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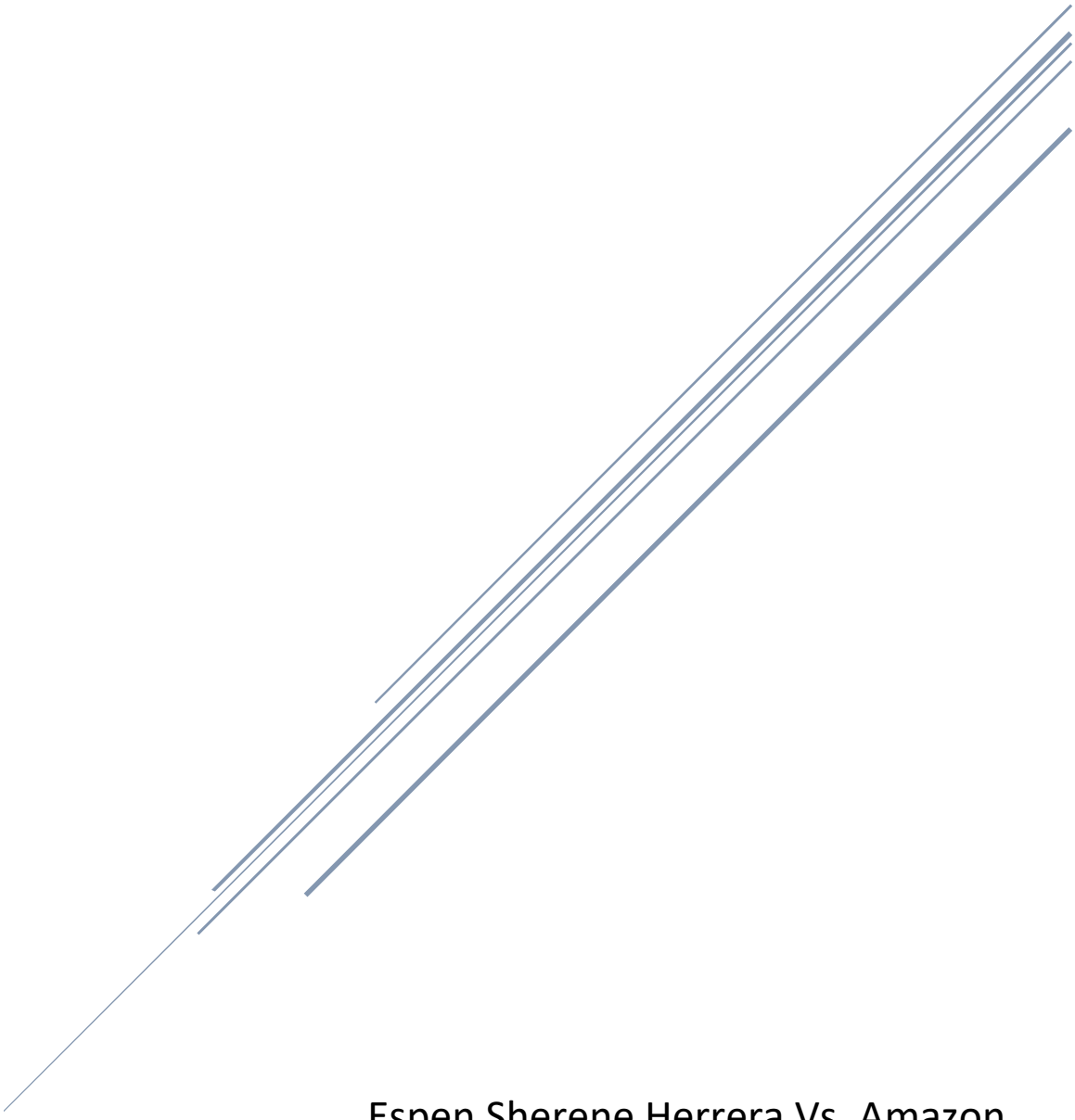

Espen Sherene Herrera Vs. Amazon
By Troy G. Garabedian DC, QME

Re: Espen Sherene Herrera
Date of Injury: 10/14/22

February 28, 2024

Sedgwick
P.O. Box 14184
Lexington, Ky. 40512
Attention: Allison Pryor – Claims

Silberman Lam Visalia
1119 N. Bush Street
Santa Ana, Ca. 92701
Attention: Sheryl Lam – Attorney

Espen Sherene Herrera
February 28, 2024

Name:	Espen Sherene Herrera
Date of Birth:	9/13/1984
Claim No.:	4A2210X2ZGR0001
Date of Injury:	10/14/22
Employer:	Amazon
SSN:	
Driver's License #:	

TABLE OF CONTENTS

Dear Ms. Pryor, Ms. Lam, and Ms. Herrera:

Re: Espen Sherene Herrera
Date of Injury: 10/14/22

INTRODUCTION

On 12/8/2023 my office received a telephone call from Silberman Lam Visalia Law Office . Silberman requested an evaluation for client Ms. Herrera Silberman indicated that I was the "last evaluator standing" after a strike: strike process. My role therefore for this evaluation is of the Panel Qualified Medical Evaluator.

Ms. Herrera was scheduled for an examination on 2/28/2024 at 9:00 a.m. at Northwest Family Chiropractic 5649 N. Palm Avenue Fresno, Ca. 93704. Ms. Herrera identified himself with a California Driver's License.

Prior to the evaluation, I provided Ms. Herrera with a copy of the complete text of Labor Code 4062.3 (e-h) and Title 8 CCR 40. I gave him the opportunity to ask questions. I answered all questions prior to proceeding with the evaluation. Face to face requirements were met in compliance with Labor Code 139.2(j), (5), and 5307.6. Total face - to - face time with Ms. Herrera was minutes.

I conducted every part of the evaluation personally, including 1) obtaining a complete history, 2) reviewing and summarizing the medical records, and 3) composing and drafting the conclusions of the Report. Office Assistant Mary Joy excerpted the Review of Records. I then made additional inquiries as necessary and appropriate to identify and determine the relevant medical issues. Historian Crislyn Importante obtained the initial outline of Ms. Herrera's history. I then made additional inquiries as necessary and appropriate to identify and determine the relevant medical issues.

In compliance with Title 8 CCR 9795, this report is being submitted as ML201-95 Comprehensive Medical Legal Evaluation by the Qualified Medical Evaluator.

HISTORY OF INJURY

ACCORDING TO THE MEDICAL RECORDS

According to the medical records that I received, Ms. Herrera has the following medical history. Ms. Herrera, a right-hand dominant female working as a packer at Amazon, initially reported to Doobay, PA on October 31, 2022, with complaints of raw, red, and painful right middle finger, attributed to repetitive hitting on the edge of the chute. She was diagnosed with paronychia (nail inflammation that may result from trauma, irritation, or infection) and prescribed sulfamethoxazole-trimethoprim. Modified work status was recommended, along with wearing a finger guard and avoiding forced grasping. Anticipated Maximum Medical Improvement (MMI) was set for November 15, 2022.

On November 4, 2022, Ms. Herrera visited Fernandez, MD, for a follow-up on her condition. She continued to experience discomfort in her right middle finger despite antibiotics. No new medications were prescribed. She was advised to continue with light duties and to follow up with her primary care physician (PCP) for a possible evaluation of Raynaud's phenomenon. Work status remained modified with the same recommendations as before.

Her next follow-up on November 10, 2022, again addressed the ongoing issue with her right middle finger. Despite completing antibiotics, she experienced increased redness, tenderness, and numbness in the finger, exacerbated by cold weather. Additionally, purple discoloration was noted in other fingers. Due to difficulties in accessing medical care, further evaluation including an MRI, consultation with a hand specialist, and X-rays were recommended. Her anticipated MMI was extended to January 5, 2023. Work status remained unchanged.

On December 2, 2022, Ms. Herrera visited Fernandez, MD for a follow-up on her right middle finger, reporting an injury sustained from hitting it on the frame of a casing where products were placed. She was diagnosed with paronychia and dislocation of the skin of the finger. Treatment included starting sulfamethoxazole-trimethoprim, pending referral authorization for hand surgery and MRI. Modified work status and continued use of a finger guard were advised, with an anticipated Maximum Medical Improvement (MMI) date of January 5, 2023.

On December 12, 2022, Ms. Herrera underwent an MRI of her right hand, revealing mild nonspecific bone marrow edema in the distal phalanx of the third finger, along with soft tissue injury. Fibrosis/scar tissue at the proximal attachment of the volar plate of the fifth finger, tenosynovitis, and small joint effusion in the metacarpophalangeal joints of the second and fourth fingers were also noted.

Subsequently, on December 16, 2022, Ms. Herrera returned to Fernandez, MD for further evaluation. The wound on her right middle finger persisted, though not actively bleeding, and remained swollen, sensitive, and tender. The MRI findings were discussed, indicating potential bone contusion and soft tissue injury. Cellulitis was also considered. Treatment included clindamycin, referral to a hand specialist pending, and a follow-up appointment in two weeks. Work status and recommendations remained unchanged.

On December 25, 2022, Ms. Herrera underwent an X-ray of her hand by Alapati, MD, which revealed no acute bone or joint abnormalities.

On December 25, 2022, Ms. Herrera sought medical attention from Thiesen, DO, reporting three months of progressively worsening infection and pain in her right fourth finger. She noted swelling that began approximately three months ago, exacerbated by wearing a band-aid and glove for work, causing irritation due to moisture. She described a split in the swollen area with worsening symptoms. Additionally, she had a recent history of osteomyelitis in her right middle finger, with associated numbness, tingling, and loss of sensation. Thiesen, DO, assessed the likelihood of chronic osteomyelitis, less likely necrotizing fasciitis, and recommended outpatient follow-up with continued ibuprofen and clindamycin. Consultation with hand surgeon Dr. Avena suggested possible amputation and outpatient follow-up.

Ms. Herrera visited Stehr, MD, on January 6, 2023, complaining of a non-healing wound on the tip of her right middle finger, attributing it to banging the fingertip against metal at work. She reported diffuse pain and aching in the finger, rating the severity at 6/10. Stehr, MD, diagnosed a cutaneous abscess and suggested a trial of double antibiotic ointment, holding off on systemic antibiotics for the time being. High-quality dressing changes were recommended, with a plan to reassess in about a week.

Follow-up on January 13, 2023, with Stehr, MD, noted ongoing pain at the laceration site of the distal phalanx of the right long finger. Medications included Polysporin and Hydrocodone acetaminophen. Ms. Herrera's work status remained modified, with no use of the right hand and instructions to keep the wound/dressing clean and dry.

On the same day, Doobay, PA documented Ms. Herrera's visit, reporting sharp and throbbing pain in the arm, as the hand specialist's recommended ointment was not received due to insurance issues. The patient had not undergone a biopsy as suggested. The assessment indicated a lesion of the finger, with pending referral authorization for hand surgery. Clindamycin treatment was ongoing, with a scheduled return in three weeks and an anticipated Maximum Medical Improvement (MMI) date of April 7, 2023. Work status remained modified, with specific limitations on hand usage and weightlifting.

On January 26, 2023, Ms. Herrera returned to the clinic for a follow-up on her right middle finger. She reported intense pain rated at 10/10, noting that the eschar had fallen off. Despite denying numbness or tingling, she acknowledged continued inadvertent bumping of the finger at work. Dr. Stehr discussed the importance of protecting the fingertip from repetitive trauma and recommended wearing an aluminum splint. Work restrictions were reiterated, emphasizing the need to keep the wound clean and dry, with the option for temporary total disability (TTD) if accommodations couldn't be met at work. Dressing changes were modified to minimize pain using adaptic. Follow-up was scheduled in one week.

On February 3, 2023, there are visit notes from both Stehr, MD, and Doobay, PA, but the details of these notes are not provided.

Ms. Herrera visited Stehr, MD again on February 17, 2023, where she reported difficulty abstaining from using her finger despite instructions. The lack of a biopsy was noted, along with the MRI findings from December 12, 2022. Diagnoses included a finger lesion and dislocation of the skin, with anticipated Maximum Medical Improvement (MMI) set for June 4, 2023. A referral to a hand specialist was planned, with a follow-up in four weeks. Work status transitioned to full duty on April 4, 2023.

Further progress notes were recorded on May 9, 2023, June 23, 2023, and August 22, 2023, by Doobay, PA.

On October 5, 2023, Ms. Herrera visited The Institute for Hand and Microsurgery for a second opinion consultation with a hand surgery specialist. She reported intermittent sharp and stabbing pain in her right middle finger, with pain radiating to her right arm, ranging from 4 to 10 out of 10 in intensity. Her symptoms worsened with moisture and movement, and she experienced tingling and numbness in the finger. The diagnosis included contusion of the right middle finger without nail damage, chronic pain, pyogenic granuloma, and chronic osteomyelitis of the right hand. Recommendations included further diagnostic studies such as MRI and bone scan, along with transdermal cream and urine drug testing.

Following this consultation, on October 7, 2023, The Institute for Hand and Microsurgery conducted a secondary treating physician review focusing on hand, neuro, and orthopedic aspects of Ms. Herrera's medical records.

ACCORDING TO MS. HERRERA

Ms. Herrera is a 39-year-old, right hand-dominant female, currently not working with her employer, Amazon. On October 14, 2022, while at the workplace as a box packer, she suffered an industrial injury to the tip of her right middle finger. She stated that she was performing her routine duties when she went to grab the item from the shelf, the edge of item which was a little squared, hit her middle finger’s tip against the wall/block. It became red and sensitive, but she thought it will go away on its own, so she didn’t report it immediately but when it became too sore, tender and swollen, she reported this to her supervisor on the 30th of October 2022. She was sent to Concentra Managed Care on 10/30/2022 where

she was seen by Dr. Dubey. She does not remember specific medicine that was given but she recalls she was asked to just keep it covered with a finger guard. She was sent back to her work with restrictions to avoid forceful grasping with it.

RELEVANT MEDICAL HISTORY

Ms. Herrera does not have a medical history relevant to the current claim for industrial injury. I asked her specifically:

- Prior Industrial Injuries: Yes - Injured index finger of right hand in 2019 with the same employer. She did not receive any treatment. The index finger is now fine and currently she has no problem with it.
- Prior non-industrial injury: No.
- Subsequent industrial injury: No.
- Subsequent non-industrial injury: No.

Finally, to be complete, I asked Ms. Herrera, "Have you EVER had injury to the similar body part (tip of right middle finger) that is now involved in this Workers' Compensation Claim?" To this, she replied, "No."

REVIEW OF RECORDS

I, Troy G. Garabedian DC, QME declare under penalty of perjury that, pursuant to Labor Code section 4628 and Title 8, California Code of Regulations section 9793(n), I have reviewed pages of 8 ½ X 11 single sided documents, chart, or paper (whether in physical or electronic form) records in connection with my examination of Ms. Herrera.

I received the following documents:

- Applicant Attorney: pages
- Defense Attorney: pages
- Claims Administrator: pages
- Total: pages

Attached to this Report are the declarations and attestations that I received from the parties.

Re: Espen Sherene Herrera
Date of Injury: 10/14/22

In compliance with Labor Codes 4062.3 (d), 4628 (a) (2), and Title 8 CCR 10682 and Title 8 CCR 41 (b)(2), below is a listing and summary of the records that I received, reviewed, and relied upon in the preparation of this report.

RECORDS - LISTED AND SUMMARIZED IN CHRONOLOGIC ORDER:

1. 10/31/22	Doobay, PA – Doctor's First Report of Occupational Injury/Illness • History: Ms. Herrera is a right hand dominant female who is a packer at Amazon. She states that repeatedly hits the middle finger on the edge of the chate which has caused her finger to become raw, red, and painful. She states that it was swollen on the DOI: 10/14/22, this has subsided some. She has been to a care, and they iced her finger. • Assessment: o Paronychia of right middle finger • Plan: o Start sulfamethoxazole – trimethoprim • Discussion/Summary: o Patient is hx abx for the paronychia and infection. o Discussed wound once with application of Bactrim ointment twice a day and 4 fingers. o Return 2-4 days. • Anticipated MMI: 11/15/22 • Work Status: o Modified work o Wear finger guard on the finger. o No forced grasping.
2. 11/4/22	Fernandez, MD – Progress Notes • History: Ms. Herrera is here for follow up on right her middle finger. She is a right hand dominant female who is a packer at amazon. She states tat repetitively hits the right middle finger on the edge of the chute which has caused her trigger to become raw, red and painful. She has been lacing antibiotics with relief. She states that she had purple fingers a few days ago to all fingers. • Assessment: Paronychia of right middle finger • Plan: o No medications were prescribed or dispensed for the encounter. o Discussion/Summary: o Continue abx and light duties, advised follow up with PCP for possible evaluation of underlying condition of Raunds phenomenon. o Follow up 1 week. • Work Status: o Modified work o Wear finger guard on the finger. o No forced grasping.
3. 11/10/22	Doobay, PA – Progress Report • History: Ms. Herrera follow up on her right middle finger. She is a right hand dominant female who is a packer at Amazon. She states that repetitively hits in right middle finger on the edge of the chute which has caused her finger to become raw, red

	and painful. She has been taking antibiotics with relief, but after completion of the antibiotics and now the cold weather she has more redness and tenderness and numbness of the finger. She has in the office purple discoloration of the other fingers. She has not been able to follow up with PTP until February as she is I the progress changing PCP. She is working on modified duties. • Functional restoration and status of healing. Ms. Herrera is approximately 25% the way toward meeting on the physical requirements of her job. • Assessment: o Injury due to laceration of hand and foot. o Paronychia of right middle finger Plan: o Dislocation of skin of finger. • Plan: o MRI, right finger o Hand specialist o X-ray. o Follow up in 2 weeks. • Anticipated MMI 1/5/22. • Work Status: o Modified work o Wear finger guard on the finger. o No forced grasping.
4. 11/18/22	Doobay, PA – Progress Report
5. 12/2/22	Fernandez, MD – Progress Notes • History: Ms. Herrera is presents today with follow up on right middle finger. She states that she hit it the lop on the frame of a casing where they placed that products. • Assessment: o Paronychia of right middle finger o Dislocation of skin of finger • Plan: o Start sulfamethoxazole – trimethoprim o Pending referral authorization for hand surgery and MRI. o Return 2 weeks o Anticipated MMI: 1/5/22 • Work Status: o Modified work o Wear finger guard on the finger. o No forced grasping.
6. 12/12/22	Radnet – MRI Right Hand Without Contrast (bad copy) • Impression: o Mild nonspecific bone marrow edema within the distal phalanx of the third finder with adjacent mild subcutaneous edema which can represent bone contusion with associated soft tissue injury. Other etiologies including early osteomyelitis and mild adjacent cellulitis are not completely excluded although probably less likely. Recommend clinical correlation. o Prominent hypointense soft tissue at the proximal attachment of the volar plate at the PIP joint of the fifth fingers suggest fibrosis/scar tissue due to chronic injury to the volar plate. o Mildly prominent injection of the fifth finger flexor tendons from the proximal phalanx raises the concern for injury to the A2 and C1 pulleys.

	○ Tenosynovitis involving the flexor tendon sheath of the fifth finger proximally at the level of the proximal phalanx and localized minimal physiologic fluid within the flexor pollicis longus tendon sheath versus minimal tenosynovitis. ○ Small joint effusion within metacarpophalangeal joints of the second and fourth fingers.
7. 12/16/22	Fernandez, MD – Progress Notes • History: Patient comes in for follow up right middle finger pain. the wound is still present. But not actively bleeding. It is still swollen at the lip and I very sensitive and fender. She had an MRI of the right hand on 12/12/22 which revealed mild non – specified bone marrow edema with the distal phalanx of the third finger with adjacent mild subcutaneous edema with can represent a bone contusion with associated soft tissue injury. Other etiologies, including earl osteomyelitis and mild cellulitis are not completely excluded although less likely. • Assessment: ○ Paronychia of right middle finger ○ Dislocation of skin of finger ○ Cellulitis • Plan: ○ Clindamycin ○ Hand specialist ○ Pending referral hand specialist ○ Follow up in 2 weeks. • Work Status: ○ Modified work ○ Wear finger guard on the finger. ○ No forced grasping.
8. 12/23/22	Fernandez, MD – Progress Notes
9. 12/25/22	Alapati, MD – XR Hand • Impression: NO acute bone or joint abnormality seen.
10. 12/25/22	Thiesen, DO – Final Report
11. 12/26/22	Thiesen, DO – Final Report • History: Ms. Herrera presents with 3 months of progressively worsening infection and pain of the right fourth finger. States that is started getting swollen about 3 months ago. Notes, that she has wearing a band – aid over it and glove for her work and notes that skin became irritated from being moist all the time. She then note3s that an area in the middle of the swelling split open and the swelling worsened. • Additional history: ○ Ms. Herrera right hand dominant recent history of osteomyelitis presents to ED c/o of worsening right middle finger pain and swelling. Associated with numbness, tingling and loss sensation. • Medical Decision Making: ○ Patient likely has chronic osteomyelitis, less likely necrotizing fasciitis as patient has had this for a while whereas necrotizing fasciitis spreads fairly quickly. Reassuring that tenderness is localized to right middle finger. Consulted hand surgeon Dr. Avena who states patient may need outpatient. Recommends outpatient follow up and willing to see patient as early as this Tuesday. Continue ibuprofen for pain and clindamycin. • Impression: Chronic multifocal osteomyelitis of right hand

	• Consults:
	  o 12/25/20 Dr. Avena recommends outpatient follow up for possible amputation.
	  o Available to see patient on Tuesday.
	• Plan:
	• Condition: Stable
	• Disposition: Discharged.
	• Follow up with : No PCP. Follow up as needed, follow up with hand surgeon Dr. Avena on Tuesday return to ED if symptoms worsen.
	• Counseled.

12. 1/6/23	Stehr, MD - Visit Notes
	• History: Ms. Herrera presents to clinic for chief complaint of a non-healing wound on the tip of her right middle finger. The patient denies any individual specific traumatic even to the finger. Rather she notes that this came on from banging the fingertip against a metal while at work. She rate her pain a 6/10. She notes diffuse pain in the finger. She has been applying triple antibiotic ointment.
	• The patient complains of pain at the laceration site of the distal phalanx of the right long finger. Severity 6/10, aching, and constant.
	• Assessment/Plan:
	  o Cutaneous abscess of right hand
	• Plan:
	  o I suggested a trial of double antibiotic ointment.
	  o I suggested that we hold off on antibiotics for the time being. We will do high quality dressing changes. I will see her back about 1 week.
	  o Did come up during the interview that she has had difficulty healing other wounds. I explained that there are some vitamin deficiencies and some other very usual and esoteric problems, that can cause difficulty wound healing. If the wound does not heal with high quality dressing changes, she may need a deep metabolic work up.
	  o I will reassess in about a week.
	  o Today test completed x-ray.
	• Medications:
	  o Polysporin
	  o Hydrocodone acetaminophen
	• Work Status:
	  o Modified work
	  o No use of right hand
	  o Must keep wound/dressing clean and dry.

13. 1/13/23	Stehr, MD - Visit Notes
14. 1/13/23	Doobay, PA – Progress Notes • History: Ms. Herrera, she has sharp and throbbing pain to the arm, reportedly the hand specialist sent an ointment, did not receive to insurance issues. The patient has not had biopsy an ointment. As noted, she had MRI of right hand on 12/22/22 which reveled mild nonspecific bone marrow edema within the distal phalanx of the third finger with adjacent mild subcutaneous edema which can represent a bone contusion with associated soft tissue injury. • Functional Restoration and status healing: Healing is in the beginning stages. • Assessment: Lesion of finger. • Plan:

	○ Still pending referral authorization for hand surgery but patient noted receiving authorization, ○ Will continue clindamycin • Return in 3 weeks. • Anticipated MMI: 4/7/23. • Work Status: ○ Modified work ○ Wear finger guard on the finger ○ No forced grasping. ○ No use of right middle finger ○ If using weights, limited to 3lbs.
15. 1/26/23	Stehr, MD - Visit Notes • History: Ms. Herrera returns to clinic today for follow up of her right middle finger. The patient today reports 10/10. She notes that the eschar has fallen off. She denies any numbness or tingling. On very thorough questioning the patient does note that she has essentially at work continuing to bump the finger. I have been explicit my instructions that she is basically not to use the right hand at work. • Assessment/Plan: ○ Cutaneous abscess of right hand. • Plan: ○ We discussed that unfortunately appears that she is having difficulty healing this as she continues to inadvertently confused the fingertip both work and at home. ○ We discussed that in order for the fingertip to heal she Must protect this from repetitive trauma. We discussed realistic ways of doing as wearing over under foam aluminum splint. ○ Discussed her work restrictions. Noted that today that she must use the right hand and that the right hand must be kept clean and is she return to work. If these accommodations cannot be met at work, then the patient should be placed on TTD so that the wound may heal before returning to work. ○ The wound does show improvement since the last visit this is healing somewhat slowly. My assumption is that if the patient can reliably the fingertip this would heal without incident. ○ Discuss her dressing change regime. It appears that she has been using regular gauze on the fingertip and there has been some adherence causing her significant pain. I introduced her to adaptic. We discussed that this minimally adherent wound dressing. Hopefully this should facilitate some of her dressing changes and minimize her pain. ○ I will see her back in 1 week. • Work Status: ○ Modified work: Today until next appointment. ○ No use of right hand ○ Must keep wound/dressing clean and dry.
16. 2/3/23	Stehr, MD - Visit Notes
17. 2/3/23	Doobay, PA – Progress Notes
18. 2/17/23	Stehr, MD - Visit Notes
19. 3/3/23	Bznouni, NP – Progress Notes
20. 3/17/23	Stehr, MD - Visit Notes
21. 4/4/23	Doobay, PA – Progress Notes

	• History: Ms. Herrera follow up on her right middle finger wound. She is seeing RHC and saw then today. She sates that they have a f/u with her 2/17/23. She has been abstaining from using her finger, but it is due to difficulty. The patient has not had biopsy yet. As noted, she had her MRI of the right hand on 12/12/22 which revealed mid non – specific bone marrow edema within the distal phalanx of the third finger with adjacent mid subcutaneous edema which can represent a bone contusion with associated soft tissue injury. • Diagnoses: o Lesion of finger. o Dislocation of skin of finger o Anticipated MMI: 6/4/23 o Follow up in 4 weeks. • Plan: o Hand specialist referral • Work Status: Full duty 4/4/23.
22. 5/9/23	Doobay, PA – Progress Notes
23. 6/23/23	Doobay, PA – Progress Notes
24. 8/22/23	Doobay, PA – Progress Notes
25. 10/5/23	The Institute for Hand and Microsurgery – Second Opinion Hand Surgery Specialist Consultant Only • Subjective Complaints: o Intermittent sharp and stabbing pain in the right middle finger. o Pain radiates to the right arm. o Pain is 4-10/10. o Right finger pain is aggravated when her hand is moist and moving or touching it. o Right finger pain is alleviated by nothing. o Pain to the right middle finger 8/10 pain when hit. o Increasing pain to the right middle finger with cold environments. o Patient notes intense pain to themed of the middle finger (right hand) when wound peels. o Tingling sensation to the right middle finger, constant. o Numbness to the right fingertip, constant. o Diagnosis: o Contusion of right middle finger without damage to nail, sequela. o Pain in right fingers. o Pyogenic granuloma o Other chronic osteomyelitis, right hand. • Assessment: o S/p right long finger blunt trauma o Right long finger chronic pain o Right pyogenic granuloma, rule out vs. foreign body o Right long finger osteomyelitis: Rule out o Treatment Recommendations: o Treatment Recommendations: o Jon status: Presently, this patient returned back to performing regular duties for the original employer. • Job Status: o Job Status: Presently, the patient returned back to performing regular duties for the original employer.

- Permanent and Stationary Status: We defer the P& S status to the PTP.
- Return Plan: RTC: Follow up evaluation is recommended in 4 weeks.
- MRR: All medical records from DOI through DFE requested on DFE.
- Radiology:
- MRI of right finger
- We presently looking to rule out following: MRI of the right finger: right pyogenic granuloma vs. foreign body.
- Recommending:
    - Finger x-ray series: AP, LAT with fingers famed, OBLQ
    - Location: Bilateral long
    - We presently looking to rule out the following:
    - Bilateral x-rays of the fingers: S/p right long finger blunt trauma w/chronic pain
    - Recommending bone scan of bilateral upper extremities.
    - We are presently looking to rule in/out following Bone scan of the BUE: Right long finger osteomyelitis rule out.
    - Transdermal Cream:
    - Naproxen
    - Diclofenac sodium
    - Zilido
    - UDT:
    - Request authorization for urine drug testing
- Discussion:
    - Ms. Espin is a 39 year old right handed, female, who sustained a working related injury to the right long finger on 10/14/22.
    - Since the patient was last evaluated by the previous PTP, there has been no additional evaluation of treatment nor has the patient completed any additional diagnostic studies.
    - The patient was working for approximately 2 years for the original employer prior to the date of injury.
    - The patient first began having symptoms: on the day of the injury.
    - The patient was working with other employers thru chubby holes. She was grabbing items out of a shoot. She was wearing median gloves. Her right long finger hit metal France of the chubby hole. At the time of the injury, the patient had pain. there was no bleeding. There was swelling. The patient was able to complete the work shift. At the beginning the patient self – treated. The long finger was red and sensitive sore the patient did not seek attention from the PCP. The patient hit her right ling finger again and the pain was unbearable. The patient was finally evaluated in the company clinic at Amcare on 10/14/22. The next day, the patient was sent to Concentra industrial clinic.
    - The patient was first evaluated by the orthopedic surgeon, Dr. Stehr, in January/February of 2023, he states that the was no infection. He recommended hyperbaric chamber or a biopsy. No treatment was rendered. The patient did not receive any cortisone injections or surgery.
    - The last evaluation with the orthopedic surgeon was in March of 2023.
    - The last evaluation with the PTP was recent and ongoing.
    - As for the work status, the patient is performing regular duties.
- Summary:

	○ The patient is presenting with a non – healing wound at the distal tip of the right long finger. ○ Sthe states that when the wound is opened, the pain is unbearable. ○ She has been evaluated by an orthopedic hand surgeon ○ She has not had nay cortisone injection or surgery. ○ We are requesting that all previous medical records, from original date of injury thorough today, he provided for my review. ○ We are recommending authorization to obtain an MRI of the right long finger. Right pyogenic granuloma vs. foreign body, ○ In addition, we now require a bone scan of the BUE: Right long finger osteomyelitis. Rule out. ○ We also require bilateral x-rays of the long fingers: S/p right long finger blunt trauma w/chronic pain. ○ Urgent: This is a consult only and we require immediate authorization for US to proceed with reevaluation and treatment. ○ Return to clinic for regular evaluation in RG. ○ When the patient return in January, we will proceed with comprehensive prolonged reevaluations of all the body parts injured. ○ With regard to work status, we are recommending that the decision remains with the PTP: at this time, the patient is back to regular duties, but the patient is under m flex schedule. • Casuation: ○ It is within reasonable degree of medical probability that specific incident or work caused, aggravated and/or exacerbated the claimants condition, disability and impairment. ○ The claimant injury arose out of employment and was caused by employment. (lab. Code sections 3600). ○ In the process of formulating opinions pertaining to causation, I take into account numerous factors. ○ These includes the mechanism of injury, the type of temporal onset of symptoms, the history given by the examinee of other pertinent objective tests, knowledge of the pathology and the pathophysiology of specific discase or injuries, knowledge of the overall health of the individual and other pertinent information including my experience, knowledge, and training. • Apportionment: ○ There is no medical evidence pre – injury restrictions, limitation or accommodation that cause or can be related to the claimant's permanent disability, therefore no apportionment. • Future Medical Care: ○ This patient is a candidate for future medical care. In the event of reoccurrence of symptoms and the absence of new causation, the patient should have access to the senior orthopedic hand surgery specialist. • AMA Impairment Rating: At this time this patient is not considered P&S and therefore, it is premature to determine permanent impairment. • Presently this patient is NOT considered Permanent and Stationary and therefore has not reached MMI. The final determination for when the patient reaches MMI and when the patient is to be considered P&S is deferred to the PTP. The work and disability status will remain under the direction of the PTP. • We recommending that this patient requires access to a Senior Surgery Specialist.

	• We require that all of our recommended diagnostic study analysis be completed by our next reevaluation. We also require that all previous medical records from the original date of injury through today we provided for our own review. • Recommendations for this patient: o That all previous records , from the original date of injury through today, be provided for our review. o Authorization is required to have this patient return to secondary treating physician follow up high complexity evaluation. o Awaiting receipt of all medical records and new diagnostic studies, to determine if this patient might be a candidate for conservative management or more invasive treatment, including surgery. • With regards to work status, we are recommending that the decision be made by the PTP.
26. 10/7/23	The Institute for Hand and Microsurgery – STP Hand/Neuro/Orthoclastic Medical Record Review.
27. 10/13/23	DWC – RFA

OCCUPATIONAL HISTORY

Ms. Herrera provided the following 15-year work history.

Date Range	Employer	Industrial Injury
April 2021 To October 21, 2023	Amazon (Second employment)	Tip of right middle finger
August 2019 To December 2020	Amazon (First employment)	Index finger of right hand
Does not recall dates	AVM	None

Ms. Herrera had worked for 3 years for Amazon prior to the industrial injury dated October 14, 2022. The Description of Employee's Job Duties that I received is signed by Ms. Herrera only (no supervisor signature). The form is dated . The Description of Job Responsibilities is described as:

> "As a box packer, my job duties involve getting a specimen sheet, putting things in a box, packing it, and shipping it off."

Activities that are described as Never (0 hours) include:

- Climbing, crawling and fine manipulation.

Activities that are described as Occasional (up to 3 hours per day) include:

- Sitting, walking, bending from the waist, squatting, kneeling, twisting at the neck level, and twisting from the waist.

Activities that are described as Frequent (3-6 hours per day) include:

- Standing, bending, power grasping with both hands, reaching above the shoulder area, and reaching below the shoulder level.

Activities that are described as Constant (6-8+ hours per day) include:

- Use of both hands, repetitive or frequent hand movements, simple grasping with both hands, and pushing and pulling with both hands.

Lifting requirements are described as:

- 0-10 lbs. 6 hours
- 11-25 lbs. 6 hours
- 26-50 lbs. 3 hours
- 51-75 lbs. 3 hours
- 76-100 lbs. 2 hours
- 100+ lbs. 0 hours

Carrying requirements are described as:

- 0-10 lbs. 1 hours
- 11-25 lbs. 1 hours
- 26-50 lbs. 1 hours
- 51-75 lbs. 1 hours
- 76-100 lbs. 0 hours

Describe the heaviest item required you to carry and the distance to be carried: “Box weighing up to 50 lbs.”

Employee Comments: “ .” .
Employer Comments: “ .”

On the DEU Form 100 Employee's Permanent Disability Questionnaire submitted and signed on it asks: “What were your job duties at the time of your injury?” Ms. Herrera responded: “As a box packer, my job duties involve getting a list, putting things in a box, sealing it, and sending it off.”

Ms. Herrera is currently not working. Her last day of work with Amazon (Employer) was October 21, 2023.

CLAIMANT REPORT OF SYMPTOMS

On a form that Ms. Herrera completed and submitted to me on the date of the QME evaluation, she described the following Current Complaints:

- Describe in your own words your symptoms with regard to your industrial injury (Tip of right middle finger). Include details regarding frequency, duration, and intensity of any symptoms:

SYMPTOMS	INTENSITY (1 -10)	FREQUENCY	DURATION
Pain in tip of the right middle finger	8	Intermittent	Since the time of injury.

- Have your symptoms gotten better, gotten worse, or have they leveled off? “Gotten worse.”

SYMPTOMS WORSE

- If your symptoms have gotten worse, over what period of time have you noticed this worsening? “My symptoms got worsened within a month's time.”
- If symptoms have gotten worse, what makes the symptoms worse and why? “My symptoms began to worsen due to the opening of the cut in the middle where I applied ointment and a Band-Aid. It became moist, swollen, and more sensitive. When I wear gloves, it feels fine, but when they become soaked, it worsens more.”

MEDICAL TREATMENT

- Do you feel that the treatment that you have received to-date has been of help? “No. I received no treatment except a finger guard initially, and my finger worsened later on.”
- Do you feel that any additional treatment – such as Chiropractic, Physical Therapy, Acupuncture, Medical Care, Surgery, etc. – would help your condition? If “yes,” what type of treatment? “Rest may help, along with taking pills and consulting a dermatologist. Regular dressing may also be beneficial.”
- Have you ever declined treatments, medications, surgeries, or other procedures in connection with this injury? “No.”

Ms. Herrera elaborated on her Current Complaints by describing:

- Tip of the right middle finger: It is tender to the touch, sore, and swollen. Proper treatment has not been received so far.

ACTIVITIES OF DAILY LIVING ASSESSMENTS

On direct questioning, Ms. Herrera described the effect of the right middle finger pain symptoms on her ability to complete activities of daily living (see AMA Guides – page 4) as follows:

Activities of Daily Living - Categories	Impact of (Tip of the right middle finger) on Activities of Daily Living:
Self-care & personal hygiene:	
• Urinating	She is not limited in this activity

• Defecating	She is not limited in this activity
• Brushing Teeth	She is not limited in this activity
• Combing Hair	She is not limited in this activity
• Bathing	She is not limited in this activity
• Dressing Oneself	She is not limited in this activity
• Eating	She is not limited in this activity
• Other	
Communication Activities:	She is not limited in this activity
• Writing	She is not limited in this activity
• Typing	She is not limited in this activity; however, she is experiencing some difficulty while typing with her right hand.
• Seeing	She is not limited in this activity
• Hearing	She is not limited in this activity
• Speaking	She is not limited in this activity
• Other	
Physical Activities	
• Standing	She is not limited in this activity
• Sitting	She is not limited in this activity
• Reclining	She is not limited in this activity
• Walking	She is not limited in this activity
• Climbing Stairs	She is not limited in this activity
• Jobs around House	She is not limited in this activity
• Other:	
Sensory Functions:	
• Hearing	She is not limited in this activity
• Seeing	She is not limited in this activity
• Tactile Feeling	She is not limited in this activity
• Tasting	She is not limited in this activity
• Smelling	She is not limited in this activity
• Other	
Non-Specialized Hand Activities:	
• Grasping	She is not limited in this activity; however, she is experiencing some difficulty while grasping with her right hand.

• Lifting	She is not limited in this activity
• Tactile (touch) Discrimination	She is limited in this activity as numbness is present, making it difficult to discriminate touch with her right middle finger.
• Other (Clicking/Clunking Wrist)	N/A
Travel Activities:	
• Riding	She is not limited in this activity
• Driving	She is not limited in this activity
• Flying	She is not limited in this activity
• Other	
Sexual Functions:	
• Orgasm (female)	She is not limited in this activity
• Lubrication (female)	She is not limited in this activity
• Erection (male)	N/A
• Ejaculation (male)	N/A
• Pain (both sexes)	She is not limited in this activity
Sleep:	
• Restful Sleep	She is not limited in this activity.
• Nocturnal Sleep Pattern	N/A
• Daytime Sleepiness	N/A
• Other	

The results of the Activities of Daily Living Assessment indicate that Ms. Herrera considers her tip of the right finger pain condition to be impairing. In my opinion, this is .

PHYSICAL EXAMINATION

OBSERVATION

- General Gait: Ms. Herrera was observed to ambulate throughout the office moving from the area into the examination area without difficulty.
- Sitting: He sat comfortably for over hour during the interview in no apparent distress.

- Rising from Chair: Minor's sign was negative, and he rose from sitting to standing without the use of his hands.
- Body Habitus:
    - He appeared his stated height of and weight of lbs.
    - There was no gross postural deformity noted.

UPPER EXTREMITY EXAMINATION

INSPECTION

- On visual inspection of the upper extremities, the arms were symmetric bilaterally in shape and size. The symptomatic right hand did not present with any notable mass, deformity, edema (swelling), redness, ecchymosis (bruising), or other abnormality. I concluded that there were no "red flags" for serious systemic or local condition such as infection, tumor, inflammatory condition, or vascular disease.
- XXXXX
- XXXXX

UPPER EXTREMITY PERIPHERAL NERVE EXAMINATION

REFLEX EXAMINATION

Reflexes of the upper extremities demonstrated:

REFLEX	LEFT	RIGHT
Biceps (Musculocutaneous nerve):	+2 (normal)	+2 (normal)
Extensor Digitorum (Radial nerve):	+2 (normal)	+2 (normal)
Triceps (Radial nerve):	+2 (normal)	+2 (normal)

The upper extremity reflexes were symmetric bilaterally. This indicates preserved and intact function of upper extremity peripheral nerves.

SENSORY EXAM

The Sensory Examination consisted of procedures to test the sensory modalities of light touch, and two point discrimination.

Superficial Tactile Sensibility (Light Touch) – This Sensory Exam was performed using a Semmes – Weinstein monofilament. A 2.83 gauge monofilament is similar to a human hair.

Two Point Discrimination – This Sensory Examination was performed using the Aesthesiometer Instrument. Normal two point discrimination is 2-4 mm. on the fingertips, 4-6 mm. on the dorsum of the fingers, 8-12 mm. on the palm, and 20-30 mm. on the dorsum of the hand.

- Radial Nerve: Sensory
  - Normal sensation to light touch at the dorsal web space between thumb and index finger bilaterally.
  - Two point discrimination testing was at the dorsal web space between thumb and index finger bilaterally.

- Ulnar Nerve: Sensory
  - Normal sensation to light touch at the distal ulnar aspect of the little finger bilaterally.
  - Two point discrimination testing was at the distal ulnar aspect of the little finger bilaterally.

- Median Nerve: Sensory
  - Normal sensation to light touch at the distal radial aspect of the index finger bilaterally.
  - Two point discrimination testing was at the distal radial aspect of the index finger bilaterally.

The upper extremity peripheral nerve sensory exam for light touch, and two point discrimination sensibility was normal with no reported alteration of sensitivity to either upper extremity – including no numbness, no hypoesthesia (reduced sensation), and no hyperesthesia (increased sensation). This indicates preserved and intact sensory function of the upper extremity peripheral nerves.

MOTOR EXAM

The motor examination was performed by manual muscle testing.

- Radial Nerve: Motor
  - Resisted wrist extension using the extensor carpi radialis longus and brevis was strong and symmetric bilaterally with no evidence of weakness or give way. This tests the motor portion of the peripheral radial nerve.
  - Resisted thumb extension using the extensor digitorum communis, indicis and minimi was strong and symmetric bilaterally with no evidence of weakness or give way. This tests the motor portion of the peripheral radial nerve.

- Ulnar Nerve: Motor
  - Resisted abduction of the little finger using the dorsal interossei and abductor digiti minimi was strong and symmetric bilaterally with no evidence of weakness or give way. This tests the motor portion of the peripheral ulnar nerve.

- Median Nerve: Motor

- Resisted thumb pinch using the lumbricales and interosseous muscles as well as the long flexors and extensors of the thumb and index finger was strong and symmetric bilaterally with no evidence of weakness or give way. This tests the motor portion of the peripheral median nerve.
- Resisted thumb opposition using the opponens pollicis and opponens digiti minimi was strong and symmetric bilaterally with no evidence of weakness or give way. This tests the motor portion of the peripheral median nerve.
- Resisted thumb abduction using the abductor pollicis brevis was strong and symmetric bilaterally with no evidence of weakness or give way. This tests the motor portion of the peripheral median nerve.

RIGHT HAND EXAMINATION

INSPECTION

- Digit Lateral Deviation – there were no findings for digit lateral deviation of any of the digits of the left hand.
- Synovial Hypertrophy – there were no findings for synovial hypertrophy of any of the digits of the left hand.
- Digit Rotational Deformity - there were no findings for digital rotational deformity of any of the digits of the left hand.
- Finger Subluxation or dislocation - there were no findings forefinger subluxation or dislocation of any of the digits of the left hand.
- Joint Passive Mediolateral Instability - there were no findings for instability of any of the digits of the left hand.
- Thumb/Finger Arthroplasty – Ms. Devany has not had surgical arthroplasty of any of the digits of the left hand.
- Constrictive Tenosynovitis - there were no findings for constrictive tenosynovitis of any of the digits of the left hand.
- Extensor Tendon Subluxation - there were no findings for extensor tendon subluxation of any of the digits of the left hand.

The right hand range of motion, as measured by finger goniometer, was as follows:

RIGHT HAND:		Carpometacarpal joint tested/normal	Metacarpo-phalangeal joint tested/normal	Interphalangeal joint tested/normal
Thumb	Extension	N/A	/40	/30
	Flexion	N/A	/60	/80
	Adduction	/0-8 cm.	N/A	N/A
	Radial Adduction	/0-50 degrees	N/A	N/A

	Opposition	/0-8 cm.	N/A	N/A

Figure 16-16 Thumb Radial Abduction Measures in Degrees the Angle of Separation Formed Between the First and Second Metacarpal in the Coronal Plane

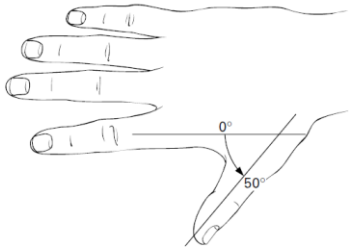

Figure 16-17 Adduction of Thumb, Measured in Centimeters From the Flexion Crease of the Thumb IP Joint to the Distal Palmar Crease Over the Level of the MP Joint of the Little Finger

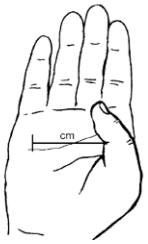

Figure 16-18 Linear Measurements of Thumb Adduction in Centimeters at Various Positions and Motion Unit Impairment Curve for Lack of Adduction

Adduction of 0 cm gives 0% impairment; 8 cm of adduction lack gives 100% impairment.

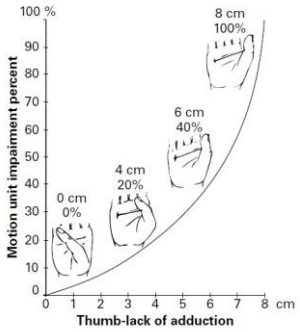

Table 16-8b Thumb Impairment Values Due to Lack of Adduction and to Ankylosis

Measured Lack of Adduction (cm)	% Thumb Impairment Due to	
	Abnormal Motion	Ankylosis
8	20	20
7	13	19
6	8	17
5	6	15
4	4	10
3	3	15
2	1	17
1	0	19
0	0	20

Relative value of functional unit is 20% of the thumb ray motion. Motion ranges from 8 to 0 cm of adduction.

Adapted from Swanson AB, Hagert CG, de Groot Swanson G. Evaluation of impairment of hand function. In: Hunter JM, Schneider LH, Mackin E, Calahan A, eds. *Rehabilitation in the Hand.* St Louis, Mo: CV Mosby Co; 1978:31-69.

Table 16-9 Thumb Impairments Due to Lack of Opposition and to Ankylosis

Measured Opposition (cm)	% Thumb Impairment Due to	
	Abnormal Motion	Ankylosis
0	45	45
1	31	40
2	22	36
3	13	31
4	9	27
5	5	22
6	3	24
7	1	27
8	0	29

Relative value of functional unit is 45% of the thumb ray motion. Motion ranges from 0 to 8 cm of oposition.

Adapted from Swanson AB, Hagert CG, de Groot Swanson G. Evaluation of impairment of hand function. In: Hunter JM, Schneider LH, Mackin E, Calahan A, eds. *Rehabilitation in the Hand.*. St Louis, Mo: CV Mosby Co; 1978:31-69.

Range of motion was completed of both hands. The measurements are as follows.

HAND: Right		Metacarpophalangeal joint Ms. Herrera/normal	Proximal Interphalangeal Joint Ms. Herrera/normal	Distal Interphalangeal Joint Ms. Herrera/normal
Fingers:				
Index	Ext.	/20	/0	/0
	Flex.	/90	/100	/70
Middle	Ext.	/20	0/0	/0
	Flex.	/90	/100	/70
Ring	Ext.	/20	/0	/0
	Flex.	/90	/100	/70
Little	Ext.	/20	/0	/0
	Flex.	/90	/100	/70
Little	Ext.	/20	/0	0/0

	Flex.	/90	/100	/70

GRIP STRENGTH TESTING

Jamar Dynamometer in Kilograms, 2nd position Dominant - Hand					
Hand	1st attempt	2nd attempt	3rd attempt	Average	Strength Loss Index
Right					
Left					

The right hand is the dominant hand and would be expected to be 5-10% stronger than the non-dominant left hand. The right hand measured stronger by percent.

ORTHOPEDIC HAND MANUEVERS

- Finklestein's Test: for pain in the radial styloid, thumb extensor, and thumb abductor muscles. This test rules out stenosing tenosynovitis of the thumb tendons.
- Froment Sign: for weak adductor pollicis adduction indicating ulnar nerve injury.
- Collateral Ligament Test: negative for collateral ligament instability of the 1st – 5th metacarpophalangeal joints.
- Bunnell's Test: for tightness of the intrinsic muscles of the hand.

JOINT PLAY OF RIGHT HAND

- Distraction carpometacarpal joint of thumb: Normal and pain free.
- Distraction 2nd-5th carpometacarpal joints: Normal and pain free.
- Ventral Glide carpometacarpal joint of thumb: Normal and pain free.
- Ventral Glide 2nd-5th carpometacarpal joints: Normal and pain free.
- Dorsal Glide carpometacarpal joint of thumb: Normal and pain free.
- Ventral Glide carpometacarpal joint of thumb: Normal and pain free.
- Ulnar Glide carpometacarpal joint of thumb: Normal and pain free.
- Radial Glide carpometacarpal joint of thumb: Normal and pain free.
- Distraction, Ventral and Dorsal Glide 1st-5th metacarpophalangeal and interphalangeal joints: Normal and pain free.

As noted above under SENSORY EXAMINATION, the sensation of the right upper extremity was normal. The radial and ulnar pulses were equal and bounding bilaterally.

EXAMINATION IMPRESSIONS

1.

DIAGNOSTIC STUDIES

On the date of the QME evaluation, Ms. Herrera did not hand cany any diagnostic studies in the form of x-rays, MRI, or CT scans. The medical records that I received describe, or make reference to, the following diagnostic studies.

- 12/12/22 - MRI Right Hand Without Contrast (Radnet)
    - Mild nonspecific bone marrow edema within the distal phalanx of the third finger with adjacent mild subcutaneous edema. Possible bone contusion with associated soft tissue injury. Other etiologies including early osteomyelitis and mild adjacent cellulitis are not completely excluded. Clinical correlation recommended.
    - Prominent hypointense soft tissue at the proximal attachment of the volar plate at the PIP joint of the fifth finger suggestive of fibrosis/scar tissue due to chronic injury to the volar plate.
    - Mildly prominent injection of the fifth finger flexor tendons from the proximal phalanx, raising concern for injury to the A2 and C1 pulleys.
    - Tenosynovitis involving the flexor tendon sheath of the fifth finger proximally at the level of the proximal phalanx, and localized minimal physiologic fluid within the flexor pollicis longus tendon sheath versus minimal tenosynovitis.
    - Small joint effusion within metacarpophalangeal joints of the second and fourth fingers.
- 12/25/22 - XR Hand (Alapati, MD)
    - Impression: No acute bone or joint abnormality seen.

Summary: Upon reviewing the diagnostic studies of Ms. Herrera's right hand, I observed a series of findings indicative of various pathological conditions.

- The MRI conducted on December 12, 2022, revealed mild nonspecific bone marrow edema in the distal phalanx of the third finger, accompanied by adjacent subcutaneous edema, suggestive of a possible bone contusion with associated soft tissue injury. Although early osteomyelitis and mild adjacent cellulitis were not entirely ruled out, clinical correlation was recommended to ascertain the precise etiology. Additionally, there was notable fibrosis/scar tissue observed at the proximal attachment of the volar plate at the PIP joint of the fifth finger, likely due to chronic injury.
    - Concerns were raised regarding injury to the A2 and C1 pulleys, with mild tenosynovitis noted in the flexor tendon sheath of the fifth finger.
    - Furthermore, localized minimal physiologic fluid within the flexor pollicis longus tendon sheath was identified, alongside a small joint effusion within the metacarpophalangeal joints of the second and fourth fingers.
- The X-ray conducted on December 25, 2022, revealed no acute bone or joint abnormalities.

Overall, these findings suggest a multifaceted pathology involving soft tissue injuries, chronic changes, and inflammatory processes within the hand.

DIAGNOSIS

ICD10 #

1.
2.
3.

4.

DISCUSSION

According to CCR 35.5 (c)(1) “The evaluator shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee’s appointment with the medical evaluator that are issues within the evaluator’s practice and areas of clinical competence. The reporting evaluator shall attempt to address each question raised by each party in the issue Cover Letter sent to the evaluator….”

Herein below I address each of the questions raised in the Cover Letter that I received from .

CAUSATION

The 2/19/2024 Cove Letter from Allison Pryor Claims Adjuster of Sedgwick Claims Management Services, Inc. requests:

- What is your diagnosis of the patient's current condition?
- What, if any, pre-existing conditions have contributed to or caused the employees current problems?

Considerations:

- The diagnosis of the patient's current condition is [Provide specific diagnosis based on medical evaluation findings]. This diagnosis is derived from a comprehensive assessment of the patient's medical history, symptoms, physical examination, and any relevant diagnostic tests conducted.
- Upon review, it has been determined that the following pre-existing conditions have contributed to or caused the employee's current problems:
    - [List pre-existing conditions that have relevance to the current problems]
    - [Briefly describe how these pre-existing conditions have impacted or exacerbated the employee's current situation]
- It's essential to note that while pre-existing conditions may have played a role, the work-related injury has significantly exacerbated the employee's current problems and necessitates appropriate medical attention and treatment.

PERMANENT AND STATIONARY

The 2/19/2024 Cove Letter from Allison Pryor Claims Adjuster of Sedgwick Claims Management Services, Inc. requests:

- If the employee has not reached Maximum Medical Improvement, how long would you estimate the period of temporary disability will continue?

Considerations:

The California Codes of Regulation state:

- CCR 10152: "A disability is considered permanent after the employee has reached maximum improvement or his or her condition has been stationary for a reasonable period of time."
- CCR 9785 – Permanent & Stationary……. the point when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year - with or without medical treatment.

And, according to the AMA Guides (p. 373), "Impairment is rated only when the individual has reached maximum medical improvement (MMI)." Further, MMI is defined (page 601) as, "A condition or state that is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. Over time, there may be some change, however, further recovery or deterioration is not anticipated."

In my opinion and within reasonable medical probability Ms. Herrera is/is not Permanent and Stationary for all conditions. I consider the Permanent & Stationary date to be 04/01/22.

Reasons for these conclusions include:

- Permanent & Stationary: Ms. Smith's cervical spine condition is apparently well stabilized. According to his own description and supported by statements in the medical records (see REVIEW OF RECORDS above for dates of service 01/01/22, and 03/10/22) his neck condition has plateaued and has not improved or worsened over the past 4-6 months. I do not anticipate his neck condition to substantially change in the next 6-12 months with or without medical treatment and therefore, his neck condition can reasonably be considered to be at maximum medical improvement and Permanent & Stationary.
- Date: Within reasonable medical probability, I consider the Permanent & Stationary date to be the date (06/07/22) of this evaluation. I state this because it does not appear in the medical records that I received that any physician has yet declared Ms. Herrera to be Permanent & Stationary and, although treatment efforts became exhausted when Ms. Herrera declined a surgical recommendation on 02/01/22, a 06/07/22 Permanent & Stationary date gives him every opportunity to benefit from medical treatment, time, and total temporary disability prior to undergoing this Permanent Impairment evaluation.

PERMANENT IMPAIRMENT

The 2/19/2024 Cove Letter from Allison Pryor Claims Adjuster of Sedgwick Claims Management Services, Inc. requests:

- Has the employee reached a permanent and stationary status from this injury? If so, what, if any, permanent partial impairment would you assess?

Considerations:

On the DEU Form 100 that Ms. Herrera provided to me signed and dated it asks:

- "What is the disability resulting from your injury?" Ms. Herrera responded, " ."
- "How does this disability affect you in your work?" Ms. Herrera responded, " ."
- "Have you ever had a permanent disability as a result of another injury or illness? If so, when? Please describe the disability. Ms. Herrera responded, " ."

PERMANENT IMPAIRMENT UNDER THE "STRICT" APPLICATION OF THE AMA GUIDES

UPPER EXTREMITY IMPAIRMENTS

According to the AMA Guides, Upper Extremity Impairment is determined based upon:

AMA GUIDES	UPPER EXTREMITY IMPAIRMENTS
Amputations	Does not apply to Ms. Smith
Digital Nerve Lesions	Does not apply to Ms. Smith
Abnormal Motion	Applies to Ms. Herrera as follows: • Abnormal Motion: o Ms. Herrera has 65/180 left shoulder flexion. According to Table 16-19, this qualifies for 1% Upper Extremity Impairment. o Ms. Herrera has left shoulder . According to , this qualifies for % Upper Extremity Impairment. o Ms. Herrera has left shoulder . According to , this qualifies for % Upper Extremity Impairment. o Ms. Herrera has left shoulder . According to , this qualifies for % Upper Extremity Impairment. o Ms. Herrera has left shoulder . According to , this qualifies for % Upper Extremity Impairment. o Ms. Herrera has left shoulder . According to , this qualifies for % Upper Extremity Impairment.

	○ Total Impairment: Adding Impairments due to "abnormal motion" - %, plus %, plus %, plus %, plus %, plus % equals % Upper Extremity Impairment.
Peripheral Nerve Disorder	Does not apply to Ms. Smith
Vascular Disorder	Does not apply to Ms. Smith
"Other Disorders"	• Carpal Instability • Resection of the distal clavicle: 10% Upper Extremity
Loss of Strength	Applies to Ms. Herrera as follows: ○ Ms. Herrera has 4+/5 right shoulder strength in resisted flexion. I estimate strength deficit to be 10%. According to Table 16-35, this qualifies for 2% Upper Extremity Impairment. ○ Ms. Herrera has 5/5 right shoulder strength in resisted extension. I estimate strength deficit to be 0%. According to Table 16-35, this qualifies for 0% Upper Extremity Impairment. ○ Ms. Herrera has 4+/5 right shoulder strength in resisted abduction. I estimate strength deficit to be 10%. According to Table 16-35, this qualifies for 1% Upper Extremity Impairment. ○ Ms. Herrera has 5/5 right shoulder strength in resisted adduction. I estimate strength deficit to be 0%. According to Table 16-35, this qualifies for 0% Upper Extremity Impairment. ○ Ms. Herrera has 5/5 right shoulder strength in resisted internal rotation. I estimate strength deficit to be 0%. According to Table 16-35, this qualifies for 0% Upper Extremity Impairment. ○ Ms. Herrera has 4+/5 right shoulder strength in resisted external rotation. I estimate strength deficit to be 10%. According to Table 16-35, this qualifies for .4% Upper Extremity Impairment. ○ Total Impairment: Adding Impairments due to "loss of strength" - 2%, plus 0%, plus 1%, plus 0%, plus 0%, plus .4% equals 3.4% Upper Extremity Impairment. According to Table 16-3, this converts to 2% Whole Person Impairment. • • Ms. Jones has left wrist strength in resisted flexion. I estimate strength deficit to be %. By analogy to Table 16-35 and considering that the functional unit of the wrist is 60% Upper Extremity (see AMA Guides page 466), this qualifies for % Upper Extremity Impairment. ○ Ms. Herrera has left wrist strength in resisted extension. I estimate strength deficit to be %. By

	analogy to Table 16-35 and considering that the functional unit of the wrist is 60% Upper Extremity (see AMA Guides page 466), this qualifies for % Upper Extremity Impairment. o Ms. Herrera has left wrist strength in resisted pronation. I estimate strength deficit to be %. By analogy to Table 16-35 and considering that the functional unit of the wrist is 60% Upper Extremity (see AMA Guides page 466), this qualifies for % Upper Extremity Impairment. o Ms. Herrera has left wrist strength in resisted supination. I estimate strength deficit to be %. By analogy to Table 16-35 and considering that the functional unit of the wrist is 60% Upper Extremity (see AMA Guides page 466), this qualifies for % Upper Extremity Impairment. o Total Impairment: Adding Impairments due to "loss of strength" - %, plus %, plus %, plus %, plus %, plus % equals % Upper Extremity Impairment. • Loss of Left Hand Grip Strength: o Ms. Herrera has "strength loss index" of left hand grip strength of % compared to right hand grip strength. According to Table 16-34, this qualifies for % Upper Extremity Impairment. • Total Impairment: Adding Impairments for Left Wrist/Hand "loss of strength" - % Upper Extremity Impairment (for the wrist) + % Upper Extremity Impairment (for the hand) equals % Upper Extremity Impairment.
Total Impairment	Add them all up…..

PERMANENT IMPAIRMENTS UNDER ALMAREZ.GUZMAN II

The 06/29/22 Cover Letter from Applicant Attorney requests:

- "Please take into consideration he holding in *Athens Administrators v. Workers Comp. Appeals Board (kite) 78 Cal. Comp. Cases 213* and issue your specific opinion if any of the WPI ratings should be "ADDED" instead of "COMBINED" using the Combined Values Chart.
- Please have your Report specifically indicate that you have considered Kite, and explain 1) why adding the WPI ratings is not applicable, or, 2) why adding the WPI ratings is a more accurate reflection of Applicant's Impairment."

The Cover Letter from requests:

- “ .”

  - Functional Limitations: Please specifically address whether has an impairment in function similar to the functional limitations outlined in the hernia impairment table on page 136, Table 6-9.
  - Functional Limitations: Please specifically address whether has an impairment in function similar to the functional limitations outlined in the Gait Disorder table in Chapter 13. See Table 13-15.
  - Other Functional Limitations:

PERMANENT IMPAIRMENT DUE TO “DIRECT ESTIMATE”

The Cover Letter from requests:

  - “Please provide an impairment rating based on the direct estimate of loss of use or function of each of injured body parts or systems. Please assess post injury loss of function for each of his injured body parts or systems and then multiply that percentage loss by the WPI for the total loss of functional use of that body part.”

ADDITIONAL IMPAIRMENT DUE TO “PAIN”

The Cover Letter from requests:

  - “If pain is involved, and burdens the injured worker’s condition slightly please indicate the extra impairment between 1% to 3% that should be added on to the impairment description for each body part.”

According to Chapter 18 of the AMA Guides, the examinee MAY qualify for additional “discretionary” Permanent Impairment related to PAIN when:

1. When there is excess pain in the context of verifiable medical conditions that cause pain
2. There exists a “well established pain syndrome without significant identifiable organ dysfunction to explain the pain.”
3. When there are “associated pain syndromes” along with a bona fide medical condition that is ratable on the basis of other Chapters in the Guides.

Further, the examinee DOES NOT qualify for additional “discretionary” Permanent Impairment related to PAIN when:

1. The examinee is judged to have low credibility
2. The pain is controversial or ambiguous
3. The pain is adequately described in the Conventional Impairment rating in other Chapters of the Guides.

- Pain Related Impairment Questionnaire (AMA Guides 5th Edition page 576 Table 18-4):

a. Self Report of Pain Severity = (range 0 – 20 with higher scores indicative of greater frequency and greater severity of pain).
b. Activity Limitation of Interference = (range 0 – 30 with higher scores indicative of greater impact of pain on the ability to perform activities of daily living).
c. Effect of Pain on Mood = (range 0 – 10 with higher scores indicative of greater impact of pain on mood/mental state).
d. Observable Pain Behaviors = (range -10 to +10).

PAIN BEHAVIOR	PRESENT/ABSENT
Facial Grimacing	
Holding or Supporting affected body parts or area	
Limping or Distorted Gait	
Frequent shifting of posture or position	
Extremely slow movements	
Sitting with rigid posture	
Moving in guarded or protective fashion	
Moaning	
Using a cane, cervical collar, or other device	
Stooping while walking	
Other:	

e. Total Pain Related Impairment Score = . According to the AMA Guides, this qualifies as " ."

- 0-6 = "No Impairment"
- 7-24 = "Mild Impairment"
- 25-42 = "Moderate Impairment"
- 43-60 = "Moderately severe Impairment"
- 61-80 = "Severe Impairment"

ADDING VERSUS COMBINING IMPAIRMENTS

A physician may consider that when there are multiple parts of body involved, the combined effect of these disabilities may have a synergistic effect, increasing disability and impairment. I think This combination of the disabilities over so many different parts of the body may make the applicant much more disabled than each of the body considered separately.

Under ordinary circumstances, when we obtain whole person impairment ratings for various parts of the body, we use the combined values chart. The combined values chart significantly reduces and individual's overall disability. Please refer to page 10 of the AMA guides, which states, "a scientific formula has not been established to indicate the best way to combine multiple impairments. Given the diversity of impairments and great variability inherent in combining multiple impairments, it is difficult to establish a formula that accounts for all situations. A combination of some impairments could decrease overall functioning more than suggested by just adding the impairment ratings for this separate impairments (for

example, blindness and inability to use both hands). When other multiple permits are combined, a less than additive approach may be appropriate.

Further, an applicant who has only an orthopedic, internal, or psych injury receives full value for his or her whole person impairment and or permanent disability. Yet, due to the artificial construction of the combined values chart, which is not based on any science or fact, an injured worker who suffers from injury to more than one part of the body or body system, such as in this case, will not get full value of his or her whole person impairment.
Therefore, please provide your opinion as to whether any whole person impairment for orthopedic injuries overlaps with any whole person impairment for any potential internal injuries and or neurologic injuries. If not, please advise whether it is more accurate to add this whole person impairment instead of using the artificial combined values chart. Also, please provide the medical reasoning for this opinion, such as these whole person impairments "do not overlap" and/or adding the whole person impairment better reflects the synergistic effects involving multiple parts of the body/conditions and/or is simply a more accurate assessment of overall disability.

SYNERGY - the interaction or cooperation of two or more systems that produce a combined effect greater than the sum of their separate effects….Combined effect (ADL loss) of the body parts is greater than the sum of their separate effects.

- What is support for "synergistic effect?"
- How does Impairment A make Impairment B worse?

OVERLAP - combined effect (ADL loss) of the body parts is less than the sum of their separate effects.

- How are limitations differentiated (Impairment A vs. Impairment B)
- Does the Whole Person Impairment correlate with the disability (ADL deficits)?

"MOST ACCURATE RATING - Have you provided the ***MOST accurate*** rating and included a statement of such – although with some substantial reasoning?

APPORTIONMENT

The 2/19/2024 Cove Letter from Allison Pryor Claims Adjuster of Sedgwick Claims Management Services, Inc. requests:

Considerations:

My formulation of the Apportionment of the Permanent Impairment follows:

- Body Part #1:
    - First Impairment: My Impairment rating is % Whole Person Impairment due to " " (fill in the Impairment – i.e. abnormal motion, gait derangement, etc.).
        - LC 4663: In my opinion and within reasonable medical probability, % of the Permanent Impairment is due to the industrial injury, and % of the Permanent Impairment is due to "other factors." In this case, other factors include:

        - Escobedo "Other Factors":
            - Pre-existing disability
            - Disability caused by the natural progression of pre-existing disease or conditions
            - Pathology
            - Asymptomatic prior conditions
            - Retroactive prophylactic work restrictions
    - Substantiating Reasons for this conclusion include:
        - Reasonable medical probability: My opinion on the above Apportionment "approximate percentages" (%/ %) is predicated on "reasonable medical probability."
        - Pertinent Facts: The facts relevant to the above Apportionment "approximate percentage" upon which I rely include:
            - Mechanism of Injury:
            - Response to Appropriate Medical Care:
            - Pre-existing condition(s):
            - Prior Industrial Injury:
        - Adequate History:
        - Adequate Examination:
        - "How" and "Why" Reasoning:
        - No Speculation: The above opinion on the Apportionment "approximate percentages" is not based on guess, speculation, surmise or conjecture.
- LC 4664: In my opinion and within reasonable medical probability, % of the Permanent Impairment is due to the industrial injury, and % of the Permanent Impairment is due to "other factors." Reasons for this conclusion include:
    - Prior Permanent Disability Award:

- Second Impairment: My Impairment rating is % Whole Person Impairment due to " " (fill in the Impairment – i.e. abnormal motion, gait derangement, etc.).
    - LC 4663: In my opinion and within reasonable medical probability, % of the Permanent Impairment is due to the industrial injury, and % of the Permanent Impairment is due to "other factors." In this case, other factors include:
        - Escobedo "Other Factors":
            - Pre-existing disability
            - Disability caused by the natural progression of pre-existing disease or conditions
            - Pathology
            - Asymptomatic prior conditions
            - Retroactive prophylactic work restrictions
    - Substantiating Reasons for this conclusion include:
        - Reasonable medical probability: My opinion on the above Apportionment "approximate percentages" (%/ %) is predicated on "reasonable medical probability."
        - Pertinent Facts: The facts relevant to the above Apportionment "approximate percentage" upon which I rely include:
            - Mechanism of Injury:
            - Response to Appropriate Medical Care:
            - Pre-existing condition(s):
            - Prior Industrial Injury:

        - Adequate History:
        - Adequate Examination:
        - "How" and "Why" Reasoning:
        - No Speculation: The above opinion on the Apportionment "approximate percentages" is not based on guess, speculation, surmise or conjecture.
    - LC 4664: In my opinion and within reasonable medical probability, % of the Permanent Impairment is due to the industrial injury, and % of the Permanent Impairment is due to "other factors." Reasons for this conclusion include:
        - Prior Permanent Disability Award:

- Body Part #2: (Repeat Procedure above)

STATEMENT OF SUBSTANTIAL MEDICAL EVIDENCE

The above opinions on Permanent Impairment, and Causation/Apportionment of the Permanent Impairment are based on:

1. Reasonable medical probability and my professional experience.
2. An adequate History as provided in the medical records and as clarified by Ms. Herrera.
3. My Physical Examination of Ms. Herrera as the Qualified Medical Evaluator.
4. Review of the available Diagnostic Studies, including new lumbar spine x-rays ordered for the purposes of this evaluation (see DIAGNOSTIC STUDIES above page), Medical Research into the Findings of the Diagnostic Studies (see MEDICAL RESEARCH above page 51), and follow up consultation with Medical Radiologist M.D. (see DIAGNOSTIC STUDIES above).
5. Is based on reasonable medical probability and does not rely on speculation or conjecture.

FUTURE MEDICAL CARE

The 2/19/2024 Cove Letter from Allison Pryor Claims Adjuster of Sedgwick Claims Management Services, Inc. requests:

- Is any further treatment required to cure the injuries/conditions caused by the work-related injury? If so, please provide a recommended treatment outline.
- Do you believe all the medical treatment to date has been necessary and directly related to the injury?

WORK STATUS

Re: Espen Sherene Herrera
Date of Injury: 10/14/22

The 2/19/2024 Cove Letter from Allison Pryor Claims Adjuster of Sedgwick Claims Management Services, Inc. requests:

- Does the employee have any permanent work restrictions?

- Balancing –restricted from activities that require balancing. Balancing is defined as -maintaining body equilibrium.
- Bending – restricted from repetitive or prolonged bending. Bending is defined as angulation from neutral position about a joint (e.g. elbow) or spine (e. g. forward).
- Carrying - restricted from carrying greater than 25 lbs. with both hands or 10 lbs. with the right hand. Carrying is defined as - transporting an object, usually holding it in the hands, arms, or on the shoulder.
- Climbing - restricted from using the right arm to assist with climbing that requires the use of the arms - such as in using a ladder. Climbing is defined as - ascending or descending ladders, stairs, scaffolding, ramps, poles, etc. using feet and legs, and/or hands and arms.
- Crawling - restricted from using the arms to support the body in crawling. Crawling is defined as - moving about on hands and knees or feet.
- Crouching – restricted from repetitive or prolonged crouching. Crouching is defined as bending body downward and forward by bending lower limbs, pelvis, and spine.
- Feeling – restricted from activities that require prolonged or repetitive feeling. Feeling is defined as perceiving attributes of objects such as size, shape, temperature, or texture by means of receptors in the skin, particularly those of the finger tips.
- Fingering – restricted from repetitive or prolonged activities requiring the fingers. Fingering is defined as picking, pinching, or otherwise working with fingers and thumb primarily (rather than with whole hand or arm as in handling).
- Grasping – restricted from repetitive or prolonged grasping. Grasping is defined as seizing, holding, grasping, turning, or otherwise working with hand or hand (fingering not involved).
- Jumping – restricted from repetitive jumping. Jumping is defined as moving about suddenly by use of leg muscle, leaping from or onto the ground or from one object to another.
- Kneeling – restricted from prolonged or repetitive kneeling. Kneeling is defined as bending legs at knees to come to rest on knee or knees.
- Lifting - restricted from lifting greater than 10 lbs. with the right upper extremity. Lifting is defined as - raising or lowering an object from one level to another (includes upward pulling).
- Overhead/Over shoulder - restricted from overhead/over shoulder work using the right upper extremity. Overhead/over shoulder is defined as - performing work activities with arm raised and unsupported, at or above shoulder level.
- Pivoting – restricted from repetitive or prolonged pivoting. Pivoting is defined as planting your foot and turning about that point.
- Pushing - restricted from pushing greater than 25 lbs. with the right upper extremity. Pushing is defined as - exerting force upon an object so that the object moves away from the force (includes slapping, striking, kicking and treadle actions).
- Pulling - restricted from pulling greater than 25 lbs. with the right upper extremity. Pulling is described as - exerting force on an object so that the object moves toward the force (includes jerking).

- Reaching - restricted from repetitive reaching below shoulder level with the right upper extremity. Reaching is defined as - extending the hands and arms in any direction.
- Running – restricted from running. Running is defined as moving in a fast pace, moving the legs rapidly so that for a moment both legs are off the ground.
- Sitting – restricted from sitting greater than minutes. Sitting is defined as remaining in the normal seated position.
- Squatting – restricted from prolonged or repetitive squatting. Squatting is defined as crouching to sit on your heels, with knees bent and weight on the balls of your feet.
- Standing – restricted from standing greater than . Standing is defined as remaining on one's feet in an upright position at a work station without moving about.
- Stooping – restricted from prolonged or repetitive stooping. Stooping is defined as bending body downward and forward by bending spine at waist.
- Turning – restricted from prolonged or repetitive turning. Turning is defined as moving about a central axis, revolve or rotate.
- Use of hand or foot controls - Restricted from use of . This is defined as controlling a machine by the use of controls.
- Walking – restricted from walking greater than . Walking is defined as moving about at a moderate pace over even or uneven ground.

DISCLOSURES

In compliance with California WCAB Rule 10978, I personally obtained the history from the patient, conducted the examination, reviewed the records and prepared this report.
In compliance with 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 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.'
I the undersigned declared under penalty of perjury that I have not violated Labor Code Section 139.3. I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

As required by the Administrative Director of the Division of Workers' Compensation under Section 9795 (c), I the undersigned declare under penalty of perjury that I spent minutes reviewing the records, and preparing my report. As allowed under Section 9795 (c) the procedure code ML201 -95 (by the Panel Qualified Medical Evaluator) is being utilized. Statements concerning any bill for services are admissible only if made under penalty of perjury that they are true and correct to the best knowledge of the physician."

I certify by my signature below that the opinions stated above are my own.

Sincerely,

Troy G. Garabedian DC, QME Dated:_____