics of the upper extremities are not yet been conducted. The patient is presenting with clear symptomatology of radiculopathy possibly superimposed on peripheral nerve entrapment. In order to fully evaluate and make additional treatment recommendations. They are

requesting authorization to conduct neurodiagnostic studies of the upper extremities at this time. The patient is receiving medications from pain management. Modification for work and disability status will be deferred to the primary treating physician and the patient will return to Dr. Haronian's attention in four to six weeks. Once neurodiagnostics have been accomplished and the MRI studies are available for review, they will make the additional treatment recommendations which have been requested by the primary.

88) February 10, 2023, Secondary Physician Pain Management Follow-Up Report and Request for Authorization, Jonathan Kohan, MD/Jared Toller, PA-C: DOI: 07/31/21; CT: 07/31/21 – 07/31/22. Interim History: The patient is back in Dr. Kohan's office today following the previous clinical visit. They have now received an MRI study of the cervical spine which was reviewed in detail today. This does show a multilevel disc herniation as well as posterior listhesis and Modic type 2 endplate changes with loss of vertebral body height at the C5-C6. There is also varying degree of disc desiccation from C2 down to C7. Most notably, there is also disc herniation noted at the level of the C5-C6 which is a 2.7 mm with abutment of the exiting nerve roots. There is also a 3.1 mm disc deformity noted at the C6-C7 with left uncovertebral joint hypertrophy with left neural foraminal narrowing. In review of the MRI study of the cervical spine does correlate with the patient's ongoing complaints of left upper extremity radiculopathy as well as pain in the neck itself. The patient has been undergoing conservative treatment and at this point, she states that she is interested in pursuing additional treatment options including cervical epidural injection which were discussed in detail today. She states her overall pain level today is 7/10. She has difficulty with lifting, pushing, pulling, bending, twisting, turning, stooping, and difficulty with gripping and grasping, and difficulty use of the left upper extremity as well as pain in the neck is constant. She is also continuing to utilize anti-inflammatory medications which will be refilled today.

Physical Examination: Physical examination shows spasm, tenderness, and guarding noted over the paravertebral muscles of the cervical spine with a decreased range of motion on flexion, extension, and lateral bending. Positive Spurling's is noted on the left with a decreased dermatomal sensation over the left C6 and C7 dermatomal distributions. Examination of the shoulder does show mild diffuse tenderness over the anterior deltoid. Impingement was inconclusive. Wrist extension strength was 4/5 and reflexes are within normal limits. Clinical Impressions: Bilateral wrist sprain/ strain with potential de Quervain's tenosynovitis and carpal tunnel syndrome. Bilateral medial epicondylitis. Bilateral shoulder sprain/ strain with impingement on the left. Cervical radiculopathy. Recommendations: Further treatment options were discussed. All conditions, risks, alternatives, and benefits were discussed in detail. The patient verbalized an understanding. The option of the cervical epidural injection was once again discussed and the patient did wish to proceed. Again, she has exhausted conservative treatment in the form of physiotherapy, activity modification, as well as anti-inflammatory medication use. Unfortunately her pain does continue to persist and we do believe that the patient's ongoing complaints are related to the pathology which was noted on the MRI study. Dr. Kohan, therefore, requesting authorization for a cervical epidural injection at the level of the C6-C7 which is the highest level in which the injection can be provided. Medications will be

refilled today. She will be re-evaluated again in 4-6 weeks' time. She is agreeable to this plan.

89) May 24, 2023, Panel Qualified Medical Evaluation, Alexander Christ, MD (Orthopedic Surgery): DOI: 07/31/22. History of Injury by patient: The patient is a 52-year-old right hand dominant female who claims cumulative trauma from 07/31/21 to 07/31/22 with a specific event on 06/02/22 while working as a manager for the Department of Motor Vehicles. She states that on 06/02/22 a customer screamed at her and threatened to punch her and this was ignored by her managers. She woke up the next day with reported numbness in her arm and neck. She was taken off work by her doctor at Kaiser from 06/03/22 and returned on 07/05/22. She continued to be symptomatic physically and psychiatrically, and the work MD took her off work in September of 2022, she returned back on 03/06/23 full time with modifications. In that time period she underwent physical therapy and acupuncture. She also was given pain medications, creams, slings, and electrotherapy. She underwent MRIs of the left shoulder and cervical spine, as well as electrodiagnostic studies of the upper extremities. She states that she was recommended for injections, but was awaiting QME evaluation. She complains now only of her left neck and shoulder. She denies any symptoms in her feet, legs, low back or ankles. She currently works full time modified duties at the same job. Present Complaints: The patient still complains of stress and neck stiffness every morning, as well as shoulder pain. She states that her shoulder hurts when it is touched. She describes the pain as aching and having numbness and tingling. She describes the discomfort most of the time and is exacerbated by doing daily house work. It does not change with coughing or sneezing. Relaxation when lying on it makes it feel better. The pain awakens her from sleep three times a week. Before her work injury, she states that the pain in her neck specifically was a 4/10, now it is an 8/10.

She describes stiffness in her neck and left shoulder, numbness in her shoulder and arm, and tingling and weakness in her neck and upper extremities. She can sit for 45 minutes, stand for 20 minutes and walk for 20 minutes comfortably at a time. She uses a wrist sling for both hands as needed. She also describes these associated with headaches, sleeping disorders and waking up in the middle of the night. A large component of her complaints is inability to sleep well. Occupational History: The patient has worked as Manager 1 for approximately 23 years at the Department of Motor Vehicles in West Hollywood. She worked 8 hours per day 40 hours per week and has done this type of work for 30 years. Her duties include customer service technician assistants, data entry, reports meeting and technician evaluation. She lifts 10 lbs. or less at a time. She is no longer receiving disability as a result of this claim. She was rated 5% WPI on 06/03/09 by Dr. Mark Mandel regarding carpal tunnel syndrome. Past Medical History: Prior to the injury in question the patient describes previous injuries to her neck, specifically one during a plant explosion across the street from West Hollywood DMV. This resulted in her having a very symptomatic headache and neck pain. Serious medical problems: Diverticulitis and IBS. Medications: Ibuprofen. Norco. Review of Systems: Positive for high blood pressure, ***cheek*** pain, numbness, tingling, headaches, coordination problems, memory loss, joint pain, stiffness, depression, anger, anxiety, peptic ulcer disease pain, change in bowel habits, pelvic pain, loss of appetite, unusual stress, urinary frequency and urgency and getting up at night to urinate. Physical Examination: Cervical Spine

Examination: Cervical spine range of motion is restricted. Deep Tendon Reflexes: Biceps: 3+ on the right and left. Triceps and Brachioradialis: +1 on the right and left. Shoulder Examination: Bilateral shoulder range of motion is restricted. Elbow Examination: Bilateral elbow range of motion is restricted. Review of Records: Dr. Christ reviewed the patient's medical/nonmedical records dated 12/04/07 to 03/01/23.

Review of Diagnostic Testing: Dr. Christ reviewed the x-ray of the right knee dated 08/26/13; x-ray of the right knee dated 11/02/17 and EMG report dated 01/27/23. Diagnosis: 1) Post-traumatic stress disorder. 2) Neck pain. 3) Left shoulder pain. Discussion: The patient claims cumulative trauma from 07/31/2022 to 07/31/2022 with a specific event on 06/02/2022 while working as a manager level 1 at the Department of motor Vehicles in West Hollywood. After being threatened by a customer, she has complained of head, neck, and shoulder pain. She has returned to work full time as of March 6, 2023 in the same occupation. She had undergone MRIs of the left shoulder and C-spine as well as Nerve Conduction Studies of the bilateral upper extremities, which were normal. Causation: The diagnosed conditions are causally related to cumulative trauma that the patient sustained during her usual and customary duties in employment. She does have history of previous neck pain for which she has sought care. She is now working full time duty. Disability Status: The patient has returned back to work full time. AME Impairment Rating and Analysis: Neck: 0% WPI. Shoulder and arms: No ratable impairment. Apportionment: The patient has a previous known history of neck pain and dysfunction with previous car accidents and an explosion across the street from her work in 2017. Therefore, it is Dr. Christ's opinion that 50% of the patient's current impairment of her neck is related to the industrial injury in question, and 50% to other factors. Functional Capacity: The patient is able to perform her usual and customary job duties at this time. She may continue to work full time. Future Medical Care: The patient requires provisions for future medical care. This includes physical therapy, chiropractic care, acupuncture, medication management for neck pain. She may require future imaging studies such as in the form of radiographs or MRIs in the future. Most importantly, she should be evaluated by a psychiatrist for her disturbances in sleep, mood and stress related to these events.

90) May 30, 2023, Secondary Physician Pain Management Follow-up Report and Request for Authorization, Jonathan Kohan, MD/Michael Nadzhafov, PA-C: DOI: 07/31/21. CT: 07/31/21 – 07/31/22. Discussion: She is a very pleasant female who presents with complaint of a chronic pain in the neck and the left shoulder. The patient continues to work. She saw medical-legal examiner several days ago, report is pending. She is scheduled to have yet another one. They did request authorization for the cervical epidural injection without any progress. The patient is using ibuprofen gel, naproxen, Prevacid, and lidocaine ointment. With medications, she is more functional and would like to have a refill today. Unfortunately, there has been no progress with the requested cervical epidural injection and they do not have any information about denial or approval. Physical Examination: On physical examination, spasm and tenderness is noted in the paravertebral muscles of the cervical spine. Discomfort with pain is noted on abduction of left shoulder against the gravity. Decreased sensation is noted in C6 and C7 dermatomal distributions

bilaterally more so on the right side. Muscle strength is 4/ 5 on flexion of the right elbow. Diagnoses: Bilateral wrist sprain/ strain with potential de Quervain's tenosynovitis and carpal tunnel syndrome. Bilateral medial epicondylitis. Bilateral shoulder sprain/ strain with impingement on the left. Cervical radiculopathy. Recommendations: Level C5-C6 is noticeable for the abutment of the right exiting nerve root. Disc deformity is 2.7 mm, right neural foraminal narrowing is noted. Uncovertebral joint hypertrophy is noticed. Level C6-C7 is noticeable for the 3.1 mm disc deformity and left uncovertebral joint hypertrophy. It does correlate with the patient's failed course of conservative treatment and clinical presentation. Thus, based on reasonable medical probability, the patient does meet criteria set by MTUS guidelines for cervical epidural injection. They are formally requesting authorization for midline cervical epidural injection at level C6-C7 targeting level C5-C6. Level C6-C7 is the highest level to do the injection safely. It will be done under the guidance of fluoroscopy. They will arrange to obtain the report of medical-legal examiner for our records. They also would like to refill the medications today as they cause no side effect and help to maintain functional capacity. Her next appointment will be in six weeks to re-assess clinical efficacy of medications and review medical records. Work status will be deferred.

91) Page 148-149. June 21, 2023, Follow-Up Report of a Secondary Physician, Edwin Haronian, MD (Orthopedic Specialty)/Nicholas Cascone, PA-C: DOI: 07/31/21; CT: 07/31/21 – 07/31/22. Discussion: The patient is returning to Dr. Haronian's attention following her previous clinical visit on 04/26/23, and she is now status post medical-legal evaluation on 05/24/23. They are awaiting the full and final report of that practitioner. Physical examination showed spasm, tenderness, and guarding in the paravertebral musculature of the cervical spine. The left shoulder had impingement and Hawkins signs with range of motion in flexion and abduction less than 100 degrees. Loss of sensation in the left C6 and C7 dermatomes. The left wrist also had positive Phalen and reverse Phalen signs with decreased grip strength and distal radial tenderness over the hands. Tenderness was noted in the left lateral epicondyle. Medications have been refilled. Her current modifications for work to be deferred to the primary treating physician, and the patient will return to this examiner's attention in 4 to 6 weeks. It is their hope to be in possession of the Medical-Legal Evaluator's full and final recommendations at the time of her return. Diagnoses: Carpal tunnel syndrome, unspecified upper limb. Cervicalgia. Shoulder region disorders, not elsewhere classified. Cervical pain. Impingement syndrome shoulder. Lateral epicondylitis elbow. Medial epicondylitis. Radial styloid tenosynovitis.

STATE COMPENSATION INSURANCE FUND

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October 12, 2023

Natalia Foley
751 S Weir Canyon Rd, Ste 157-455
Anaheim CA 92808-9280

Claim Number: 06758786
Employee: Pepper Smith
Date of Injury: 07/31/2022

RE: Pepper Smith vs. Dept Motor Vehicles Att Human Resources
WCAB Number: ADJ16540205

Dear Ms. Foley

Attached are the following reports and/or records in the above-captioned case:

Reports	Date
Eric Gofnung, D.C.	08/30/2023
1399 Blank Letter for Med Legal Only	10/11/2023

Enclosed is the proposed letter and records we intend to send to the Qualified Medical Evaluator in 20 days.

Please notify us if there are any objections.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE.

Sincerely

John Merritt
John Merritt
(714) 347-5121

Enc: Proof of Service by Mail (Form 3222)

Mailing Address: PO Box 65005, Fresno CA 93650

Claim Number: 06758786
Employee: Pepper Smith
Date of Injury: 07/31/2022
Employer: Dept Motor Vehicles Att
Human Resources

PROOF OF SERVICE BY MAIL (1013a.2015.5C.C.P.)
STATE OF CALIFORNIA, COUNTY OF Riverside

I, the undersigned, am employed in the County of Riverside, State of California. I am over the age of eighteen years and not a party to the within entitled action. My business address is 3301 Day Street, Riverside, CA 92507-5025.

On, 10/13/23 *(Date)*, I served the within

Eric Gofnung, D.C. of 08/30/2023
1399 Blank Letter for Med Legal Only

on the interested parties in said action by placing a true copy thereof, enclosed in an envelope addressed as follows:

Natalia Foley, 751 S Weir Canyon Rd, Ste 157-455 Anaheim CA 92808-9280

Representing, Pepper Smith

I am readily familiar with State Compensation Insurance Fund's practice of collection and processing correspondence for mailing. Under that practice such envelope would be sealed and deposited with U. S. postal service on that same day with postage thereon fully prepaid at Riverside *(City)* California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after the date of deposit for mailing in this affidavit.

Executed Riverside on 10/13/23 *(Date)*, at Riverside *(City)*, California I declare under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

Kimberlie Noyles

State Fund Representative

1401

October 12, 2023

Alexander Christ
Alexander B Christ, Md
8221 N Fresno St
Fresno CA 93720-2041

Claim Number: 06758786
Employee: Pepper Smith
Date of Injury: 07/31/2022

Dear Dr. Christ

Thank you for your service as the Panel Qualified Medical Evaluator. Please review the enclosed report from Primary Treating Physician Dr. Gofnung and issue a supplemental report discussing if you agree or disagree with the determinations made by Dr. Gofnung.

State Fund has complied with Labor Code section 4062.3. I further attest the total number of pages provided herein is 52 pages. This packet may include the non-billable, non-informational blank backsides of double-sided documents and are excluded from the total page count provided above. I certify that the same is true of my own knowledge, except as to those matters which upon my information or belief I believe them to be true. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: *October 12, 2023* Signature: *John Merritt*

Sincerely

John Merritt
John Merritt
(714) 347-5121

Enc: List of Records

cc: Natalia Foley, 751 S Weir Canyon Rd, Ste 157-455, Anaheim, CA 92808-9280

Claim Number: 06758786
Employee: Pepper Smith
Date of Injury: 07/31/2022

2 6121283 000000006 004 054 06758786

ATTENTION: MEDICAL PROVIDERS

Previously Sent- Previously reviewed attachments/documents are not billable.

COPIES - Please dispose the records in a manner that ensures medical confidentiality or return them to State Fund for disposal.

ATTENTION : STATE FUND
If records are returned, do not reimage.

Name	Date	Previously Sent
Eric Gofnung, D.C.	08/30/2023	

1401