



HEALTH INSURANCE CLAIM FORM

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

JUSTIN WILLIAMSON
TRAVELERS INS
PO BOX 660055
DALLAS, TX 75266

CARRIER →

PICA												PICA																							
1 MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FEDERAL BLACKLUNG	OTHER	1a INSURED'S I.D. NUMBER (For Program in Item 1)																												
<input type="checkbox"/> (Medicare#)	<input type="checkbox"/> (Medicaid#)	<input type="checkbox"/> (ID#/DoD#)	<input type="checkbox"/> (Number/Day)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)	<input checked="" type="checkbox"/> (ID#)	FWH9561																												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BABAYAN, RIMA				3. PATIENT'S BIRTH DATE MM DD YY 07 10 1956				SEX M F X				4. INSURED'S NAME (Last Name, First Name, Middle Initial) BABAYAN, RIMA																							
5. PATIENT'S ADDRESS (No., Street) 269 S. WESTERN AVE. # 208				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 269 S. WESTERN AVE. # 208																											
CITY LOS ANGELES			STATE CA	CITY LOS ANGELES			STATE CA																												
ZIP CODE 90004		TELEPHONE (Include Area Code) ()		ZIP CODE 90004		TELEPHONE (Include Area Code) ()																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																							
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____																							
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
d. INSURANCE PLAN NAME OR PROGRAM NAME												d. CLAIM CODES (Designated by NUCC)																							
11. INSURED'S POLICY GROUP OR FECA NUMBER												12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																							
SIGNED SIGNATURE ON FILE												DATE 10 / 10 / 2024																							
SIGNED SIGNATURE ON FILE												DATE 10 / 10 / 2024																							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 14 22				15. OTHER DATE QUAL 09 03 19				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a _____ 17b NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below 24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A S33.5XXA	B S39.012A	C M54.16	D M62.830	E S43.401	F S46.011A	G M71.22	H S83.391	I S83.242A	J M76.102	23. PRIOR AUTHORIZATION NUMBER																									
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY				B PLACE OF SERVICE EMG				C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS				D MODIFIER				E DIAGNOSIS POINTERS				F \$ CHARGES		G DAYS OR UNITS		H EPOT Family Plan		I ID QUAL	J RENDERING PROVIDER ID. #								
1 08 18 24 08 18 24 11	ML-203	-95														650.00							NPI	1508970609											
2 08 18 24 08 18 24 11	ML-PRR															1191.00	447						NPI												
3																							NPI												
4																							NPI												
5																							NPI												
6																							NPI												
25 FEDERAL TAX I.D. NUMBER 274916916	SSN EIN <input checked="" type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. a. 1508970609				27. ACCEPT ASSIGNMENT? (For Govt. Claims, See Q13) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 1841.00				29. AMOUNT PAID \$ 0.00				30. Rwd for NUCC Use																	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) Sharona Drake D.C., Q.M.E.												32. SERVICE FACILITY LOCATION INFORMATION 3450 WILSHIRE BLVD. SUITE 608 LOS ANGELES, CA 90010												33. BILLING PROVIDER INFO & PH# (818) 232-7020 SHARONA DRAKE D.C., Q.M.E. 19528 VENTURA BLVD. SUITE 640 TARZANA, CA 91356											

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1 Ernesto Campos II
2 PEARLMAN, BROWN & WAX, L.L.P.
3 15910 Ventura Boulevard, 18th Floor
4 Encino, CA 91436
5 (818) 501-4343 - Office
6 (818) 386-5700 - Fax
7 emc@4pbw.com

8 Attorneys for Defendant
9 TRAVELERS PROPERTY CASUALTY COMPANY OF
10 AMERICA, workers' compensation insurance carrier for
11 FOREST LAWN MEMORIAL PARK ASSOCIATION,
12 administered by TRAVELERS

13 **WORKERS' COMPENSATION APPEALS BOARD**

14 **FOR THE STATE OF CALIFORNIA**

15 RIMA BABAYAN,
16 *Applicant,*
17 vs.
18 FOREST LAWN MEMORIAL PARK
19 ASSOCIATION,
20 *Defendants.*

WCAB CASE NO: ADJ16541008;
ADJ16541440

DECLARATION BY PROVIDER OF
RECORDS FOR MEDICAL-LEGAL
EXAMINATION PURSUANT TO
LABOR CODE SECTION 4062.3

PQME: SHARONA DRAKE, D.C.
APPOINTMENT DATE: N/A

I, Ernesto Campos II, declare as follows:

I am a paraprofessional and an employee of Pearlman, Brown & Wax in Concord, California.

Prior to providing documents to the physician for record review, the undersigned complied with the provisions of Labor Code section 4062.3.

The undersigned agrees and acknowledges that, per 8 CCR 9793(n), a page is defined as an 8 1/2 by 11 single-sided document, chart or paper, whether in physical or electronic form. Multiple condensed pages or documents displayed on a single page shall be charged as separate pages.

The undersigned hereby attests that the total number of pages provided to the physician is 447.

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9830998

1 I declare under penalty of perjury that the foregoing is true and correct to the best of my
2 knowledge.

3 Dated: August 7, 2024

4 Respectfully submitted,

5 PEARLMAN, BROWN & WAX, L.L.P.

6 
7 ERNESTO CAMPOS II, Paraprofessional
8 Attorneys for Defendant
9 TRAVELERS PROPERTY CASUALTY
10 COMPANY OF AMERICA, workers'
11 compensation insurance carrier for FOREST
12 LAWN MEMORIAL PARK ASSOCIATION,
13 administered by TRAVELERS

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SHARONA DRAKE, D.C., Q.M.E.

19528 Ventura Blvd., Suite 640; Tarzana, CA 91356 phone:(818)232-7020 fax:(888)809-9734

DATE OF SERVICE: AUGUST 18, 2024

TRAVELES INSURANCE

ATTENTION: JUSTIN WILLIAMSON
P.O.BOX 660055
DALLAS, TX 75266

DEFENSE ATTORNEY

LAW OFFICE OF: PEARLMAN BROWN & WAX
ATTENTION: STEVEN H. WAX, ESQ.
15910 VENTURA BLVD. 18TH FLOOR
ENCINO, CA 91436

APPLICANT ATTORNEY

LAW OFFICES OF: BARKHORDARIAN LAW
ATTENTION: MAILHUONG TA, ESQ.
6047 BRISTOL PKWY.
CULVER CITY, CA 90230

Claimant Name:	RIMA BABAYAN
Employer:	FOREST LAWN MEMORIAL PARK
Date of Birth:	JULY 10, 1956
Soc. Sec. No.:	053-56-6484
Claim Number:	FWH9561; UNASSIGNED
WCAB / EAMS Number:	ADJ 16541440; ADJ16541008
Injury Date (s):	04 / 14 / 2022; CT. 09 / 03 / 2019 - 04 / 18 / 2022

CHIROPRACTIC PANEL QME 4th SUPPLEMENTAL REPORT

To all parties concerned:

I am in receipt of a supplemental report request dated August 06, 2024, asking me to review and comment on medical records sent. I originally evaluated this injured worker, Rima Babayan, a now 68-year-old right-handed, female, for the purpose of a comprehensive qualified medical evaluation on January 17, 2023, following selection of my name from a state panel list (number 7531564). I then issued two supplemental reports dated, May 26, 2023, and July 06, 2023, and re-evaluated the patient on January 18, 2024 and issued a third supplemental report dated March 18, 2024.

Then I was deposed on July 26, 2024, when it was agreed for me to review new records, in light of my examination findings and "issue a supplemental report addressing the issue of causation of injury and/or apportionment per labor Code section 4663".

Please be advised, that this State Panel QME Supplemental report and evaluation were conducted under the applicable guidelines of SB 899, SB683, LC 4628, CCR 10682, LC 4663, LC4664, and any other laws, regulations, and case-law applicable to this case that I may be aware of.

BILLING JUSTIFICATION

This "basic Supplemental report" has met the official Medical Legal Fee Schedule criteria for billing under the code ML-203 (See accompanying billing statement and "CMS 1500" billing form).

The time spent on this case will be detailed at the end of the report. Please note, this report has been issued at the request of the parties involved following selection of my name from a state panel list, as a panel qualified medical evaluator, and therefore is payable even if the claim is denied. In addition, this is a Medical Legal report and therefore does not qualify for a discount.

ATTESTATIONS

Defense attorney, Law Office Of: Pearlman Brown & Wax, provided an attestation under CCR9793 (n) signed on, August 07, 2024 declaring under penalty of perjury that 447 Pages of Documents were provided for my review.

I therefore attest to and declare, per my signature at the end of this report that I have received for review, a total of 447 pages.

LETTER (s) OF INSTRUCTION

Defense attorney, Steven H. Wax, Esq. provided a letter of instruction dated August 06, 2024, stating the following:

"Dear Dr. Drake:

Please recall that office represents Travelers Insurance Company, workers' compensation insurance carrier for Forest Lawn Memorial Park Association.

It was a pleasure to meet you at your cross-examination of July 26, 2024.

At that time, you noted records that were to be reviewed in your March 18, 2024 report, had not been received.

I am enclosing for your review the following records:

- Transcript of applicant's Vol I deposition dated 1/16/23
- Transcript of applicant's Vol II deposition dated 11/13/23
- Vital Health Medical Group
- Dr. Donald Plance
- Dr. Michael Spearman
- LA County Olive View UCLA Medical Center
- LA County Mid Valley Comprehensive Health Center
- Dr. Gregory Adamson
- Dr. Scott Powell

These records detail medical treatment obtained by the applicant prior to her date of employment, September 3, 2019, and prior to the specific date of injury of April 14, 2022. Please pay special attention to the records of Dr. Donald Plance which contains an MRI of the cervical spine conducted on 5/16/2016 and extensive treatment to the left shoulder and neck.

These records go to the issue of causation and/or apportionment of disability.

Please review these records in light of your examination findings and please issue a supplemental report addressing the issue of causation of injury and/or apportionment per labor Code section 4663.

Please note, the case law does allow for apportionment of pre-existing pathology even in the absence of disability".

It should further be noted that all phases of report generation, including record review, report formation and all related activities, and opinions contained herein were conducted and reached solely by myself, without the delegation of tasks to or participation of other parties. All opinions and conclusions delineated below are my own, unless otherwise indicated and stipulated.

This report as detailed at the end, is billed in ML-203 billing level.

HISTORY OF INJURY (AS REPORTED BY THE PATIENT)

THIS SECTION REMAINS THE SAME AS BEFORE

The patient appeared to be reasonably cooperative with providing information concerning the above captioned work injury; however, she was very detail oriented and explained a lot of unrelated information. Besides, she had a hard time staying with the subject at hand, would lose her train of thought easily, and jump from a subject to the next; therefore, extracting the needed material from the relayed information, during the time I spent with her, was a demanding task. Such circumstances made the communication between the injured worker and I harder, and significantly increased the time needed to conduct the examination. The following history was obtained from the patient to the best of her recollection, and as situation permitted, therefore, I reserve the right to issue a supplemental report upon written request, should any additional information be made available to me subsequent to this report and should such information cause me to substantially change my opinion on any of the issues. Please also note that the patient was asked to show/perform the mechanism of injury, and/or Workstation and Ergonomic Set-Ups, if necessary.

As Ms. Babayan reported, she started her employment for Forest Lawn Cemetery on September 03, 2019, as a *Pre-Need Advanced Planner*. The first 3 months of her employment were considered a training period for her. She worked 6 days a week, 8 hours a day. She worked on commission basis, so as she explained, "The more time and effort would put into it, the better the profit". Most of her time would be spent "on the field, finding prospects", but she also had to attend the scheduled office sales meetings and trainings as well. To keep track of her schedule, she had to provide her managers (David Moe, and Grace Chong) a copy of her weekly agenda. If she was to show a property, she would schedule on her own, based on her availabilities. To find prospects, she "would use different sales techniques", such as; "Table top", set up a table and talk to different people to sale; door knocking, go door to door to sale, Health Fairs, Los Angeles County Fairs, Memorial/Labor day setups at Forest Lawn, and Telephone sales. Once she found her prospects, then she had to set up an appointment to show them the property. Showing the property meant taking the client to the exact plot side to show them the property. If approved, then she would create contracts, go over plans, show them caskets and plaques/gravestones. The physical requirements of her job involved; driving, sitting behind a desk or computer, typing and keyboarding as well as, standing, walking, stooping, holding the neck in a fixed forward position for a long time, bending at the waist in a fixed forward position for a long time, twisting at the waist, kneeling, climbing, repetitive bending, repetitive use of both hands, simple gripping and grasping, fine manipulation, forceful gripping, forceful grasping, reaching above shoulder level, reaching below shoulder level, squatting, pushing, pulling, carrying, pivoting, lifting (up to 40 pounds), bending turning twisting of the neck, reaching, walking on uneven grounds/ hills, and holding awkward positions for a long period of time.

Work Set-Up: As the patient explained, to setup a tabletop, she had to pick up the needed supplies, such as the table, chairs, banners, pens, papers, from supply room at the Forest Lawn and load them into her car, and then at the

designated place, would unload and setup. Then pick up and drop off at the Forest Lawn again.

She added, "There was a lot of preparation needed before meeting the prospect, such as, taking pictures of the property, making videos, and of course the paperwork. To take the pictures, or make videos, I sometime spent hours, made many trips to different plots (which required walking up and down the hill, on an uneven surface and/or grass), took the pictures from different angles, made videos and then sat behind the computer to edit them and make them even more presentable (sitting behind the computer for hours at the time). Sometimes I had to meet with the prospects a few times, driving to them, and taking them to see different plots. And then there were a lot of follow-up appointments, in person meetings, on the phone, or zoom meetings (all required sitting, driving, walking, or standing for a prolonged period of time)".

Workstation and Ergonomic Set-Up: She would spend about 3 to 4 hours a day behind the computer. She either worked at home behind a desk she had set up in her bedroom or would go to "Forest Lawn designated work room". At her home, the set up was not ideal. Her laptop or computer was set up on the desk; the monitor was situated in front of her, but her hand and body position were not ergonomically correct (as demonstrated by the patient). Besides, at her house the chair she used was not an office chair and after a while, it felt uncomfortable. However, at the "Forest Lawn designated work room", the workstation set up was much better. Her laptop or computer was set up on the desk; the monitor was situated in front of her, and her hand and body position were ergonomically positioned in a correct manner (as demonstrated by the patient). But she couldn't go to the "Forest Lawn designated work room" as often, because "would save time, when worked at home".

She also explained, Forest Lawn Cemetery, has different locations in Glendale, Hollywood Hills, Covina, Palm Springs, Long Beach, and Cypress in Orange County; and she would drive to different locations as needed. Sometimes would drive to long distance locations (such as OC, or Palm Springs) at least once a week ("even more in the beginning" of her employment).

Please note, on April 05, 2022, the patient was crossing street to enter her house, after work, and was going to do the rest of her work at home. On that day, Ms. Babayan fell, landing forward and injuring her left shoulder and right knee. The next day, she saw Dr. Sharim, MD., and MRI studies of the left shoulder and right knee were ordered. The results were sent to Dr. Powell, MD, an orthopedic surgeon, which recommended surgery for the left shoulder. In the meanwhile, she kept on working until her specific injury of 04/14/2022; which she thinks, "made everything worse".

Specific Accident 04/14/2022: (*Please note; the patient was asked to try to replay her specific accident scene for me.*) On this day, she slipped and fell while showing property to a prospective client at the Hollywood Hills Park of Forest Lawn. As she explained, she picked up her client and took her to the Hollywood Hills Park of Forest Lawn. She showed the prospect different plots. As she was showing her one of the last plots, the prospect suddenly commented and asked about another plot nearby. Ms. Babayan called the office to find out about the availability of that plot. Then, with the map in one hand and her phone in the other, she started walking down the hill. There was a muddy area which she did not realize was there, and stepped into it, right foot first. Therefore, her right foot slipped. To stop herself from rolling down the hill she twisted her body and tried to balance her weight, by bending and twisting the knees. Eventually landed on her knees, back and both shoulders (but since her phone was in her right hand and the office manager was still on the phone with her, she thinks she rolled to the right shoulder "or maybe the impact was more on the right shoulder"). She said, "It all happened so fast". At the time she was talking with the office manager on the phone. The office manager noticed her falling and asked if she needed help, but since Ms. Babayan was in shock and embarrassed in front of her client she said "No". Then she took her client back and dropped her off and then attended a Zoom meeting at 9:00 am with her doctor, Dr. Powell, MD. (as this appointment was set up before).

She filed an incident report and was sent to the Clinic and taken off work. She was then given treatments for her right shoulder, low back and knees.

CT 09/05/2019 to 04/18/2022: The patient explained while performing her customary and usual work duties,

she gradually developed pain in her lumbar spine. She also claims sleeping disorder, and dental issues as result of her cumulative trauma. She attributes the onset of her orthopedic symptoms to the strenuous and repetitive nature of her work duties. She further stated her non-orthopedic symptoms (sleep issues and the dental issues resulting from bruxism while sleeping) developed as a result of her stress at work "specifically the stress and pressure of finding leads/potential clients". She claimed that due to her day-to-day stress of work activities, she developed dental problems including grinding and clenching of her teeth. She recalled first experiencing either grinding or clenching in 2019 when she went to see a dentist, Dr. Nakood. Before that, she had a night guard, which was given by Dr. Arakelian in Woodland Hills in 2018, but "the stress at Forest Lawn made those dental issues worse". The pain (orthopedic pain) "were developed over time, and gradually worsened". She stated that she spent 30% of the time in the office, and the rest was spent out in the field meeting clients, etc. She said, "when setting up a table top, I had to lift, carry, load, unload, set up and then again put the table, chairs and banner back in the car and carry it back to the supply room. This was not easy for me. At times, I had to park my car far from the event site, and just carry the table and other supplies all the way there. Besides, I had a rolling bag with the printer and my laptop which I pulled, pushed, or carried around with myself all the time. I also drove around, sitting for a long period of time. Sitting behind the computer required sitting as well. Or sometimes, I had to stand all day long, during the events, talking to people, to find prospects. Besides, when showing a property, I had to walk up and down the hills. Sometimes, I would visit the property many times, to make videos, or mark the location. Doing these repetitive duties added up and started my pain". She first noticed pain in the lower back, sometimes in August or September 2019, and the pain gradually worsened.

Her last day of work was on 04/18/2022.

She finally decided to hire legal care to pursue her case legally. Eventually she designated Dr. Samimi, MD, as her primary treating physician.

HISTORY OF TREATMENTS RECEIVED (BASED ON PATIENT'S REPORT AND REVIEWED RECORDS)

An MRI study of the Cervical Spine was performed on 04/19/2013, and the results as read by Kimberly Foust, M.D. & Patrick Kane, M.D. were as follows: NO ACUTE OSSEOUS ABNORMALITY. MULTI-LEVEL DEGENERATIVE CHANGES, AS DESCRIBED ABOVE.

XR CERVICAL SPINE ROUTINE; Dated 04/19/2013, signed by Kimberly Foust, M.D. & Patrick Kane, M.D.
FINDINGS/IMPRESSION: There is loss of the normal cervical lordosis. The vertebral body heights are normal without evidence of fracture. There is mild C4-C5, moderate C3-C4 and severe C5-C6 and C6-C7 degenerative disc disease. The C1 and C2 lateral masses are symmetric. There is no evidence of odontoid fracture. Bilateral uncovertebral joint osteoarthritis is present from C3-C4 to C6-C7. There is mild bilateral C3-C4 neuroforaminal stenosis. Mild bilateral facet osteoarthritis is present at C4-C5. The prevertebral soft tissues are normal. NO ACUTE OSSEOUS ABNORMALITY. MULTI-LEVEL DEGENERATIVE CHANGES, AS DESCRIBED ABOVE.

MRI CERVICAL SPINE W/O CONTRAST; Dated 04/23/2013, signed by Maurice Hale, M.D.
FINDINGS/IMPRESSION: THERE IS CANAL STENOSIS AT C4-5 AND C5/6 BUT NO CORD SIGNAL ABNORMALITY, MISALIGNMENT, BONE MARROW SIGNAL ABNORMALITY, SCOLIOSIS OR FOCAL LESION. THERE IS DIFFUSE DISC DESICCATION, MARKED OSTEOPHYTOSIS AND ABNORMAL ENDPLATE SIGNAL INTENSITY AT C3-4 REFLECTING ACUTE INFLAMMATION. THE CERVICOMEDULLARY JUNCTION, PRE VERTEBRAL SOFT TISSUES AND VISUALIZED PORTIONS OF THE POSTERIOR FOSSA ARE GROSSLY UNREMARKABLE. INDIVIDUAL:DISC SPACES REVEAL THE FOLLOWING: C2-3: THERE IS NORMAL DISC SPACE HEIGHT AND NO POSTERIOR DISC PROTRUSION,

CANAL STENOSIS OR 1,/ NERVE ROOT IMPINGEMENT. C3-4_ THERE IS MARKED DISC SPACE NARROWING AND 3 MM BROAD-BASED POSTERIOR DISC PROTRUSION ELEVATING THE POSTERIOR LONGITUDINAL LIGAMENT AND ENCROACHING BOTH NEUROFORAMEN BUT NO CANAL STENOSIS OR NERVE ROOT IMPINGEMENT. C4-5: THERE IS NORMAL DISC SPACE HEIGHT BUT A STENOSING THE SPINAL CANAL AND ENCROACHIN CANAL STENOSIS OR NERVE ROOT IMPINGEMENT. C5-6. THERE IS MARKED DISC SPACE NARROWING A 4MM LEFT PARACENTRAL DISC HERNIATION STENOSING THE SPINAL CANAL AND ENCROACHING HE LEFT NEUROFORAMEN WHILE1IMPINGING THE IPSILATERAL NERVE ROOT. C6-7: THERE IS MODERATE DISC SPACE NARROWING AND 4 MM RIGHT PARACENTRAL DISC HERNIATION ELEVATING THE POSTERIOR LONGITUDINAL LIGAMENT AND ENCROACHING THE RIGHT GREATER THAN LEFT NEUROFORAMEN AND IMPINGING THE RIGHT NERVE ROOT BUT NO CANAL STENOSIS. C7-T1: THERE IS SLIGHT DISC SPACE NARROWING AND 2 MM POSTERIOR DISC PROTRUSION EFFACING THE VENTRAL THECAL SAC AND ENCROACHING BOTH NEUROFORAMEN BUT NO CANAL STENOSIS OR NERVE ROOT IMPINGEMENT. THE AXIAL IMAGES LIKEWISE REVEAL CANAL STENOSIS AT C4-5 AND C5-6 AND NEUROFORAMENAL ENCROACHMENT FROM C3-4 THROUGH C7-T1 EXACERBATED BY FACET/LIGAMENTUM FLAVUM HYPERTROPHY BUT NO PARAVERTEBRAL SOFT TISSUE DISEASE. 4 MM DISC HERNIATIONS FROM C4-5 THROUGH C6-7 STENOSING THE SPINAL CANAL, ENCROACHING THE NEUROFORAMEN & IMPINGING NERVE ROOTS AS DESCRIBED AGGRAV. D BY OSTEOARTHRITIS & DISC DESICCATION. 3 MM BROAD-BASED C3-4 DISC PROTRUSION ELEVATING THE POSTERIOR LONGITUDINAL LIGAMENT & ENCROACHING BOTH NEUROFORAMEN. 2 MM C7-T1 DISC PROTRUSION EFFACING THE VENTRAL THECAL SAC & ENCROACHING BOTH NEUROFORAMEN.

MRI Cervical Spine, 04/23/2013, signed by Maurice Hale, M.D. Impression: 4 MM DISC HERNIATIONS FROM C4-5 TI-IROUGH C6-7 STENOSING THE SPINAL CANAL, ENCROACHING THE 3 MM BROAD-BASED C3-4 DISC PROTRUSION ELEVATING THE POSTERIOR LONGITUDINAL LIGAMENT & ENCROACHING BOTH NEUROFORAMEN. 2 MM C7-T1 DISC PROTRUSION EFFACING THE VENTRAL THECAL SAC & ENCROACHING BOTH NEUROFORAMEN.

An MRI study of the CERVICAL SPINE was performed on 04/23/2013, and the results were read by Maurice Hale, M.D. Impression: 4 mm disc herniations from C4-5 through C6-7 stenosing the spinal canal, encroaching the neuroforamen and impinging. RVE roots as described by osteoarthritis and disc desiccation. 3 mm broad-based C3-4 disc protrusion elevating the posterior longitudinal ligament and encroaching both neuroforamen. 3.2 mm C7-T1 disc protrusion effacing the ventral thecal sac and encroaching both neuroforamen.

The X-RAY of the LEFT ANKLE was done on 11/01/2013, and the results were read by Richard Witten, M.D., and are as follows: Impression: Mild to moderate diffuse degenerative findings. No fracture or other significant appearing abnormality is detected.

The X-RAY of the CERVICAL SPINE was done on 11/01/2013. The results as read by Richard Witten, M.D., were as follows: Impression: C5-C6 interbody fusion. Whether this is surgical or due to infection or some other process is uncertain from this single exam. Chronic degenerative disk disease as detailed above. No subluxation or other acute process is suspected.

XR OF THORACIC SPINE; Dated 11/01/2013, signed by Ricard Witten, M.D. Impression: Mild to moderate diffuse degenerative findings. No fracture or other significant appearing abnormality is detected.

XR CERVICAL SPINE AP/LAT; Dated 11/01/2013, signed by Ricard Witten, M.D. Impression: C5-C6 interbody fusion. Whether this is surgical or due to infection or some other process is uncertain from this single exam. Chronic degenerative disk disease as detailed above. No subluxation or other acute process is suspected.

CERVICAL SPINE COMPLETE; Dated 11/01/2013, signed by Richard Witten, M.D. FINDINGS/IMPRESSION: The C5-C6 disk space is obliterated. There is no laminectomy defect. Without other information, the possibilities of surgical fusion and/or the result of infection or trauma must be considered. The alignment of these vertebral bodies is normal. There are osteophytes at the margins of each of the cervical vertebral bodies from C3 to T1. The C3-C4 and C6-C7 disk spaces are narrowed consistent with chronic degenerative disk disease. There is no fracture. There is no prevertebral swelling. The AP diameter of the cervical spinal canal is normal. C5-C6 interbody fusion. Whether this is surgical or due to infection or some other process is uncertain from this single exam. Chronic degenerative disk disease as detailed above. No subluxation or other acute process is suspected.

THORACIC SPINE; Dated 11/01/2013, signed by Richard Witten, M.D. FINDINGS/IMPRESSION: There is very slight increase in the round back shape of the thoracic spine in lateral view. Large osteophytes are directed anteriorly bordering the T9-10 disk. The vertebral bodies are normal in alignment. The disk spaces are rather well preserved throughout. No fracture of vertebral bodies or included ribs is shewn. No paravertebral mass is detected. Mild to moderate diffuse degenerative findings. No fracture or other significant appearing abnormality is detected. NOTE: Radiculopathy is not visible in radiographs.

XR FINGER PA/LAT, XR FOOT RIGHT; Dated 08/10/2014, signed by Ricard Witten, M.D. Impression: No evidence of acute trauma or significant joint disease in the right thumb. Hallux valgus, bunion and hammertoe formation and heel spurs are prominent in the right foot. No fracture to the second toe or elsewhere is detected.

XR ANKLE LEFT; Dated 09/22/2014, signed by Thomas Zung, M.D. Impression: Overlying soft tissue prominence. Minimal degenerative changes of left ankle. Small left inferior calcaneal spur. No fracture, subluxation, lytic lesion or bony erosions.

A SOAP NOTE dated 04/28/2015 and signed by Lina M. Rodriguez. Revealed that the patient was complaining of L ankle post traumatic arthritis. Therefore, all treatment options including conservative surgical options were explained to the patient. She decided to continue with conservative management.

An MRI study of the CERVICAL SPINE, was performed on 10/05/2015. The results as read by Gasser M. Hathout, M.D., were as follows: Impression: Very severe disc space narrowing at C5-6, with near complete fusion of the C5 and C6, with near complete fusion of the C5 and C6 vertebral bodies, likely post degenerative auto-fusion, but other etiologies cannot be excluded. This finding was present on prior plain film examination of 2013. Moderately severe degenerative disc disease at C6-7, and moderate/moderately severe degenerative disc disease at C3-4, C4-5, and C7-T1. Straightening and slight reversal of the normal cervical lordosis. Mild to moderate spinal canal narrowing at C5-6 due to broad-based posterior osteophyte formation. Mild spinal canal narrowing at C4-5 and C6-7. No evidence of large disc bulge, gross focal disc herniation, high grade spinal canal stenosis, gross cord impingement, or gross cord signal abnormality at any level. Multilevel neural foraminal stenosis, most pronounced at C3-4 as described above. Clinical correlation for radiculopathy is suggested.

MRI C SPINE W/O CONTRAST; Dated 10/05/2015, signed by Gasser M. Hathout, M.D.

FINDINGS/IMPRESSION: There is severe loss of disc height at C5-6, with near-complete fusion of the C5 and C6 vertebral bodies, likely secondary to severe degenerative spondylosis. There is moderate/moderately severe degenerative disc disease at C3-4, C4-5 and C6-7, as well as mild to moderate degenerative disc disease at C2-3 and C7-T1. There is straightening and slight reversal of the normal cervical lordosis centered at C5-6. There is a slight anterolisthesis of C2 on C3. At C5-6, there is some posterior osteophyte formation, with mild to moderate spinal canal narrowing, with effacement of the cerebrospinal fluid surrounding the cord and mild ventral cord flattening. There is mild spinal canal narrowing at C4-5 and C6-7. However, there is no evidence of large disc bulge, gross focal disc herniation, high grade spinal canal stenosis, severe cord impingement, or gross cord signal abnormality at any level. Uncovertebral and hypertrophic facet arthropathy produce moderately severe to severe right and moderately severe left C3-4, moderate left C5-6, moderate left C6-7 and moderate bilateral C7-T1 neural foraminal stenosis. Clinical correlation for radiculopathy, particularly C4 radiculopathy is suggested. Very severe disc space narrowing at C5-6, with near complete fusion of the C5 and C6 vertebral bodies, likely post-degenerative auto-fusion, but other-etiologies cannot be excluded. This finding was present or prior plain film examination of 2013. Moderately severe degenerative disc disease at C6-7, and moderate/moderately severe degenerative disc disease at C3-4, C4-5, and C7-T1. Straightening and slight reversal of the normal cervical lordosis. Mild to moderate spinal canal narrowing at C5-6 due to broad-based posterior osteophyte formation. Mild spinal canal narrowing at C4-5 and C6-7. No evidence of large disc bulge, gross' focal disc herniation, high grade spinal canal stenosis, -gross cord impingement, or gross cord signal abnormality at any level. Multilevel neural foraminal stenosis, most pronounced at C3-4 as described above. Clinical correlation for radiculopathy is suggested.

MRI study of the Cervical Spine performed on 10/05/2015, revealed the following results: Impression: Very severe disc space narrowing at C5-6, with near complete fusion of the C5 and C6 vertebral bodies, likely post-degenerative auto-fusion, but other: etiologies cannot be excluded. This finding was present on prior plain film examination of 2013. Moderately severe degenerative disc disease at C6-7, and moderate/moderately severe degenerative disc disease at C3-4, C4-5, and C7-T1. Straightening and slight reversal of the normal cervical lordosis. Mild to moderate spinal canal narrowing at C5-6 due to broad-based posterior osteophyte formation. Mild spinal canal narrowing at C4-5 and C6-7. No evidence of large disc bulge, gross focal disc herniation, high grade spinal canal stenosis, gross cord impingement, or gross cord signal abnormality at any level.

ADULT PRIMARY CARE OUTPT PROVIDER NOTE; Dated 05/03/2016, signed by Nastaran Rafiei, M.D.

Assessment/Plan: Cervical radiculopathy. Pt declines any pain meds; referred to PT. Ordered EMG/NCS; keep appt as scheduled on 717116; ordered labs. Ordered: ALT, Blood, Routine collect, 05/03/16, Lab Collect, Cervical radiculopathy, Order for future visit, Print Label By Order Location, HUD PC.

An ELECTRONEUROMYOGRAPHIC REPORT was issued on 06/22/2016, by Nastaran Rafiei, M.D. The following were the impressions: "This is an abnormal study. There is electrodiagnostic evidence of bilateral median neuropathies at the wrists (i.e. carpal tunnel syndrome), which is moderately severe bilaterally, slightly worse on the right. There is no electrodiagnostic evidence of a left cervical root lesion (e.g. radiculopathy)".

OFFICE VISIT; Dated 12/05/2017, signed by Maria Estela Castro, NP. CHIEF COMPLAINT: HAD A FALL 3 DAYS AGO. HISTORY OF PRESENT ILLNESS: SHE HIT HER BACK AND CURRENTLY EXPERIENCING PAIN IN THE BACK. ASSESSMENT: Other obesity due to excess calories. PAIN UNSPECIFIED. Fall on same level from slipping, tripping, and stumbling with subsequent striking against other object, initial encounter. PLAN: Procedures: OV FOLLOW UP LVL 3L. Medications: DICLOFENAC 3% APPLY AS NEEDED; Qty: 0 Refills 0. LIDOCAINE 5% OINTMENT; APPLY AS NEEDED; Qty: 0, Refills 0. Care Plan: ORDERED MRI OF THE WHOLE SPINE FOR FURTHER EVALUATION OF PAIN.

On 08/24/2021, the patient was presented to Dr. Matthew Nalamlieng, M.D., with a chief complaint of foot pain.

Please note, on April 05, 2022, the patient was crossing street to enter her house, after work, and was going to do the rest of her work at home. On that day, Ms. Babayan "fell, landing forward and injuring her left shoulder and right knee". The next day, she saw Dr. Sharim, MD., and MRI studies of the left shoulder and right knee were ordered. The results were sent to Dr. Powell, MD, an orthopedic surgeon, which recommended surgery for the left shoulder. In the meanwhile, she kept on working, with the pain in her left shoulder and right knee, until her specific injury of 04/14/2022. After her specific injury of the 04/14/2022 she acquired pain in bilateral knees, lower back, and right shoulder.

The X-RAY OF THE RIGHT KNEE, done on 04/07/2022, and read by Haroutun Abrahamian, M.D., revealed the following: Impression: Medial compartment osteoarthritis with a small to moderate size joint effusion. Quadriceps tendon enthesopathy.

The X-RAY OF THE LEFT SHOULDER, done on 04/07/2022, and read by Haroutun Abrahamian, M.D., revealed the following: Impression: Mild degenerative changes about the left shoulder.

MRI study OF THE LEFT SHOULDER, performed on 04/07/2022, and read by Haroutun Abrahamian, M.D. revealed the following results: Impression: Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial-thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis with adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis.

X-RAY OF THE LEFT SHOULDER- ONE VIEW; Dated 04/07/2022, signed by Haroutun Abrahamian, M.D.
FINDINGS/IMPRESSION: Osseous structures are intact without evidence for an acute fracture or dislocation. Mild joint space narrowing and osteophytosis are seen at the acromioclavicular and glenohumeral joints. Visualized chest is clear. Soft tissue planes are well maintained. Mild degenerative changes about the left shoulder.

X-RAY OF THE RIGHT KNEE – THREE VIEWS; Dated 04/07/2022, signed by Haroutun Abrahamian, M.D.
FINDINGS/IMPRESSION: There is no significant soft tissue abnormality. Small to moderate size joint effusion is present. Osseous structures are intact without evidence for a fracture or dislocation. Joint space narrowing and osteophytosis are seen about the medial compartment. The lateral compartment and patellofemoral joints are well maintained. An enthesophyte is identified at the quadriceps tendon insertion to the patella. Medial compartment osteoarthritis with a small to moderate size joint effusion. Quadriceps tendon enthesopathy.

MRI OF THE LEFT SHOULDER WITHOUT CONTRAST; Dated 04/07/2022, signed by Haroutun Abrahamian, M.D. FINDINGS/IMPRESSION: ACROMIOCLAVICULAR JOINT: A type I acromion is noted. The acromioclavicular joint demonstrates mild arthrosis. There is mild to moderate subacromial/subdeltoid bursa fluid. ROTATOR CUFF TENDONS: The supraspinatus and infraspinatus tendons are thickened and heterogeneous in signal consistent tendinosis. This reaches fluid signal at the supraspinatus footprint spanning 5.5 mm consistent with a partial-thickness tear without retraction or associated muscle bulk atrophy. The remainder of the rotator cuff tendons demonstrate normal signal and morphology. The rotator cuff muscle bulk and signal are normal. LABRUM AND LONG HEAD OF THE BICEPS TENDON: The long head of the biceps tendon is identified at its anatomic location along the bicipital groove without evidence for tendinopathy or tear. The visualized labrum is grossly intact on a non-intra-articular contract: exam. There are no paralabral cysts to suggest a tear. MISCELLANEOUS: Subcoracoid bursa fluid is present. Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial-thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis with adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis.

The X-RAY OF THE LEFT SHOULDER, done on 04/08/2022, read by Haroutun Abrahamian, M.D., revealed the following results: Impression: Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial-thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis with adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis.

The patient visited Dr. Scott Powell, M.D.'s, office on 04/14/2022. The following treatment plans were recommended: "Plan: Knee: She was advised to take over-the-counter anti-inflammatories (NSAIDs) as needed and to apply ice to the affected area as needed. The patient's x-rays were reviewed and discussed. The patient was advised to begin a formal physical therapy program aimed at reducing pain caused by osteoarthritic changes. The patient was provided with a requisition for 6 sessions of physical therapy and advised to attend PT 2x per week for 3 weeks. Shoulder: She was advised to take over-the-counter anti-inflammatories (NSAIDs) as needed and to apply ice to the affected area as needed. The diagnosis was discussed with the patient. Non-operative versus operative treatment options were discussed. Operative treatment was described as a left shoulder arthroscopic rotator cuff repair Non-operative treatment was described as physical therapy and/or pain management strategies, including cortisone injections. The patient has elected to pursue conservative management at this time and was provided with a requisition for 6 sessions of physical therapy. She was advised to attend physical therapy 2x per week for 3 weeks. Our office will follow up with the patient in 4 weeks via phone to assess her progress with physical therapy. Additionally, the patient was advised to inquire about a left shoulder cortisone injection. The patient was encouraged to consult her primary care physician regarding this injection".

OFFICE VISIT; Dated 04/14/2022, signed by Scott Powell, M.D. HPI - Knee: Patient is a 65 years old female who presents via telemedicine and is a new patient to our office, referred for evaluation and treatment regarding her left shoulder pain and right knee pain. She reports this pain began after she sustained a fall on April 5th. The patient reports that her left shoulder pain and right knee pain have generally persisted since onset. Plans - Knee: Patient was advised to take over-the-counter anti-inflammatories (NSAIDs) as needed and to apply ice to the affected area as needed. The patient's x-rays were reviewed and discussed. The patient was advised to begin a formal physical therapy program aimed at reducing pain caused by osteoarthritic changes. The patient was provided with a requisition for 6 sessions of physical therapy and advised to attend PT 2x per week for 3 weeks. Plans - Shoulder: Patient was advised to take over-the-counter anti-inflammatories (NSAIDs) as needed and to apply ice to the affected area as needed. The diagnosis was discussed with the patient. Non-operative versus operative treatment options were discussed. Operative treatment was described as a left shoulder arthroscopic rotator cuff repair Nonoperative treatment was described as physical therapy and/or pain management strategies, including cortisone injections. The patient has elected to pursue conservative management at this time and was provided with a requisition for 6 sessions of physical therapy. She was advised to attend physical therapy 2x per week for 3 weeks.

A DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS, was issued on 04/18/2022, by Raffi Kazazian, M.D. The patient was declared to be "unable to perform his usual work" and recommended to return to modified work on 4/18/2022, with the following restrictions – Shoulder. Left shoulder restrictions include – No overhead work. Lifting, pushing, or pulling limitations up to 5 lbs. The patient was to follow-up on 4/28/2022.

RIGHT SHOULDER SERIES; done on 04/18/2022, by P. Kashfian, M.D., revealed the following: Impression: Osteoarthritic changes of the acromioclavicular joint.

RIGHT SHOULDER SERIES; done on 04/28/2022, by B. Shayestehfar, M.D., revealed the following: Impression: No evidence of fracture or dislocation.

On 04/28/2022, Raffi Kazazian, M.D, declared the patient to be "unable to perform his usual work" and recommended to return to modified work on 04/28/2022, with the following restrictions – Shoulder. Left shoulder restrictions include – No overhead work. Lifting, pushing, or pulling limitations up to 5 lbs. The patient was to follow-up on 5/16/2022.

A CHART NOTE issued on 04/28/2022, by Raffi Kazazian, M.D., revealed the following plans: "The following radiology/test was ordered: MRI Bilateral Shoulder Without Contrast. Knee Without Contrast. MRI Bilateral Spine - Lumbar/Sacral Without Contrast".

A WORK STATUS SUMMARY, was issued on 04/28/2022, by Raffi Kazazian, M.D. The patient was to return to work with restrictions, from 4/28/22 thru 5/16/22. Restrictions – Shoulder. Left shoulder restrictions include – No overhead work. lifting, pushing, or pulling limitations up to 5 lbs. He was to return for a follow-up appointment on 5/16/22

The PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2), that was issued on 04/28/2022, by Raffi Kazazian, M.D., revealed the following: The patient was instructed to return to modified work on 04/18/2022 with the restrictions. The following radiology / test was ordered: MRI Bilateral Shoulder Without Contrast. radiology/test Knee Without Contrast. MRI Bilateral Spine - Lumbar/Sacral Without Contrast. The patient was to follow-up on 5/16/2022.

A CHART NOTE; dated 05/16/2022, was issued by Raffi Kazazian, M.D. The patient was to return to work modified duty. 5/16/22 - The patient has been advised to proceed with right shoulder MRI on 5/20/22, L/S MRI on 5/23/22, and B/L knee MRI on 5/24/22. She was to return to work with restrictions, from 5/16/22 thru 5/31/22, and follow-up on 05/31/22.

A PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2); was issued on 05/16/2022, by Raffi Kazazian, M.D. The primary treating physician wrote, "She did see Dr Scott Powell (ortho) through private insurance, she rec'd NSAID, ice, CSI, PT and possible arthroscopic surgery. She states she has an authorization to see another orthopedic specialist. She has her rt shoulder MRI scheduled on 5/20/22, L/5 MRI on 5/23/22 and 13/1. Knee MRI on 5/24/22. She is currently on modified duty". The patient was recommended to follow-up with her appointments, and return to modified duty, on 5/16/22. She was advised to proceed with rt Shoulder MRI on 5/20/22. L/S MRI on 5/23/22, and b/l. knee MRI on 5/24/22.

An MRI study of the RIGHT SHOULDER WITHOUT CONTRAST, was performed on 05/17/2022. The results as signed by Haroutun Abrahamian, M.D., was as follows: Impression: Full-thickness supraspinatus tendon tear with retraction by 10 mm and has mild muscle. Bulk/fatty atrophy. Adjacent infraspinatus and subscapularis tendinosis. High-grade partial-thickness tong head of the biceps tendon tear and retraction. Mild to moderate acromioclavicular joint arthrosis with adjacent subacromial/subdeltoid bursitis.

MRI OF THE LEFT SHOULDER WITHOUT CONTRAST; Dated 05/17/2022, signed by Haroutun Abrahamian, M.D. FINDINGS/IMPRESSION: ACROMIOCLAVICULAR JOINT: A type I acromion is noted. The acromioclavicular joint demonstrates mild to moderate arthrosis. There is mild to moderate subacromial/subdeltoid bursa fluid. ROTATOR CUFF TENDONS: The supraspinatus is heterogenous in signal consistent tendinosis with a full thickness tear anteriorly with retraction by 10 mm and has mild muscle bulk/fatty atrophy. The adjacent infraspinatus tendon is thickened suggestive for tendinosis. The subscapularis tendon is also heterogenous in signal. The teres minor tendon demonstrates normal signal and morphology. The rotator cuff muscle bulk and signal are

normal. LABRUM AND LONG HEAD OF THE BICEPS TENDON: The long head of the biceps tendon is identified on its anatomic location along the bicipital groove but is diminutive in size at the lesser tuberosity and intraarticular portion suggestive for a high grade partial thickness tear/retraction. The visualized labrum is grossly intact on non-intra-articular contrast exam. There are no paralabral cysts to suggest a tear. MISCELLANEOUS: Subcoracoid bursa fluid is present. Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis and adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis.

An MRI study of the LEFT KNEE WITHOUT CONTRAST; was done on 05/19/2022. The results were translated by Haroutun Abrahamian, M.D., and were as follows: Impression: Peripheral extrusion of the medial meniscus from the joint line as well as heterogeneous signal at the anterior horn/body junction. A complex degenerative tear cannot be excluded at this site without post contrast imaging. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment as described above. Subchondral edema versus bone contusion of the lateral femoral condyle posterior nonweightbearing aspect. Small to moderate size joint effusion. Quadriceps tendon enthesopathy.

On 05/23/2022, the patient underwent an MRI study of the LUMBAR SPINE WITHOUT CONTRAST, which was translated by Haroutun Abrahamian, M.D. The results were as follows: Impression: Mild to moderate disc desiccation of L4-L5 with a 3.5 mm broad-based disc protrusion and facet arthrosis causing mild central canal and neural foraminal stenosis bilaterally. Mild disc desiccation of L5-S1 with a 2 mm broad-based disc protrusion asymmetric to the right with facet arthrosis and an 8 mm complex synovial cyst in the right neural foramen causing mild central canal stenosis as well as moderate right-sided and mild to moderate left-sided neural foraminal stenosis. Less significant findings at the remainder of the disc levels as described above. Heterogeneous marrow signal diffusely which is nonspecific but may represent osteopenia. Pathologic process cannot basically without oncologic workup.

MRI studies of the LEFT SHOULDER WITHOUT CONTRAST done on 05/24/2022, and signed by Haroutun Abrahamian, M.D., revealed the following results: Impression: Supraspinatus and infraspinatus tendinosis with a persistent 3.5 mm partial-thickness supraspinatus footprint tear without retraction or associated muscle bulk atrophy. Mild acromioclavicular joint arthrosis with adjacent subacromial/subdeltoid bursitis.

MRI study of the RIGHT KNEE WITHOUT CONTRAST, was done on 05/24/2022, and the results were transcribed by Haroutun Abrahamian, M.D. Impression: Peripheral extrusion of the medial meniscus from the joint line without a definite tear. Intrasubstance generation of the lateral meniscus at the body without a definite tear. MR arthrogram may be performed for further evaluation/characterization if clinical concern persists. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment. Quadriceps tendon enthesopathy. Mild prepatellar bursitis.

A PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2); was issued on 05/31/2022, by Raffi Kazazian, M.D. The patient was instructed to return to modified work on 04/18/2022 with limitations or restrictions. In that visit, she stated she had PRP injection to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She stated she has authorization to see another orthopedic specialist. The following treatment plans were recommended: "I recommend a consultation and treatment with a qualified Orthopedist. I recommend a consultation and treatment with a qualified orthopedic back specialist. I recommend physical therapy: three times weekly for three weeks. Follow-up on 6/14/2022".

A CHART NOTE, was issued on 05/31/2022, by Raffi Kazazian, M.D. The following treatment plans were recommended for her: "ORTHOPEDIST REFERRAL: I recommend a consultation and treatment with a qualified Orthopedist. I recommend a consultation and treatment with a qualified orthopedic back specialist. I recommended physical therapy: three times weekly for three weeks. Follow-up on 5/14/2022. Return to work modified duty".

A WORK STATUS SUMMARY, was issued on 06/13/2022, by Raffi Kazazian, M.D. The patient was to return to work with restrictions, from 6/13/22 thru 6/27/22, and follow-up on 6/27/22.

A PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2); was issued on 06/13/2022, by Raffi Kazazian, M.D. The patient was to follow-up on 6/27/2022. She was to return to work modified duty.

A CHART NOTE, issued on 06/13/2022, by Raffi Kazazian, M.D. The patient was instructed to follow-up on 6/27/2022.

A PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2); was issued on 06/27/2022, by Raffi Kazazian, M.D. The patient was to return to work modified duty, and follow-up on 7/11/2022.

The patient followed up with the PRIMARY TREATING PHYSICIAN (Raffi Kazazian, M.D.), on 07/11/2022. She was to return to modified work duties (restrictions were changed to 10 pounds), and follow-up on 7/25/2022.

A PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2); was issued on 07/28/2022, by Raffi Kazazian, M.D. She was returned to modified work duties and instructed to follow-up on 8/12/2022. She was also recommended to continue Physical Therapy. She was pending ortho appt for R shoulder and b/l knee.

An APPLICATION FOR ADJUDICATION OF CLAIM; was filed on 08/10/2022. Date of Injury: CT: 09/03/2019-04/18/2022. Injured Body Parts: LUMBAR SPINE, SLEEPING DISORDER, DENTAL.

The patient followed-up with the PTP (Raffi Kazazian, M.D.), on 08/12/2022. The following treatment plans were recommended: "REQUEST FOR PHYSICAL THERAPY AUTHORIZATION: I recommended physical therapy: Two times weekly for two weeks. TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 9/16/2022. Return to work modified duty".

On 08/15/2022, the patient was examined by Gregory J. Adamson, M.D., for her "Left shoulder pain". The following treatment plans were discussed: "We discussed the implications of a rotator cuff tear in detail. Over time, a rotator cuff tear may stay the same or increase in size. With time, atrophic changes will develop, which are irreversible. With an arthroscopic repair, we discussed 95% get complete or near complete pain relief. 80% get back 80% or more of their premorbid function. Without surgery, 50% will progress in size and symptomatology. Presently, given the small size of the partial thickness rotator cuff tear, I recommend that she attend a trial course of formalized physical therapy. We will plan to see her back in 4 weeks for repeat clinical evaluation of her left shoulder".

HISTORY & PHYSICAL REPORT; Dated 08/15/2022, signed by Gregory J. Adamson, M.D. Assessment & Plan: Left rotator cuff tear (M75.102). Impression: Bursal-sided partial thickness rotator cuff tear, left shoulder. Current Plans: Pt Education - How to Access Health Information Online using Patient Portal and 3rd Party Apps: discussed with patient and provided information. XR SHOULDER LEFT, 2 VIEWS (73030). X-RAY OF LEFT

ACROMIOCLAVICULAR JOINT WITH AND WITHOUT WEIGHT (73050). Overweight for height (E66.3). Current Plans: LIFESTYLE EDUCATION REGARDING DIET (98960).

WORKERS COMPENSATION INITIAL ORTHOPAEDIC CONSULTATION REPORT; Dated 09/06/2022, signed by Gregory J. Adamson, M.D. History of Present Injury As Described By Patient: The patient is a right hand dominant 66-year-old woman who presents today with a friend for an evaluation of her right shoulder and to review her MRI. On 04/14/2022, she injured her right shoulder when she slipped on mud while showing cemetery property. She had severe pain and discomfort. She rated her pain at a 9/10. On 05/17/2022, she obtained a right shoulder MRI. In June 2022, she started attending formalized physical therapy. She attended 12 sessions with minimal relief. Since then, she has been experiencing occasional minimal to moderate pain localized over the biceps region. She describes her pain as throbbing and pulsating. She occasionally has spasm in her biceps, which causes burning pain. She has discomfort at night that is positional in nature. She has hallucination with range of motion. She has discomfort at night that is positional in nature. She has limitation with range of motion. Her pain is better with Bio-Relieve. Her pain is exacerbated by certain movements, walking and ascending stairs. PRESENT COMPLAINTS: Right shoulder pain. DIAGNOSTIC IMPRESSION: Small tear in the supraspinatus with associated early atrophic changes, right shoulder. WORK RESTRICTIONS: TTD. PLAN: We discussed the implications of a rotator cuff tear in detail. Overtime, a rotator cuff tear may stay the same or increase in size. With time, atrophic changes will develop, which are irreversible. With an arthroscopic repair, we discussed 95% get complete or near complete pain relief 80% get back 80% or more of the premorbid function. Without surgery, 50% will progress in size and symptomatology. Presently, we will try her on another course of formalized physical therapy at a different venue. I will request for this today. We will plan to see her back in 4 weeks for repeat clinical evaluation.

On 09/09/2022, Dr. Raffi Kazazian, M.D., recommended for the patient to return to continue Physical Therapy and continue Orthopedics, return to work modified duty and to follow-up on 9/23/2022.

On 09/12/2022, the patient followed up with Dr. Gregory J. Adamson, M.D. The following was discussed: "Treatment Plan: She will continue with formalized physical therapy. We will plan to see her back in 4 weeks for repeat clinical evaluation".

WORKERS COMPENSATION INITIAL ORTHOPAEDIC CONSULTATION REPORT; Dated 09/12/2022, signed by Gregory J. Adamson, M.D. History of Present Illness: The patient is seen today in follow up for her left shoulder. Since last seen, she has been experiencing occasional moderate pain and discomfort. She has been attending formalized physical therapy and states that it is helpful. She has been exercising with Theraband at physical therapy. She has also tried laser therapy and states that it is helpful. IMPRESSION: Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder. TREATMENT PLAN: She will continue with formalized physical therapy. We will plan to see her back in 4 weeks for repeat clinical evaluation.

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2); Dated 09/13/2022, signed by Gregory J. Adamson, M.D. PLAN: We discussed the first line of treatment is rest, ice, elevation, anti-inflammatories and physical therapy, if the patient is unresponsive to that consideration can be given towards injections with corticosteroid vs viscosupplementation vs PRP. If the patient is unresponsive to all of the above consideration can be given towards arthroplasty surgery. Presently, we will try her on a course of formalized physical therapy. I will request for this today. We will plan to see her back in 4 weeks for repeat clinical evaluation.

On 09/15/2022, Dr. Roy F. Ashford, M.D., issued a DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS. The patient visited the Dr., for a consultation, due to lower back pain radiating to both legs. The following was discussed: "The current problem demonstrates no direct neurologic involvement. I find only signs of strained muscles. There is nothing significant on x-ray other than age related degenerative changes as expected. I do

not think that an MRI would allow more insight on the problem. If things change neurologically, I would consider getting an MRI later. Physical therapy and a good home exercise program will help start a habit of regular exercise, warm-ups, and stretching. I have explained different approaches for exercise, discussed resources such as health clubs, YMCAs, and pools in the area. I do not like long term use of medications for this, but anti-inflammatories certainly can provide early benefits. Careful behaviors, attention to posture, avoidance of heavy lifting and proper mechanics have all been stressed. Today the patient obtained an order to start physical therapy focusing on core stabilization".

On 09/22/2022, the patient visited Dr. Babak Samimi, M.D. Dr. Samimi, wrote, "Based on my best medical judgement, lack of evidence to the contrary and based on reasonable medical probability, the following conclusions have been made: The patient sustained an industrial related injury. Apportionment will be calculated at the time the patient reaches MMI. I request authorization to evaluate and treat the patient's left shoulder on an industrial basis as she is authorized for Right shoulder and Bilateral knee as well as the low back. These injuries involved the mechanism she was causing these accepted injuries would have caused or at least aggravated the Left shoulder symptoms as well. For the Bilateral Shoulder: REQUEST additional 12 sessions Physical Therapy: Shoulder ROM, Strengthening, Stretching, Modalities. I had a lengthy conversation with the patient regarding treatment options, risks, and benefits. Patient expressed understanding. Ultimately, recommended RIGHT Reverse Total Shoulder Replacement Surgery: Pt has severe degenerative joint disease and an irreparable rotator cuff tear (rotator cuff arthropathy) confirmed by x-ray and clinical exam and has failed conservative treatment including NSAIDs, RICE, Activity Modification, and PT. I recommend reverse total shoulder replacement to allow for improved pain and function. Ultimately, Recommend Left Shoulder Arthroscopic Surgery: Pt has a Rotator Cuff Tear and Impingement confirmed by MRI and clinical exam and has failed conservative treatment including NSAIDs, RICE, Activity Modification, and Therapy. Therefore, I recommend arthroscopic surgery for rotator cuff repair, subacromial decompression, glenohumeral debridement, and possible Mumford procedure, and surgery as indicated. Consider injection with cortisone. The patient is apprehensive about cortisone injections as she is prediabetic. For the Bilateral Knee: Activity Modification. REQUEST 12 sessions of Physical Therapy: Knee ROM, Strengthening, Stretching, Gait Training, Modalities. Consider injection with cortisone vs. viscosupplementation. Again, the patient is apprehensive about cortisone injection due to prediabetes. Ultimately, Recommend Bilateral Total Knee Replacement Surgery. The patient would like to continue with conservative measures while considering treatment options. For the Lumbar Spine: Activity Modification. Apply Heat. Gentle Massage. NSAIDs. REQUEST 12 sessions of Physical Therapy: Referral for a course of physical therapy for Lumbar ROM, Strengthening, Stretching, Pelvic Stabilization, Core, Modalities (massage, gentle manipulation, heat, ice, electric stimulation, iontophoresis, ultrasound, etc.). REQUEST referral to Pain Management Specialist for evaluation and treatment including Lumbar Epidural Injection, Facet Block Injection vs other injections. Elevated BMI: Counseled the patient on the risks of high BMI and the importance of losing weight. A combination of proper diet and regular exercise was recommended". She was placed on TTD and was to follow up in 6 weeks.

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2); Dated 10/18/2022, signed by Gregory J. Adamson, M.D. Interim History: The patient is seen today in follow up for her left shoulder. Since last seen, she has been feeling slightly better. She has been experiencing occasional moderate pain localized over the deltoid region. Occasionally, this pain radiates down her arm. She describes her pain as burning. She feels that her range of motion has gotten better. She has been attending formalized physical therapy, which has been very helpful. She has been using ice. IMPRESSION: Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder. TREATMENT PLAN: She will continue formalized physical therapy. We will plan to see her back in 4 weeks for repeat clinical evaluation.

A DEPOSITION was conducted of the patient on JANUARY 16, 2023.

An APPLICATION FOR ADJUDICATION OF CLAIM, was filed on 01/17/2023, to AMEND APPLICATION TO ADD HER LEFT SHOULDER, SLEEP DISORDER, AND DENTAL, for the Date of Injury: 04/14/2022, and the Injured Body Parts: SHOULDERS, BACK, & KNEE.

On 01/17/2023, Dr. David Schames, DDS., issued a report titled, "INITIAL REPORT IN THE FIELD OF DENTISTRY AND REQUEST FOR AUTHORIZATION". Dr. Schames wrote, "It is with reasonable medical probability that the industrial exposure which caused patient to have resultant orthopedic pain would have aggravated any preexisting bruxism. The scientific literature has documented that a person can have bruxism in response to pain. Patient reports she finds she is clenching her teeth and bracing her facial musculature in response to her orthopedic pain. The scientific literature has documented that pain can cause psychological distress. The scientific literature has also documented that persistent pain is extremely distressing and psychological problems may become evident if the pain lasts for a continuous period of time. Patient states her resultant facial and jaw pain have caused increased stress and anxiety. As discussed above, the scientific literature has documented that a person can have bruxism of clenching and bracing of the facial muscles of mastication in response to pain as well as in response to stress. Therefore, it is with reasonable medical probability that patient's bruxism was aggravated on an industrial basis. Upon examination, I found patient has Myalgia of her facial muscles of mastication where palpation of the musculature evoked subjective tenderness and there were objective palpable taut bands within the musculature".

I previously evaluated the patient on January 17, 2023, for the injury that she sustained in a work- related accident, following selection of my name from a state panel list (number 7531564), and upon written request and without objection. At that time, as it appeared from the review of the records provided, examination of the patient, history of the treatments received (as reported by the patient and reviewed available records) and the consistency of patient complaints and findings, it was my opinion that all treatment that was reasonably necessary to cure and/or relief the effects of the injury had not been provided, and the reasonable treatment would consist of additional treatments including chiropractic care and physiotherapy. I recommended for her to continue a treatment regimen (of chiropractic care and physiotherapy) for 2 times a week for 6 weeks, also, in agreement with Dr. Samimi's recommendations, a regimen of Shoulder ROM, Strengthening, Stretching, Modalities, were recommended. In addition, the patient was recommended to receive a Nerve Conduction Velocity test of the upper extremities, to determine the adequacy of the conduction of the nerve impulses and rule out any possible nerve injury; as well as a Functional Capacity Test, to determine her abilities to perform activities of daily living.

02/21/2023, the patient was evaluated by Vernon Brian Williams, MD, and a report was issued, titled: "SPORTS NEUROLOGY AND PAIN MANAGEMENT". The patient complained of Lumbar spine pain, and bilateral shoulder pain. The following were discussed: "At this point I recommend: HRV. RFA for lumbar facet/MBBs at bilateral L4-5 and L5-S1. RFA for lumbar PT with massage. Medbridge HEP. We have provided prolonged education regarding home exercise program followed by demonstration and observation of therapeutic exercises and performance space. Patient was provided with digital examples of a curated program using Medbridge platform. The patient may be a candidate for lumbar medial branch rhizotomy".

On 04/25/2023, Dr. David Schames, DDS., issued a report, titled: PERMANENT AND STATIONARY REPORT IN THE FIELD OF DENTISTRY BY MEANS OF TELEHEALTH. He wrote, "The following is a Permanent and Stationary Discharge report in my area of expertise, for patient who was evaluated and treated at our office for injuries sustained on the date(s) indicated above".

On 09/14/2023, Dr. Babak Samimi, M.D., wrote: "The patient presents for follow up evaluation and reports mild relief of her BI LATERAL knees with the Supartz injections #3 provided on 8/3/23. She had a new QME supplemental report which was made available for review today. She is still pending appointment with pain management specialist. She has obtained an EMG/Nerve Conduction Study, which was ordered and recommended by a QME. The request for physical therapy for her RIGHT shoulder was denied but for the LEFT shoulder is still pending. She did have the dental evaluation, which has been pending for some time. Plan: RIGHT SHOULDER: Ultimately, she is a candidate for a reverse total shoulder replacement. I LEFT SHOULDER: Now recommended for evaluation and treatment by PQME on 1/17/23 AND 7/6/23 Sharon Drake DC. The patient has not had any physical therapy for the LEFT shoulder.

REQUEST 12 sessions Physical Therapy: ROM, Strengthening, Stretching, Modalities. Recommend Left Shoulder Arthroscopy, Glenohumeral Debridement, Synovectomy, Subacromial Decompression, Distal Clavicle Excision, Rotator Cuff Repair, possible Biceps Tenodesis and surgery as indicated. The patient is not a surgical candidate due to her BMI. Ultimately, Recommend Bilateral Total Knee Replacement Surgery: Pt has severe degenerative joint disease (arthritis) confirmed by x-ray and clinical exam and has failed conservative treatment including NSAIDs, RICE, Activity Modification, PT, and Steroid Injections. I recommend total knee replacement surgery to allow for improved pain and function. However, I recommend weight loss prior to considering surgery".

A PANEL QUALIFIED MEDICAL EVALUATION WITH REVIEW OF MEDICAL RECORDS report was issued on 09/21/2023, by Babak Abrishami, DDS. The doctor wrote, "The applicant has reached permanent and stationary and MMI status from a dental, temporomandibular joint and orofacial pain perspective approximately three to four months after she was being provided with a mouth guard and her condition reached a plateau, which was on 04/01/2023. PRECLUSIONS/WORK LIMITATIONS: I believe that this patient can return to her previous job as far as her dental is concerned with the following limitations: No heavy lifting. Lifting heavy objects may cause her to clench her teeth hard and that could cause further TMJ and teeth damage, which will also increase myofascial pain".

A report was issued on 11/07/2023, by Babak Abrishami, DDS., titled "PANEL QUALIFIED MEDICAL EVALUATION SUPPLEMENTAL REPORT WITH REVIEW OF MEDICAL RECORDS". The patient was presented to the doctor's office on August 23, 2023, for a Panel Qualified Medical Evaluation. The doctor wrote: "I was being provided with medical and dental records to review and issue a supplemental report. After reviewing the records, my opinions and conclusions reported in my original QME report will remain the same with no changes. There is no new information in the records provided to me that alters any of my opinions and conclusions".

Another DEPOSITION was conducted of the patient on NOVEMBER 13, 2023.

I re-evaluated the patient on January 18, 2024, and issued a report, indicating that the patient was P&S at the time, therefore rating her impairments.

REVIEW OF AVAILABLE MEDICAL RECORDS

The following medical records were available for me to review:

NEW RECORDS

1. **XR CERVICAL SPINE ROUTINE:** Dated 04/19/2013, signed by Kimberly Foust, M.D. & Patrick Kane, M.D. FINDINGS/IMPRESSION: There is loss of the normal cervical lordosis. The vertebral body heights are normal without evidence of fracture. There is mild C4-C5, moderate C3-C4 and severe C5-C6 and C6-C7 degenerative disc disease. The C1 and C2 lateral masses are symmetric. There is no evidence of odontoid fracture. Bilateral uncovertebral joint osteoarthritis is present from C3-C4 to C6-C7. There is mild bilateral C3-C4 neuroforaminal stenosis. Mild bilateral facet osteoarthritis is present at C4-C5. The prevertebral soft tissues are normal. NO ACUTE OSSEOUS ABNORMALITY. MULTI-LEVEL DEGENERATIVE CHANGES, AS DESCRIBED ABOVE.

2. **MRI CERVICAL SPINE W/O CONTRAST:** Dated 04/23/2013, signed by Maurice Hale, M.D. FINDINGS/IMPRESSION: THERE IS CANAL STENOSIS AT C4-5 AND C5/6 BUT NO CORD SIGNAL ABNORMALITY, MISALIGNMENT, BONE MARROW SIGNAL ABNORMALITY, SCOLIOSIS OR FOCAL LESION. THERE IS DIFFUSE DISC DESICCATION, MARKED OSTEOPHYTOSIS AND ABNORMAL ENDPLATE SIGNAL INTENSITY AT C3-4 REFLECTING ACUTE INFLAMMATION. THE

CERVICOMEDULLARY JUNCTION, PRE VERTEBRAL SOFT TISSUES AND VISUALIZED PORTIONS OF THE POSTERIOR FOSSA ARE GROSSLY UNREMARKABLE. INDIVIDUAL:DISC SPACES REVEAL THE FOLLOWING: C2-3: THERE IS NORMAL DISC SPACE HEIGHT AND NO POSTERIOR DISC PROTRUSION, CANAL STENOSIS OR 1/ NERVE ROOT IMPINGEMENT. C3-4_ THERE IS MARKED DISC SPACE NARROWING AND 3 MM BROAD-BASED POSTERIOR DISC PROTRUSION ELEVATING THE POSTERIOR LONGITUDINAL LIGAMENT AND ENCROACHING BOTH NEUROFORAMEN BUT NO CANAL STENOSIS OR NERVE ROOT IMPINGEMENT. C4-5: THERE IS NORMAL DISC SPACE HEIGHT BUT A STENOSING THE SPINAL CANAL AND ENCROACHIN CANAL STENOSIS OR NERVE ROOT IMPINGEMENT. C5-6. THERE IS MARKED DISC SPACE NARROWING A 4MM LEFT PARACENTRAL DISC HERNIATION STENOSING THE SPINAL CANAL AND ENCROACHING HE LEFT NEUROFORAMEN WHILE1IMPINGING THE IPSILATERAL NERVE ROOT. C6-7: THERE IS MODERATE DISC SPACE NARROWING AND 4 MM RIGHT PARACENTRAL DISC HERNIATION ELEVATING THE POSTERIOR LONGITUDINAL LIGAMENT AND ENCROACHING THE RIGHT GREATER THAN LEFT NEUROFORAMEN AND IMPINGING THE RIGHT NERVE ROOT BUT NO CANAL STENOSIS. C7-T1: THERE IS SLIGHT DISC SPACE NARROWING AND 2 MM POSTERIOR DISC PROTRUSION EFFACING THE VENTRAL THECAL SAC AND ENCROACHING BOTH NEUROFORAMEN BUT NO CANAL STENOSIS OR NERVE ROOT IMPINGEMENT. THE AXIAL IMAGES LIKEWISE REVEAL CANAL STENOSIS AT C4-5 AND C5-6 AND NEUROFORAMENAL ENCROACHMENT FROM C3-4 THROUGH C7-T1 EXACERBATED BY FACET/LIGAMENTUM FLAVUM HYPERSTROPHY BUT NO PARAVERTEBRAL SOFT TISSUE DISEASE. 4 MM DISC HERNIATIONS FROM C4-5 THROUGH C6-7 STENOSING THE SPINAL CANAL, ENCROACHING THE NEUROFORAMEN & IMPINGING NERVE ROOTS AS DESCRIBED AGGRAV. D BY OSTEOARTHRITIS & DISC DESICCATION. 3 MM BROAD-BASED C3-4 DISC PROTRUSION ELEVATING THE POSTERIOR LONGITUDINAL LIGAMENT & ENCROACHING BOTH NEUROFORAMEN. 2 MM C7-T1 DISC PROTRUSION EFFACING THE VENTRAL THECAL SAC & ENCROACHING BOTH NEUROFORAMEN.

3. **CERVICAL SPINE COMPLETE:** Dated 11/01/2013, signed by Richard Witten, M.D. FINDINGS/IMPRESSION: The C5-C6 disk space is obliterated. There is no laminectomy defect. Without other information, the possibilities of surgical fusion and/or the result of infection or trauma must be considered. The alignment of these vertebral bodies is normal. There are osteophytes at the margins of each of the cervical vertebral bodies from C3 to T1. The C3-C4 and C6-C7 disk spaces are narrowed consistent with chronic degenerative disk disease. There is no fracture. There is no prevertebral swelling. The AP diameter of the cervical spinal canal is normal. C5-C6 interbody fusion. Whether this is surgical or due to infection or some other process is uncertain from this single exam. Chronic degenerative disk disease as detailed above. No subluxation or other acute process is suspected.

4. **THORACIC SPINE:** Dated 11/01/2013, signed by Richard Witten, M.D. FINDINGS/IMPRESSION: There is very slight increase in the round back shape of the thoracic spine in lateral view. Large osteophytes are directed anteriorly bordering the T9-10 disk. The vertebral bodies are normal in alignment. The disk spaces are rather well preserved throughout. No fracture of vertebral bodies or included ribs is shewn. No paravertebral mass is detected. Mild to moderate diffuse degenerative findings. No fracture or other significant appearing abnormality is detected. NOTE: Radiculopathy is not visible in radiographs.

5. **FINAL REPORT:** Dated 12/18/2013, signed by Steven Dalati, M.D. Chief Complaint: LLQ pain. Age: 57. LMP: 2007. HPI: Patient is a 57yo G4P2022 with LLQ pain since 4/2013. Pt noted she had finished a Kale salad when the pain started. Initially sharp, then an ache. 4/10, no noted aggravators or alleviators. Possible pain exacerbated with heavy lifting but unsure. Pain is intermittent. Radiation to the umbilicus. Assessment and Plan: Patient is a 57yo woman with LLQ pain. Pain: Unlikely GYN in origin. Pt is postmenopausal x 5 years with 1 episode of PMB in 2009. Pt reports D&C with good results. Since then no issues. Pt ultrasound shows small fibroids that are unlikely to be any source of pain. Encouraged pt to start a pain diary and RTC for review and identification of pain source. HCM UTD via PCP.

6. **CT ABDOMEN WITH CONTRAST, CT PELVIS WITH CONTRAST; CT ABDOMEN W/O;** Dated 03/21/2014, signed by Kevin M. Spitler, M.D. & Cecilia M. Jude, M.D. FINDINGS/IMPRESSION: The liver is diffusely hypodense, suggestive of fatty infiltration. There is focal more significant fatty infiltration in the left lobe of the liver adjacent to the gallbladder fossa. There is enlargement of the liver. The spleen with splenule, pancreas, gallbladder, kidneys, and adrenal glands are normal in size and attenuation. The bowel is normal in caliber and thickness. The appendix is normal. There are multiple small mesenteric nodes, nonspecific. No abdominal or pelvic ascites or lymphadenopathy by CT size criteria is identified. The urinary bladder is unremarkable. There is a surgical clip at the right adnexa. There is a 1.3 x 0.7 cm left adnexal fatty lesion, likely a dermoid. The uterus demonstrate a 2.4 cm mass with areas of fat attenuation, likely a fibroid. Lung bases are clear. There is a subcentimeter soft tissue density in the subcutaneous tissues over the left gluteal musculature, which may correlate with history of injections. There is atherosclerotic calcification in the aorta. There are punctate sclerotic lesions in the right iliac bone, right femur and left femur, likely bone islands. Hepatic steatosis. 1.3 x 0.7 cm left adnexal fatty lesion, likely a dermoid. The uterus demonstrate a 2.4 cm mass with areas of fat attenuation, likely a lipoleiomyoma.

7. **FINAL REPORT;** Dated 06/17/2014, signed by Sonya Tat, M.D. Chief Complaint: LLQ pain. Age: 57. LMP: 2007. HPI: Patient is a 57yo G4P2022 with LLQ pain since 4/2013. Pt noted she had finished a Kale salad when the pain started. Initially sharp, then an ache. 4/10, no noted aggravators or alleviators. Possible pain exacerbated with heavy lifting but unsure. Exacerbated by walking, position change. Pain is intermittent. Radiation superiorly. Does not want to take pain meds. Urinary frequency 10x/day; urge, has not had incontinence. Notes stream is also interrupted. IMPRESSION: Hepatic steatosis. 1.3 x 0.7 cm left adnexal fatty lesion, likely a dermoid. The uterus demonstrate a 2.4 cm mass with areas of fat attenuation, likely a lipoleiomyoma. Endometrial echo complex is suboptimally imaged especially in the region of the fundus where the large fibroid is identified. The visualized EEC appears homogeneous measuring up to 3.3 mm. Ovaries not seen on this examination in this 57-year-old female. Assessment and Plan: Patient is a 57yo woman with LLQ pain with incidental finding of 1.3x0.7cm adnexal lesion, not seen on prior UTZ in 9/2013. Pain: Unlikely GYN in origin. Pt is postmenopausal x 5 years with 1 episode of PMB in 2009. Pt reports D&C with good results. Since then no issues. Pt ultrasound shows small fibroids that are unlikely to be any source of pain. Adnexal lesion, likely not contributing to pain. If cyst is stable, dispo from 19A to PCP for pain management. L dermoid cyst. Repeat pelvic UTZ to follow-up. Urinary symptoms. UA, UCx with TFU. HCM UTD via PCP. Last Pap: 10/2013 nil. Last Mammo: 10/2013 ACR 2.

8. **FINAL REPORT;** Dated 08/10/2014, signed by Breena Taira, M.D. & Wilfredo Del Rosario, NP Chief Complaint: LLQ pain. Age: 58. LMP: 2007. HPI: Patient is a 58 y.o. female s/p closed R thumb in car door last night. Also had trauma to R 2nd toe a few weeks ago with persistent pain. DECISION MAKING: Patient is a 58 y/o non DM, RHD female p/w right thumb pain since last night, jammed finger car door, PE able to flex and extend, nailbed hematoma, Also c/o right 2nd toe pain X 3 weeks after hyperextension. FROM, no open skin, able to flex and extend, SILT intact.

9. **XR FINGER PA/LAT, XR FOOT RIGHT;** Dated 08/10/2014, signed by Richard Witten, M.D. FINDINGS/IMPRESSION: Three views of the right thumb show no fracture or dislocation. The shadow of the sesamoid in the first image should not be mistaken for fracture of the head of the first metacarpal. Right foot exam shows hallux valgus of about 35 degrees with mild metatarsus varus and moderate bunion formation. The toe tends to turn under before. Attention is given to the second toe. No displaced fracture or evidence of dislocation shown. There is a large plantar are and a smaller Achilles heel spur. No evidence of acute trauma is detected in the right foot. No evidence of acute trauma or significant joint disease in the right thumb. Hallux valgus, bunion and hammertoe formation and heel spurs are prominent in the right foot. No fracture to the second toe or elsewhere is detected.

10. **FINAL REPORT;** Dated 08/12/2014, signed by Beavis, M.D. Chief Complaint: LLQ pain. Age: 58. LMP: 2007. HPI: Patient is a 58yo G4P2022 with LLQ pain since 4/2013 and a 3cm fibroid on UTZ, and 1cm possible dermoid on CT who presents for follow up of her pain, review of repeat ultrasound. The patient reports that she noticed the pain get better, but yesterday she bent over felt pain in her LLQ for <1 minute, and then the pain resolved after she stood up. She does note a dull left sided deep pain which she "knows is from my condition." She also wants to know if she can get disability for her condition. The pain is mostly aggravated by position change/movement. Lately, she

has also been feeling very tired and sad, no suicidal ideation. She wants to know if this is from the cyst in her ovary. Urinary frequency 10x/day; urge, has not had incontinence. Notes stream is also interrupted. IMPRESSION: Hepatic steatosis. 1.3 x 0.7 cm left adnexal fatty lesion, likely a dermoid. The uterus demonstrate a 2.4 cm mass with areas of fat attenuation, likely a lipoleiomyoma. Endometrial echo complex is suboptimally imaged especially in the region of the fundus where the large fibroid is identified. The visualized EEC appears homogeneous measuring up to 3.3 mm. Ovaries not seen on this examination in this 57-year-old female. Assessment and Plan: Patient is a 57yo woman with LLQ pain with incidental finding of 1.3x0.7cm adnexal lesion, not seen on prior UTZ in 9/2013. 1) Pain with 0.8cm dermoid cyst - I explained that the cyst is not likely the source of her pain. However, only physical exam finding is mild CMT which she says reproduces the pain, so will empirically treat with doxycycline. Pt ultrasound shows small fibroids that are unlikely to be any source of pain. Given mild CMT, will empirically treat with doxycycline x 10 day course and re-evaluate with exam after repeat UTZ in 6 months to ensure no increase in size of fibroids or cyst (although stable over one year). #Fatigue: suspect related to mood. Pt denies SI/HI. CBC and TSH to rule out thyroid dysfunction and anemia, f/u PMD. HCM UTD via PCP. Last Pap: 10/2013 nil -Last Mammo: 10/2013 ACR 2.

11. **FINAL REPORT:** Dated 09/22/2014, signed by Nouvong, M.D. Chief Complaint: Left ankle pain, right 2nd toe pain. Present Illness: 58 yo F complains of left ankle pain and 2nd toe pain. She had left ankle ORIF (2005, Florida) with hardware removal on 2006. She says that since then she is experiencing limited ROM and pain with walking. Pain is worse in the morning and gets better with motion. No trauma to the area and she does not wear supportive shoes. Also, she complains of right 2nd digit pain after she bumped it 2 months ago. She presented to the ED and they ruled out a fracture. She denies skin changes or open lesions. Ambulates with regular shoes. IMPRESSION: No evidence of acute trauma or significant joint disease in the right thumb. Hallux valgus, bunion and hammertoe formation and heel spurs are prominent in the right foot. No fracture to the second toe or elsewhere is detected. Assessment/Plan: Patient is a 58 yo female with left ankle pain, likely post-traumatic arthritis and right 2nd met head pain possibly 2/2 transfer metatarsalgia vs synovitis vs plantar plate pathology. Rec MT pad, Budin splint and superfeet insert and wear supportive shoe, "motion controlled". X-ray, left ankle 3 views, WB, today. RTC 2 months for f/u and review left ankle X-ray. DWA Nouvong.

12. **FINAL REPORT:** Dated 09/24/2014, signed by V. Rodriguez, RN. S: Patient is a 58yo G4P2022 PMP woman with LLQ pain since 4/2013 incidental myoma & dermoid presents for follow up. She reports continued LLQ pain and burning throughout flank and up to subcostal area. She is concerned that this could be indicative of a Gyn cancer. She has had no vaginal bleeding or abn discharge. At her last visit she was empirically treated with doxycycline for CMT on exam. She reports that her cervix was again very tender during her TVUS that she'd had prior to coming to this visit. She has a PCP who she has not seen since 1/2014. IMPRESSION: Hepatic steatosis. 1.3 x 0.7 cm left adnexal fatty lesion, likely a dermoid. The uterus demonstrate a 2.4 cm mass with areas of fat attenuation, likely a lipoleiomyoma. Endometrial echo complex is suboptimally imaged especially in the region of the fundus where the large fibroid is identified. The visualized EEC appears homogeneous measuring up to 3.3 mm. Ovaries not seen on this examination in this 57-year-old female. Assessment and Plan: Patient is a 58yo woman with LLQ pain with incidental findings of lipoleiomyoma and dermoid, presents for follow-up. We discussed the nature of her pain, especially in light of her concerns that this could be indicative of a Gyn cancer. We discussed that her absence of constitutional complaints, absence of VB, decrease in size of mass, as well as her weight gain and healthy appetite, make a growing malignancy extremely unlikely. We also reviewed that it was unlikely, for the above symptoms, that the dermoid would be causing her pain radiating up to her ribs. I recommended that the patient consider non-gyn sources of her pain including GI or musculoskeletal. For this, I recommended that she be seen by a PCP for further workup and recommendation. For her reassurance, I recommended that we repeat pelvic ultrasound in 6mo to eval for stability of the myoma and dermoid. WWE: Last Pap: 10/2013 nil. Last Mammo: 10/2013 ACR 2. RTC 6mo.

13. **PELVIC ULTRASOUND:** Dated 03/02/2015, signed by Carissa M. White, M.D. & Gail C. Hansen, M.D. FINDINGS/IMPRESSION: The uterus measures 9.3 cm x 3.3 cm x 4.2 cm. Reidentified is a .3.1 cm x 2.9 cm x 3.3 cm hyperechoic transmural mass in the midline to the left uterine fundus, compatible with a lipoleiomyoma, not significantly changed. There is also a 1.3 cm x 0.8 cm x 1.1 cm intramural fibroid in the anterior lower uterine segment, unchanged. The endometrial thickness measures 2.0 mm. The right ovary is not visualized. The left ovarian volume is 2.8 mL. Again seen is a hyperechoic mass in the left ovary, now measuring 1.5 cm x 1.3 cm), compared to 0.8 cm

previously. Flow is present in the ovary. No free fluid is seen the cul-de-sac. Stable 3.3 cm fundal lipoleiomyoma. Slight interval decrease in size of the intramural anterior uterine wall fibroid, which now measures approximately 1.3 cm. Interval increase in size of the left ovarian echogenic lesion, likely a dermoid, which now measures 1.5 cm. Normal-blood flow is seen in the left ovary.

14. **FINAL REPORT:** Dated 03/20/2015, signed by Michelle Han, RN. S: Patient is a 58 yo F rtc for evaluation of right foot metatarsalgia and left ankle arthritis. Pt received imaging studies and for Left ankle and states she has been doing rom exercises. Pt has also tried metatarsal pads and deep toebox shoes which have not helped for R foot. Pt states she is forced to wear open toed shoes to keep 2nd digit and bunion from hurting. Of note patient is a caregiver for her mother. IMPRESSION: No evidence of acute trauma or significant joint disease in the right thumb. Hallux valgus, bunion and hammertoe formation and heel spurs are prominent in the right foot. No fracture to the second toe or elsewhere is detected. Left Ankle: NWB. Overlying soft tissue prominence. Minimal degenerative changes of left ankle. Small left inferior calcaneal spur. No fracture, subluxation, lytic lesion or bony erosions. Assessment/Plan: Patient is a 58 yo female with left ankle pain, likely post-traumatic arthritis, right 2nd met head pain with pain with drawer test concerning for plantar plate tear, right bunion deformity. Recommend New WB imaging, as previous exams are NWB. Recommend US to rule out Plantar plate tear. In-depth discussion regarding surgical management right foot hammertoe, and bunion deformities. Pt understands post operative period and understands that any surgical procedures done to Right would increase WB and likely pain to LLE given L ankle arthritis. Pt would like to think about surgical options and return after further imaging. Will need to discuss with patient nature of caregiving for her mother. Will query type of care as pt may need to be able to provide alternative provider of care while she is in post-operative period. Lace up ankle brace and AZ AFO ordered for L ankle arthritis. Discussed possibility of left ankle fusion in future and will continue to pursue conservative management at this time. RTC in 3-4 weeks for further discussion. Attending: Dr. Truong.

15. **FINAL REPORT:** Dated 03/23/2015, signed by Michelle Han, RN. S: Patient is a 58yo C4P2022 PMP woman with LLQ pain since 4/20L3 incidental myoma & dermoid presents for follow up. LMP: 10 years ago. She reports continued LLQ pain and burning that goes up to subcostal area and left flank for the past year and a half. Comes and goes every day, does not take medications for it, gets up to 4/L0. Does not radiate to vagina or labia. Denies vaginal itching/discharge, or bleeding. States pain has gotten much better since last visit, at most 4/10 pain. In the past she was treated with doxycycline for CMT on exam. Has not been sexually active for 10 years since divorce. Has had negative testing in the last few years with no new partners since then. She has a PCP in Glendale. No bladder issues, no dysuria. Denies unintentional weight loss. PMP 10 years, no bleeding currently. IMPRESSION: Stable 3.3 cm fundal lipoleiomyoma. Slight interval decrease in size of the intramural anterior uterine wall fibroid, which now measures approximately 1.3 cm. Interval increase in size of the left ovarian echogenic lesion, likely a dermoid, which now measures 1.5 cm. Normal blood flow is seen in the left ovary. Assessment and Plan: Patient is a 58 yo woman with LLQ pain with incidental findings of lipoleiomyoma and dermoid, presents for follow-up. #LLQ pain: overall improved since last visit. Unlikely to be caused by small dermoid looking cyst in left ovary. Images reviewed with Dr. Oregon. Although has increased in size according to US read, on our read the actual echogenic part measured is 0.9cm, stable from prior ultrasounds done in past year and a half. Does not need to be reimaged further instructed to f/u with PCP for this LLQ pain to search for non-gyn causes such as GI or MSK. Pt agreed, has PCP in Glendale. Currently does not have bowel issues does not need f/u in gyn clinic. Does not need f/u in gyn clinic.

16. **FINAL REPORT:** Dated 04/07/2015, signed by Maiko Macchiarella, RN. S: Left sided Pelvic pain - Onset 10days ago. Per patient she felt sharp pain initially when bending over, now c/o throbbing intermittent pain. States no fever at home. (-)nausea, (-)vomiting, (-)hematemesis, (-)back pain, (-)dysuria, (-)melena, (-)diarrhea. +increased frequency of urination, denies dysuria. Plan: Care discussed with patient. Printed instructions provided and explained. The opportunity to ask questions and have them answered was given. Prescriptions were given. Safe Pain Medicine Prescribing in Emergency Department Pamphlet. Patient was instructed to return if condition changes. Patient discharge with steady gait. Patient received written and verbal instructions. Dispo Assessment: Patient is without concerns at this time.

17. **FINAL REPORT:** Dated 04/07/2015, signed by John Lee, M.D. S: Patient is a 58 F with fibroids, hx of ectopic pregnancy in past, presents with 2 years of left sided pelvic pain. Has PMD in Glendale, worked up, U/s 3/15 revealing for dermoid cyst on ovary, +fibroids. Sent to gyn who told her these do not explain her sxs but did not offer any alternatives. no dysuria, mild urinary frequency. She has follow up with PMD. Wants to test for urinary tract infection. A/P: Likely fibroids vs dermoid cyst vs adhesions from previous ectopic pregnancy. Less likely UTI. Will check urine dip to appease patient's worries (given its low cost, noninvasive). If pos, will treat for simple cystitis, if negative, will refer back to PMD.
18. **PODIATRY CLINIC NOTE:** Dated 04/28/2015, signed by Nhu Do, DPM. S: Patient is a 58 yo F rtc f/u right bunion, 2nd HT pain and L ankle post traumatic arthritis. Hx of left ankle surgeries x 2. Denies new trauma. Denies getting brace from last visit. here for that. Doesn't want surgeries at this time but does want to explore options. Cannot tolerate closed toed shoe gear mainly due to HT deformity. Also has difficulty in flat type of shoe gear. Used to work selling windows and walked a lot. Today wear sandals. A/P: Patient is a 58 yo F with hx of prior L ankle surgeries with L ankle pain likely 2/2 posttraumatic arthritis, R HAV with bunion deformity, R 2nd HT deformity with likely predislocation syndrome. Discussed at length findings and imaging results. Explained to pt all tx options including conservative surgical options. Explained risks, benefits and alternatives. Pt wishes to continue with conservative management. Asked about ankle arthroscopy and PRP. Informed pt she may need to get second opinion at OSH for PRP, facility does not offer PRP. explained likely arthritis would not improve with PRP intraarticular injection. Will recommend lace up ankle brace, physical therapy per pt request taping, splinting for R bunion & HT deformity, wide toebox Shoe gear information dispensed. RTC f/u in 2-3 mos after PT. DWA Dr. Wang.
19. **SOAP NOTE:** Dated 08/19/2015, signed by Lina M. Rodriguez, M.D. S: Patient is a 62 yo with no hx of skin cancer, here for spots on back and chest for long time. New spot on right finger for the past year. no pain or pruritus. A/P: SKs, back, cherry angiomas, chest, dermatofibromas, arm and back all benign. Myxoid cyst. Can see ortho hand for removal 'is desi red by pt. Xerosis emollients daily. Dry skin care discussed. Seen and discussed with Dr. Fitzgerald.
20. **MRI C SPINE W/O CONTRAST:** Dated 10/05/2015, signed by Gasser M. Hathout, M.D. FINDINGS/IMPRESSION: There is severe loss of disc height at C5-6, with near-complete fusion of the C5 and C6 vertebral bodies, likely secondary to severe degenerative spondylosis. There is moderate/moderately severe degenerative disc disease at C3-4, C4-5 and C6-7, as well as mild to moderate degenerative disc disease at C2-3 and C7-T1. There is straightening and slight reversal of the normal cervical lordosis centered at C5-6. There is a slight anterolisthesis of C2 on C3. At C5-6, there is some posterior osteophyte formation, with mild to moderate spinal canal narrowing, with effacement of the cerebrospinal fluid surrounding the cord and mild ventral cord flattening. There is mild spinal canal narrowing at C4-5 and C6-7. However, there is no evidence of large disc bulge, gross focal disc herniation, high grade spinal canal stenosis, severe cord impingement, or gross cord signal abnormality at any level. Uncovertebral and hypertrophic facet arthropathy produce moderately severe to severe right and moderately severe left C3-4, moderate left C5-6, moderate left C6-7 and moderate bilateral C7-T1 neural foraminal stenosis. Clinical correlation for radiculopathy, particularly C4 radiculopathy is suggested. Very severe disc space narrowing at C5-6, with near complete fusion of the C5 and C6 vertebral bodies, likely post-degenerative auto-fusion, but other-etiologies cannot be excluded. This finding was present or prior plain film examination of 2013. Moderately severe degenerative disc disease at C6-7, and moderate/moderately severe degenerative disc disease at C3-4, C4-5, and C7-T1. Straightening and slight reversal of the normal cervical lordosis. Mild to moderate spinal canal narrowing at C5-6 due to broad-based posterior osteophyte formation. Mild spinal canal narrowing at C4-5 and C6-7. No evidence of large disc bulge, gross' focal disc herniation, high grade spinal canal stenosis, -gross cord impingement, or gross cord signal abnormality at any level. Multilevel neural foraminal stenosis, most pronounced at C3-4 as described above. Clinical correlation for radiculopathy is suggested.
21. **ADULT PRIMARY CARE OUTPT PROVIDER NOTE:** Dated 05/03/2016, signed by Nastaran Rafiei, M.D. & Jungeun Karen Kim, NP. Chief Complaint: MRI f/up. History of Present Illness: Patient is a 59 y/o male here for SD appt for MRI result (done in 10/15/2015) which was ordered by Dr. Phan in 8/28/2015 (PCP:Chan): H/O chronic neck pain since 2013; pain radiating down to shoulders and arms; hands numbness and tingling sensation; no

known injury; pt declines any pain meds; wants to have "nerve study" pt is also requesting blood tests. Assessment/Plan: Cervical radiculopathy. Pt declines any pain meds; referred to PT. Ordered EMG/NCS; keep appt as scheduled on 717116; ordered labs. Ordered: ALT, Blood, Routine collect, 05/03/16, Lab Collect, Cervical radiculopathy, Order for future visit, Print Label By Order Location, HUD PC.

22. **ELECTRONEUROMYOGRAPHIC REPORT:** Dated 06/22/2016, signed by Nastaran Rafiei, M.D. FINDINGS/IMPRESSION: The left median CMAP demonstrated a mildly prolonged distal latency, normal amplitude, and normal velocity. The right median CMAP demonstrated a moderately prolonged distal latency, normal amplitude, and normal velocity. The left ulnar and right ulnar CMAPs were normal. The left median SNAP demonstrated a moderately prolonged peak latency, and moderately reduced amplitude. The right median SNAP demonstrated a moderately prolonged peak latency, and moderately reduced amplitude. The left ulnar and right ulnar SNAPs were normal. Needle EMG of selected muscles of the left upper extremity was normal. This is an abnormal study. There is electrodiagnostic evidence of bilateral median neuropathies at the wrists (i.e. carpal tunnel syndrome), which is moderately severe bilaterally, slightly worse on the right. There is no electrodiagnostic evidence of a left cervical root lesion (e.g. radiculopathy).

23. **OFFICE VISIT:** Dated 12/05/2017, signed by Maria Estela Castro, NP. CHIEF COMPLAINT: HAD A FALL 3 DAYS AGO. HISTORY OF PRESENT ILLNESS: SHE HIT HER BACK AND CURRENTLY EXPERIENCING PAIN IN THE BACK. ASSESSMENT: Other obesity due to excess calories. PAIN UNSPECIFIED. Fall on same level from slipping, tripping, and stumbling with subsequent striking against other object, initial encounter. PLAN: Procedures: OV FOLLOW UP LVL 3L. Medications: DICLOFENAC 3% APPLY AS NEEDED; Qty: 0 Refills 0. LIDOCAINE 5% OINTMENT; APPLY AS NEEDED; Qty: 0, Refills 0. Care Plan: ORDERED MRI OF THE WHOLE SPINE FOR FURTHER EVALUATION OF PAIN. ORDERED STRESS TEST AS SUGGESTED BY CARDIOLOGY FROM PREVIOUS REFERRAL.

24. **US RETROPERITONEAL COMPLETE:** Dated 06/26/2018, signed by Eugene Choi, M.D. FINDINGS/IMPRESSION: KIDNEYS: Right kidney: 11.9 cm. Left kidney: 12.8 cm. Morphology: Normal. Hydronephrosis: None. Focal findings: None. URINARY BLADDER: Unremarkable. OTHER RETROPERITONEAL FINDINGS: Aorta: Normal. IVC: Normal. Lymph nodes: No adenopathy. Unremarkable sonographic evaluation of the kidneys. No hydronephrosis or obstructive uropathy.

25. **CT ABDOMEN WITHOUT CONTRAST:** Dated 05/03/2021, signed by Alexander Somwaru, M.D. FINDINGS/IMPRESSION: Lower Chest: Visualized lung bases and heart are unremarkable. Assessment of the solid viscera, vasculature, and gastrointestinal tract is limited by the lack of intravenous contrast. Liver: Large and steatotic-unchanged. Slight left and caudate lobar hypertrophy. Bile Ducts: Normal caliber. Gallbladder: No calcified gallstones. Normal wall. Pancreas: Within normal limits. No pancreatic duct dilatation. Spleen: Mild splenomegaly-unchanged. Adrenals: Within normal limits. Kidneys: Within normal limits. Abdominal Lymph Nodes: Within normal limits. Stomach: Small hiatal hernia with mural thickening of the distal esophagus. Visualized Bowel: Normal caliber. Vessels: Moderate aortoiliac vascular calcifications. In abdominal aorta is normal in size. Bones: No suspicious osseous lesion. Soft tissues: Increased diastasis recti with large, shadow, fat-containing anterior abdominal wall hernia; hernia defect measures up to 8.5 cm in width. Increased diastasis recti with large, shallow, fat-containing anterior abdominal wall hernia. No bowel involvement. Hepatosplenomegaly and hepatic steatosis. Please correlate for chronic hepatocellular disease (steatohepatitis and cirrhosis) and portal venous hypertension. Small hiatal hernia with esophageal thickening that may be due to esophagitis and/or under distention however please consider correlation with endoscopy to ensure the absence of a potential neoplasm.

26. **X-RAY OF THE LEFT SHOULDER- ONE VIEW:** Dated 04/07/2022, signed by Haroutun Abrahamian, M.D. FINDINGS/IMPRESSION: Osseous structures are intact without evidence for an acute fracture or dislocation. Mild joint space narrowing and osteophytosis are seen at the acromioclavicular and glenohumeral joints. Visualized chest is clear. Soft tissue planes are well maintained. Mild degenerative changes about the left shoulder.

27. **X-RAY OF THE RIGHT KNEE – THREE VIEWS:** Dated 04/07/2022, signed by Haroutun Abrahamian, M.D. FINDINGS/IMPRESSION: There is no significant soft tissue abnormality. Small to moderate size joint effusion is present. Osseous structures are intact without evidence for a fracture or dislocation. Joint space narrowing and osteophytosis are seen about the medial compartment. The lateral compartment and patellofemoral joints are well maintained. An enthesophyte is identified at the quadriceps tendon insertion to the patella. Medial compartment osteoarthritis with a small to moderate size joint effusion. Quadriceps tendon enthesopathy.
28. **MRI OF THE LEFT SHOULDER WITHOUT CONTRAST:** Dated 04/07/2022, signed by Haroutun Abrahamian, M.D. FINDINGS/IMPRESSION: ACROMIOCLAVICULAR JOINT: A type I acromion is noted. The acromioclavicular joint demonstrates mild arthrosis. There is mild to moderate subacromial/subdeltoid bursa fluid. ROTATOR CUFF TENDONS: The supraspinatus and infraspinatus tendons are thickened and heterogeneous in signal consistent tendinosis. This reaches fluid signal at the supraspinatus footprint spanning 5.5 mm consistent with a partial-thickness tear without retraction or associated muscle bulk atrophy. The remainder of the rotator cuff tendons demonstrate normal signal and morphology. The rotator cuff muscle bulk and signal are normal. LABRUM AND LONG HEAD OF THE BICEPS TENDON: The long head of the biceps tendon is identified at its anatomic location along the bicipital groove without evidence for tendinopathy or tear. The visualized labrum is grossly intact on a non-intra-articular contract: exam. There are no paralabral cysts to suggest a tear. MISCELLANEOUS: Subcoracoid bursa fluid is present. Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial-thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis with adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis.
29. **OFFICE VISIT:** Dated 04/14/2022, signed by Scott Powell, M.D. HPI - Knee: Patient is a 65 years old female who presents via telemedicine and is a new patient to our office, referred for evaluation and treatment regarding her left shoulder pain and right knee pain. She reports this pain began after she sustained a fall on April 5th. The patient reports that her left shoulder pain and right knee pain have generally persisted since onset. The patient reports that she consulted her PCP. who advised her to obtain a right knee x-ray, left shoulder x-ray, and a left shoulder MRI. The patient reports that she has completed the recommended imaging. Our office has the reports and images on file at this time. Regarding her right knee, the patient presents with persistent, constant pain at the lateral aspect, rated at a baseline of 5/10 but reaching a 9/10 with stair ascension/descension and when standing from a seated position. The patient reports difficulty with weightbearing. Additionally, she reports limited ROM (with flexion) and weakness. She denies popping/clicking and numbness/tingling. Notably, the patient reports that she recently sustained a separate fall, which caused injury to her left knee. HPI - Shoulder: Regarding her left shoulder, the patient currently presents with persistent, constant pain in the anterior aspect rated at a 7/10, as well as limited ROM (with abduction/forward elevation) and weakness. The patient reports difficulty with overhead movements and an inability to lift objects exceeding 5 lbs in weight. The patient denies night pain and instability. The patient denies taking any anti-inflammatory medication for her right knee and left shoulder pain at this time. Plans - Knee: Patient was advised to take over-the-counter anti-inflammatories (NSAIDs) as needed and to apply ice to the affected area as needed. The patient's x-rays were reviewed and discussed. The patient was advised to begin a formal physical therapy program aimed at reducing pain caused by osteoarthritic changes. The patient was provided with a requisition for 6 sessions of physical therapy and advised to attend PT 2x per week for 3 weeks. Plans - Shoulder: Patient was advised to take over-the-counter anti-inflammatories (NSAIDs) as needed and to apply ice to the affected area as needed. The diagnosis was discussed with the patient. Non-operative versus operative treatment options were discussed. Operative treatment was described as a left shoulder arthroscopic rotator cuff repair. Nonoperative treatment was described as physical therapy and/or pain management strategies, including cortisone injections. The patient has elected to pursue conservative management at this time and was provided with a requisition for 6 sessions of physical therapy. She was advised to attend physical therapy 2x per week for 3 weeks. Our office will follow up with the patient in 4 weeks via phone to assess her progress with physical therapy. Additionally, the patient was advised to inquire about a left shoulder cortisone injection. The patient was encouraged to consult her primary care physician regarding this injection. Chief Complaint: Left shoulder pain/right knee pain. Assessment: M25.561 Pain in right knee. M25.512 Pain in left shoulder. M75.102 Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic. M17.11 Unilateral primary osteoarthritis, right knee. Plan: CPT 99203 95 1.00 UN OFFICE OIP NEW LOW 30-44 MIN.

30. **MRI OF THE LEFT SHOULDER WITHOUT CONTRAST:** Dated 05/17/2022, signed by Haroutun Abrahamian, M.D. FINDINGS/IMPRESSION: ACROMIOCLAVICULAR JOINT: A type I acromion is noted. The acromioclavicular joint demonstrates mild to moderate arthrosis. There is mild to moderate subacromial/subdeltoid bursa fluid. ROTATOR CUFF TENDONS: The supraspinatus is heterogenous in signal consistent tendinosis with a full thickness tear anteriorly with retraction by 10 mm and has mild muscle bulk/fatty atrophy. The adjacent infraspinatus tendon is thickened suggestive for tendinosis. The subscapularis tendon is also heterogenous in signal. The teres minor tendon demonstrates normal signal and morphology. The rotator cuff muscle bulk and signal are normal. LABRUM AND LONG HEAD OF THE BICEPS TENDON: The long head of the biceps tendon is identified on its anatomic location along the bicipital groove but is diminutive in size at the lesser tuberosity and intraarticular portion suggestive for a high grade partial thickness tear/retraction. The visualized labrum is grossly intact on non-intra-articular contrast exam. There are no paralabral cysts to suggest a tear. MISCELLANEOUS: Subcoracoid bursa fluid is present. Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis and adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis.

31. **MRI OF THE RIGHT SHOULDER WITHOUT CONTRAST:** Dated 05/17/2022, signed by Haroutun Abrahamian, M.D. FINDINGS/IMPRESSION: ACROMIOCLAVICULAR JOINT: A type I acromion is noted. The acromioclavicular joint demonstrates mild to moderate arthrosis. There is mild to moderate subacromial/subdeltoid bursa fluid. ROTATOR CUFF TENDONS: The supraspinatus is heterogenous in signal consistent tendinosis with a full thickness tear anteriorly with retraction by 10 mm and has mild muscle bulk/fatty atrophy. The adjacent infraspinatus tendon is thickened suggestive for tendinosis. The subscapularis tendon is also heterogenous in signal. The teres minor tendon demonstrates normal signal and morphology. The rotator cuff muscle bulk and signal are normal. LABRUM AND LONG HEAD OF THE BICEPS TENDON: The long head of the biceps tendon is identified on its anatomic location along the bicipital groove but is diminutive in size at the lesser tuberosity and intraarticular portion suggestive for a high grade partial thickness tear/retraction. The visualized labrum is grossly intact on non-intra-articular contrast exam. There are no paralabral cysts to suggest a tear. MISCELLANEOUS: None. Full thickness supraspinatus tendon tear with retraction by 10 mm and has mild muscle bulk/fatty atrophy. Adjacent infraspinatus and subscapularis tendinosis. High grade partial thickness long head of the biceps tendon tear and retraction. Mild to moderate acromioclavicular joint arthrosis and adjacent subacromial/subdeltoid bursitis.

32. **MRI OF THE LEFT KNEE WITHOUT CONTRAST:** Dated 05/19/2022, signed by Haroutun Abrahamian, M.D. FINDINGS/IMPRESSION: BONES AND CARTILAGE: Osseous structures are intact without focal bone marrow edema. Partial thickness chondrosis is identified in all 3 compartments with full thickness chondrosis and subchondral edema involving the medial compartment peripherally where there is joint space narrowing and osteophytosis. Subchondral edema versus bone contusion is identified involving the lateral femoral condyle posterior nonweightbearing aspect. Tibial tuberosity-trochlear groove (TT-TG) distance is within normal limits. SOFT TISSUES: Small to moderate size joint effusion is present. No synovial cyst. Hoffa's fat pad demonstrates normal signal without evidence of contusion or impingement. Normal muscle bulk and morphology. MENISCI: The lateral meniscus demonstrates normal signal and morphology. No evidence of a lateral meniscus tear or intrasubstance degeneration. The medial meniscus is peripherally extruded from the joint line with heterogenous signal at the anterior horn/body junction. A complex tear at this level cannot be excluded without postcontrast imaging. Enthesophytes are identified at the quadriceps tendon insertion to the patella. CRUCIATE LIGAMENTS: The anterior and posterior cruciate ligaments are intact. COLLATERAL LIGAMENTS: The medial and lateral collateral ligaments as well as patellar retinacula are intact. TENDONS: The quadriceps and patellar tendons demonstrate normal signal and morphology. MISCELLANEOUS: None. Peripheral extrusion of the medial meniscus from the joint line as well as heterogeneous signal at the anterior horn/body junction. A complex degenerative tear cannot be excluded at this area without postcontrast imaging. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment as described above. Subchondral bone contusion of the lateral femoral condyle posterior nonweightbearing aspect. Small to moderate size joint effusion. Quadriceps tendon enthesopathy.

33. **MRI OF THE RIGHT KNEE WITHOUT CONTRAST:** Dated 05/24/2022, signed by Haroutun Abrahamian, M.D. FINDINGS/IMPRESSION: BONES AND CARTILAGE: Osseous structures are intact without

focal bone marrow edema. Partial thickness chondrosis is identified in all 3 compartments with full thickness chondrosis and subchondral edema involving the medial compartment peripherally where there is joint space narrowing and osteophytosis. Subchondral edema versus bone contusion is identified involving the lateral femoral condyle posterior nonweightbearing aspect. Tibial tuberosity-trochlear groove (TT-TG) distance is within normal limits. **SOFT TISSUES:** Small to moderate size joint effusion is present. No synovial cyst. Hoffa's fat pad demonstrates normal signal without evidence of contusion or impingement. Normal muscle bulk and morphology. **MENISCI:** The lateral meniscus demonstrates normal signal and morphology. No evidence of a lateral meniscus tear or intrasubstance degeneration. The medial meniscus is peripherally extruded from the joint line with heterogenous signal at the anterior horn/body junction. A complex tear at this level cannot be excluded without postcontrast imaging. Enthesophytes are identified at the quadriceps tendon insertion to the patella. **CRUCIATE LIGAMENTS:** The anterior and posterior cruciate ligaments are intact. **COLLATERAL LIGAMENTS:** The medial and lateral collateral ligaments as well as patellar retinacula are intact. **TENDONS:** The quadriceps and patellar tendons demonstrate normal signal and morphology. An enthesophyte is identified at the quadriceps tendon insertion to the patella. **MISCELLANEOUS:** Mild prepatellar bursa fluid is present. Peripheral extrusion of the medial meniscus from the joint line without a definite tear. Intrasubstance generation of the lateral meniscus at the body without a definite tear. MR arthrogram may be performed for further evaluation/characterization if clinical concern persists. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment. Quadriceps tendon enthesopathy. Mild prepatellar bursitis.

34. **HISTORY & PHYSICAL REPORT:** Dated 08/15/2022, signed by Gregory J. Adamson, M.D. History of Present Illness: The patient is a 66 year old female. Assessment & Plan: Assessment & Plan: Left rotator cuff tear (M75.102). Impression: Bursal-sided partial thickness rotator cuff tear, left shoulder. Current Plans: Pt Education - How to Access Health Information Online using Patient Portal and 3rd Party Apps: discussed with patient and provided information. XR SHOULDER LEFT, 2 VIEWS (73030). X-RAY OF LEFT ACROMIOCLAVICULAR JOINT WITH AND WITHOUT WEIGHT (73050). Overweight for height (E66.3). Current Plans: LIFESTYLE EDUCATION REGARDING DIET (98960).

35. **WORKERS COMPENSATION INITIAL ORTHOPAEDIC CONSULTATION REPORT:** Dated 09/06/2022, signed by Gregory J. Adamson, M.D. History of Present Injury As Described By Patient: The patient is a right hand dominant 66-year-old woman who presents today with a friend for an evaluation of her right shoulder and to review her MRI. On 04/14/2022, she injured her right shoulder when she slipped on mud while showing cemetery property. She had severe pain and discomfort. She rated her pain at a 9/10. On 05/17/2022, she obtained a right shoulder MRI. In June 2022, she started attending formalized physical therapy. She attended 12 sessions with minimal relief. Since then, she has been experiencing occasional minimal to moderate pain localized over the biceps region. She describes her pain as throbbing and pulsating. She occasionally has spasm in her biceps, which causes burning pain. She has discomfort at night that is positional in nature. She has hallucination with range of motion. She has discomfort at night that is positional in nature. She has limitation with range of motion. Her pain is better with Bio-Relieve. Her pain is exacerbated by certain movements, walking and ascending stairs. **PRESENT COMPLAINTS:** Right shoulder pain. **DIAGNOSTIC IMPRESSION:** Small tear in the supraspinatus with associated early atrophic changes, right shoulder. **WORK RESTRICTIONS:** TTD. **PLAN:** We discussed the implications of a rotator cuff tear in detail. Overtime, a rotator cuff tear may stay the same or increase in size. With time, atrophic changes will develop, which are irreversible. With an arthroscopic repair, we discussed 95% get complete or near complete pain relief 80% get back 80% or more of the premorbid function. Without surgery, 50% will progress in size and symptomatology. Presently, we will try her on another course of formalized physical therapy at a different venue. I will request for this today. We will plan to see her back in 4 weeks for repeat clinical evaluation.

36. **HISTORY & PHYSICAL REPORT:** Dated 09/06/2022, signed by Gregory J. Adamson, M.D. History of Present Illness: The patient is a 66 year old female. Assessment & Plan: Left rotator cuff tear. Impression: Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder. Current Plans: Pt Education - How to Access Health Information Online using Patient Portal and 3rd Party Apps: discussed with patient and provided information. Assessment & Plan: Tear of right supraspinatus tendon (M75.101). Impression: Small tear in the supraspinatus with associated early atrophic changes, right shoulder. Current Plans: Pt Education - How to Access

Health Information Online using Patient Portal and 3rd Party Apps: discussed with patient and Doctor's First Report (WC001). XR SHOULDER RIGHT, 2 VIEWS (73030). X-RAY OF RIGHT ACROMIOOLAVICULAR JOINT WITH AND WITHOUT WEIGHT (73050).

37. **WORKERS COMPENSATION INITIAL ORTHOPAEDIC CONSULTATION REPORT:** Dated 09/12/2022, signed by Gregory J. Adamson, M.D. History of Present Illness: The patient is seen today in follow up for her left shoulder. Since last seen, she has been experiencing occasional moderate pain and discomfort. She has been attending formalized physical therapy and states that it is helpful. She has been exercising with Theraband at physical therapy. She has also tried laser therapy and states that it is helpful. IMPRESSION: Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder. TREATMENT PLAN: She will continue with formalized physical therapy. We will plan to see her back in 4 weeks for repeat clinical evaluation.

38. **HISTORY & PHYSICAL REPORT:** Dated 09/12/2022, signed by Gregory J. Adamson, M.D. History of Present Illness: The patient is a 66 year old female. Assessment & Plan: Left rotator cuff tear. Impression: Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder. Current Plans: Pt Education - How to Access Health Information Online using Patient Portal and 3rd Party Apps: discussed with patient and provided information.

39. **PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2):** Dated 09/13/2022, signed by Gregory J. Adamson, M.D. Interim History: The patient is a 66-year old woman who presents today for an evaluation of both knees and to review her MRIs. On 04/14/2022, she injured both knees when she slipped on a muddy incline while showing a cemetery property. She felt her knee twist as she tried to steady herself. She fell on the anterior aspect of her knees. Since then, she has been experiencing frequent moderate pain localized anteriorly and modality right worse than left. She has clicking sensations. She has stiffness. She has pain at night that is positional in nature, which disturbs her sleep. She has difficulty ascending and descending stairs. Past medical/surgical history, medications, and allergies are all well documented and present in the chart. PRESENT COMPLAINTS: Frequent moderate bilateral knee pain that is aggravated by prolonged standing, lying on her back and side walking long distances, and walking up and downstairs. DIAGNOSTIC IMPRESSIONS: Traumatic synovitis, both knees, with underlying gonarthrosis. Small tear in the supraspinatus with associated early atrophic changes right shoulder. WORK RESTRICTIONS: TTD. PLAN: We discussed the first line of treatment is rest, ice, elevation, anti-inflammatories and physical therapy, if the patient is unresponsive to that consideration can be given towards injections with corticosteroid vs viscosupplementation vs PRP. If the patient is unresponsive to all of the above consideration can be given towards arthroplasty surgery. Presently, we will try her on a course of formalized physical therapy. I will request for this today. We will plan to see her back in 4 weeks for repeat clinical evaluation.

40. **HISTORY & PHYSICAL REPORT:** Dated 09/13/2022, signed by Gregory J. Adamson, M.D. History of Present Illness: The patient is a 66 year old female. Assessment & Plan: Other synovitis and tenosynovitis, left lower leg (M65.862). Other synovitis and tenosynovitis, right lower leg (M65.861). Impression: Traumatic synovitis, both knees, with underlying gonarthrosis. Current Plans: Pt Education - How to Access Health Information Online using Patient Portal and 3rd Party Apps: discussed with patient and provided information. XR KNEE BILATERAL, 2 VIEWS (73560). XR KNEE BILATERAL, STANDING AP VIEW (73565). PR-2 Report (WC002). Left rotator cuff tear (M75.102). Impression: Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder. Addendum Note (Rose Meltzer; 10/4/2022 2:16 PM). Addendum on 10/04/2022: Correction to right shoulder impression. Tear of right supraspinatus tendon (M75.101). Impression: Small tear in the supraspinatus with associated early atrophic changes, right shoulder.

41. **HISTORY & PHYSICAL REPORT:** Dated 09/15/2022, signed by Roy F. Ashford, M.D. History of Present Illness: Patient words: I am new to Dr Ashford (workers comp) I am here due to lower back pain radiating to both legs. The patient is a 66 year old female. Note: Patient presents to the clinic as a new patient for evaluation of her low back pain radiating to both legs. She previously had a lumbar MRI scan that is available for review. This is worker's compensation. The patient reports while at work showing property to her client. She had went back to grab some paperwork due to the client was interested in another property, as she was walking back she had stepped into a mud puddle

which caused her to slip landing onto her back, Injury occurred on 04/14/2022. At the beginning of her injury she was unable to walk, Recently she has noticed pain with sitting. Today she denies any numbness in the shin or calf. There is no muscle weakness. The leg radiculopathy today has resolved. Assessment & Plan: Lumbar strain (S39.012A). Current Plans: Pt Education - How to Access Health Information Online using Patient Portal and 3rd Party Apps: discussed with patient and provided information. Overweight for height (E66.3). Current Plans: LIFESTYLE EDUCATION REGARDING DIET (98960). Note: MRI scan of the lumbar spine obtained on 05/23/2022 were reviewed. This demonstrates a mild bugle at L4-5 and L3-4. Overall dimension of the canal is wide open. The foramen is wide open. There is no evidence of stenosis. L2-3 is open. There is evidence of thickened ligaments but is open at L3-4. No stenosis at L4-5. Disc degenerations at the right facet joint at L4-5. Mild stenosis in the lateral recess at L4-5 and L5-S1. Assessment: Lumbar strain. Degenerative disc, lumbar. Plan: The current problem demonstrates no direct neurologic involvement. I find only signs of strained muscles. There is nothing significant on x-ray other than age related degenerative changes as expected. I do not think that an MRI would allow more insight on the problem. If things change neurologically, I would consider getting an MRI later. Physical therapy and a good home exercise program will help start a habit of regular exercise, warm-ups, and stretching. I have explained different approaches for exercise, discussed resources such as health clubs, YMCAs, and pools in the area. I do not like long term use of medications for this, but anti-inflammatories certainly can provide early benefits. Careful behaviors, attention to posture, avoidance of heavy lifting and proper mechanics have all been stressed.. Today the patient obtained an order to start physical therapy focusing on core stabilization.

42. **PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)**; Dated 10/18/2022, signed by Gregory J. Adamson, M.D. Interim History: The patient is seen today in follow up for her left shoulder. Since last seen, she has been feeling slightly better. She has been experiencing occasional moderate pain localized over the deltoid region. Occasionally, this pain radiates down her arm. She describes her pain as burning. She feels that her range of motion has gotten better. She has been attending formalized physical therapy, which has been very helpful. She has been using ice. IMPRESSION: Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder. TREATMENT PLAN: She will continue formalized physical therapy. We will plan to see her back in 4 weeks for repeat clinical evaluation.

43. **HISTORY & PHYSICAL REPORT**; Dated 10/18/2022, signed by Gregory J. Adamson, M.D. Chief Complaint/HPI: The patient is a 66 year old female. No pertinent past medical history. Problems Reconciled. Assessment & Plan: Left rotator cuff tear (M75.102). Impression: Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder.

DEPOSITION OF RIMA BABAYAN, DATED JANUARY 16, 2023:

The applicant's date of birth is July 10, 1956.

Applicant's injury date is 04/14/22;09/03/19-04/18/22.

My full name is Rima Babayan. She had her deposition taken before with regards to her divorce about 20 years prior to this one. She lived at 1 250 North New Hampshire Avenue, Number 8, Los Angeles, California, at this time. She has been living at this address since about 02/12/22 and lived there alone. South Western Avenue was still her mailing address at this time. She was born in Rezaieh, Iran, on 07/10/56. Aside from living in California since 1977, she had lived in New York from 1975 through 1977. Her divorce with Albert Babayan was finalized in 2000 or 2003. They were married for 19 years. The patient had two sons who were financially independent of her. She was not working at this time, nor was she self-employed. She last worked on 04/18/22 at Forest Lawn. She received temporary disability workers' compensation insurance benefits from Travelers Insurance three days after 04/18/22 and she consistently received those benefits every two weeks since. She received \$3,079.42 for each check. Aside from her temporary disability benefits from Travelers, she quarterly received income from her divorce. She and her ex-husband owned 25% of an LLC. She receives a K1 every year. She received \$6,500 for a quarter last time. She was first hired by Forest Lawn on 09/03/19, and she worked consistently for them through her last day of work, 04/18/22. She worked

as an Advanced Planner for them, and she was responsible for selling pre-need services. In April 2022, Angineh Goocherians was their office manager, David Moe was their supervisor, and Grace Chong was their regional manager. Diana Saffles was their office manager prior to Angineh. She stated that she had training for the first three months before they were sent to Glendale Forest Lawn. She stated that she spent 3 0% of the time in the office, and the rest was spent out in the field meeting clients, etc. Her gross income for the first four months was \$30,000, and in the last year it was \$110,000 gross. They received benefits from EDD during the pandemic from March 2020 through approximately March 2021. She did not continue to receive a salary from that period, but they were getting unemployment benefits and they still had their training, meetings, etc. She was unemployed before she started working for Forest Lawn, and her last employer prior to Forest Lawn was California Deluxe Windows. Her employment with California Deluxe Windows ended in 2008. She temporarily worked for California Deluxe Windows in 2012 for less than a year, and she again returned to work for them in 2018 or 2019 for about three or four months, but in a different division, which was Americana. She stopped working for California Deluxe Windows in 2008 when management changed. She stated that she also had to take care of her mother. She broke her left ankle when she fell in Fort Harrison hotel in Clearwater in 2005 while working in a sales position for California Deluxe Windows and she remained off work for a few months then returned to work in November 2005. No personal injury claim was filed against the hotel. She had two surgeries on her left ankle. Steel plates and screws were placed in 2005, but she had an allergic reaction to those, so she had another surgery in 2006 to take them out. Surgery was performed in Florida. Dr. Wood treated her ankle. She had physical therapy as follow-up medical treatment. She had prescriptions from the doctor when she returned. She did not sustain any work-related injuries during either of the two brief periods that she worked for California Deluxe and American, in 2012 and 2018 through 2019. She was aware that two claims were filed on her behalf by her attorney against Travelers and Forest Lawn. She had a claim that she injured her back, right shoulder, and knees in 04/14/22 while working for Forest Lawn. She believed she aggravated her left shoulder due to her fall. With regards to her second claim, she developed injuries to her back and knees, sleep problems, and dental injury from 09/03/19 through 04/18/22 due to her day-to-day work activities at Forest Lawn. She had no pain or discomfort in her knees before being hired. She had not seen a doctor with regard to her pain in both knees prior to 09/03/19. She had not taken medication for any medical condition when Forest Lawn initially hired her in September 2019. She did not have aches or back pains before being hired at Forest Lawn, but she had chiropractic adjustments with Dr. Spearmen in 2013 on Fountain in Los Angeles. She that she worked there once a week for three or four months, and Dr. Spearmen gave her adjustments. She worked as a receptionist for Dr. Spearmen, and she took orders, helped customers, and was paid for her efforts. Her employment there probably ended in 2014. She did not file any legal claim against Dr. Spearmen or sustain any injuries while working for Dr. Spearmen. She saw Dr. Garo Bouldoukian thrice in La Crescenta for chiropractic treatment of her left shoulder. Her sleep issues began after her fall on 04/14/22 due to orthopedic pain, as she could not find a comfortable position to sleep. She had no sleeping difficulties prior to 04/14/22. She began to have low back pain in about February 2020 after their training when she had to carry tables to her car, set them up outside, and put promo pieces to meet customers. She saw Dr. Ario Gordin in Valencia for her back prior to 04/14/22. She stated that she might have told Dr. Gordin that she felt back pain from her work activities. She stated that she had set tables twice or thrice a week, before and after the pandemic, around the end of December 2019, in January 2020, and in March 2021. She stated that she did not have to lift and carry tables in March 2021 until her last day as much as she did initially. She reported her back pain to their Human Resources and Mr. Morones. Mr. Morones offered her to go to the clinic, and she accepted his offer. She also told Mr. Morones sometime in 2021 to April 2022 that she did not want to do the tables anymore. She also added that there was another lady who had back complaints. After the conversation with Mr. Morones, very light and smaller tables were provided, which were much easier to handle. She recalled filling out a report that mainly mentioned her back pain. She believed that carrying and standing caused back pain while she was with Forest Lawn. Besides tables and banners, she also had to carry Forest Lawn bags of promos weighing about 5-15 pounds. She was kept on the books and was paid all her benefits after her time off work due to the pandemic from March 2020 through March 2021. She did not go out to public areas during that period. She had gone to malls and shopping centers twice to thrice a week before the pandemic, and there was a year when she did not do it at all. From March 2021 through April 2022, she only had to set tables once or twice, which were lighter compared to before. Her primary form of selling for Forest Lawn from March 2021 through 04/19/22 was going door to door, seeing clients, or giving out promos. During the last year she worked, she was required to go to public areas about 10-20 times to market for Forest Lawn. She agreed that Forest Lawn publicized too the advanced planners that there was going to be an event at the Burbank Mall. She stated that the office gave

them schedules for when they had to work there, when to do park duty, and when to go to the grocery shopping venue. She did not have a chair to sit down in Burbank Mall and Northridge Mall, but there was a chair at Eagle Rock. She related that she had back pain due to standing and walking all day during these sales events. She stated that some places she went to had sign-up sheets that recorded each of the events that she went to, but the YMCA was her own, so she had her own days. She stated that YMCA closed down during the pandemic, and she did not go there at all between 2021 and 2022. With regard to records, she stated that she had to flag appointments the day before or look for properties before meeting with the client. She added that if the Forest Lawn gave the appointment, they would know, but if it was her appointment, then it was her own. Between March 2021 and April 2022, she stated that properties that did not sell were in between 10-20. She agreed that not all properties were on the hillside, and some were on flat land. She worked mainly in Glendale and Hollywood Hills. She also showed properties at Glendale. She stated that she experienced pain in both knees mainly after her fall, but prior to that, she attributed her pain from walking up and down the hills. She did not go to see a doctor for her knee pain at any time before approximately March 2021. After her fall, she saw Dr. Plance who administered the platelet-rich plasma (PRP) injection to her knees. She stated she had her first PRP injection after April. She related that Dr. Plance told her it would not help because she had an ACL tear and should have surgery. She had x-rays of the right knee and left shoulder on her first fall on 04/05/22, just nine days prior to the fall on 04/14/22. Her primary doctor, Dr. Homayoun Sharim at 201 South Glendale Avenue, requested an x-ray. She also claimed that due to her day-to-day work activities, she developed some dental problems including grinding and clenching of her teeth, which she has had before, and it just worsened. She recalled first experiencing either grinding or clenching in 2018 or 2019 when she went to see a dentist, Dr. Nakoud, in Granda Hills. Before that, she had a night guard, which was given by Dr. Arakelian in Woodland Hills in 2018. A new night guard was ordered because the other one would not fit anymore and was so thick. She indicated that she was prescribed a night guard because her teeth were wearing down and she had a crack. She related that she was not continuously wearing the night guard from the first time she was prescribed it until the date of the accident on 04/14/22. She indicated she frequently used the night guard because she was uncomfortable with the one she had. She related that she still has clenching and grinding with her teeth, and she was having more pain in her mouth at this time. She indicated that the pain or discomfort in her body was causing her to clench or grind her teeth more. Within the last 12 months, she had Dr. Nakoud and Dr. Gogan/Gogon, who performed cleaning of her teeth at 321 North Larchmont. She saw Dr. Gogan two times for cleaning. The first time she saw Dr. Gogan, he took x-rays and was going to send her to a doctor to make a night guard. The last time she saw him was about 10 days ago. She stated she saw him back in June or July last year and he planned to fix the grinding of her teeth. She denied seeing other dentists besides Dr. Nakoud, Dr. Gogan, and Dr. Arakelian over the last five years. She stated she noticed an increased right-sided jaw pain between the date of hire on 09/03/19 and just prior to the specific injury on 04/14/22. She stated that some days it was hard, and some days it was fine. She indicated that even when the time of the deposition, she could feel an increase in her symptoms. She claimed that on 04/14/22 she had an appointment with Armenia, a female client. She picked Armenia up at about 8:00 a.m. from her work, which was very close to Forest Lawn. Armenia had to go back to work at 9:00 a.m. This was her third or fourth appointment with this client in a year, showing her and her husband different properties. This time, Armenia came by herself. She picked her up because she could not drive on the freeway. And so, they went to Hollywood Hills. The night before, she was at Forest Lawn and flagging all the different properties with different price ranges for two hours. She was there until 7:00 p.m. And the next morning, she picked up Armenia and they went to Hollywood Hills. The last two places she showed Armenia were in the Peaceful Memory Section, which was the least expensive and sloppy place. They went down and Armenia look at it and indicated she did not like it as it was kind of sloppy. Armenia then looked to the right, saw a flatter place, and wanted to go there. She then got the map from the car, which was parked on the road next to where they were. Armenia stayed where they used to be while she went up and got the map and her phone. She called the office on speakerphone to find out if the property that Armenia liked was available. As she was talking to the girl, Angineh, in the office and walking down, she did not realize that she stepped into a soggy mud place. Her right foot slide down. And as she was sliding down towards the client, she tried to stop herself as she was afraid, she would hit the client if she rolled down. She pushed her feet down to stop herself and twisted her body. She fell down on her buttocks first, back and shoulder. And then she turned to her right and ended up lying down on her entire back. Angineh, who was still on the phone, asked her if she was okay. She indicated that although she was in shock and kind of teary, she continued asking Angineh if the other property was available or not. She related that at the time she fell, she was talking to two people in the office. She forgot the other person's name as she was new and the other one was Angineh. She was lying there when Armenia

came up and was trying to help her. Armenia told her she had a bad fall, in which she denied. As she did not want to pull Armenia, she turned on her knees and hands and got up. She refused Angineh's offer to call security because she had to take Armenia back to the office. Armenia was worried about her job and boss, so she took Armenia back to her workplace. She went to the office and reported the accident. Diana Saffles and Angineh told her that she should go to the clinic. Next Monday, she eventually went to the clinic. She went there every two weeks starting from April 1 8th. She indicated that she was not receiving any treatment because Dr. Kazazian was just evaluating her. They were waiting for authorizations. After she was authorized to see Dr. Adamson in August 2022, she stopped seeing Dr. Kazazian. She was still under the care of Dr. Adamson for her left shoulder. She saw him about a month ago and was recommended physical therapy. She just saw Dr. Adamson once for her right shoulder and knees. She also received treatments from Dr. Samimi on 09122122 for her knees, back and right shoulder. Dr. Samimi administered Durolane injections in her knees, which was much more painful at first, and then gradually, the pain disappeared. But her pain was still the same. She also has clicking. Dr. Samimi told her that she had to wait and see if this would help every six weeks or so. She last saw Dr. Samimi in December. Workers' Compensation denied Dr. Samimi's recommendation of physical therapy. She stated that she only saw Dr. Gevokian at Pathways Medical 10730 Riverside Drive in Toluca Lake for her overall body treatments, including Vitamin C and IV therapy to remove the inflammation. She was scheduled to see Dr. Drake, a QME. She mentioned during the deposition that she had a fall on 04/05/22 and sustained injury to her left shoulder. She was crossing a pedestrian lane when she fell due to uneven asphalt. Her foot got stuck and went forward. She did not go to the emergency room or urgent care facility immediately after that fall. The day after her fall, she saw Dr. Sharim for her physical exam and blood test. She informed Dr. Sharim about her fall and complained of left shoulder pain and movement as well as right knee soreness. Dr. Sharim ordered MRI and x-ray. The next day, she got an appointment at United Medical where the MRI and x-ray were performed. She was told not to use her hand and arm. She also saw Dr. Plance, who referred her to an orthopedic surgeon, Dr. Powell at 2021 Santa Monica Boulevard, Suite E, California, 90404. Dr. Powell indicated that she might need surgery for the left shoulder. She related she misunderstood Dr. Powell's recommendation. She thought it was open surgery and later found that it was arthroscopic surgery. She stated that when she fell on the 14th, she had a scheduled Zoom meeting with Dr. Powell. That was when she was told that she would need surgery. She had injured her ankle in 2005. Over the last 15 years, she just saw her OB-GYN Dr. Lantry. She also had Cigna-HMO. She also had hiatal hernia and had colonoscopy done by Dr. Boghossian. She had cyst in her right index finger. In 2007, she went to Glendale Adventist because she had heart palpitations. She went to emergency, and she was kept overnight. She also went to Angel's Wings Medical Association for UTI. In her present condition, she believed that she was not able to return to work as an advanced planner for Forest Lawn. It was her knees, back, and shoulders that were preventing her from working as an advanced planner. When she would pick up especially on her right shoulder and bicep, she would get spasm and she have to drop whatever she has. Since she has been off work since 04/2022, she noticed that her right shoulder and low back were worse. She stated that her left shoulder was better. She was taking biorelief, and she was taking a lot of supplements, natural supplements, stem cell supplements, and standard process supplements. She received medical treatment for the pain in her abdomen area at Olive View Medical Center in 2014. After her accident on the sidewalk, she had an MRI to her left knee on 04/07/22. She had another MRI of the left shoulder in 05/24/22. She has seen Dr. Schames in 12/2022. She stated that Dr. Schames took pictures of her mouth and teeth. She was told that she was grinding and a mouthguard or a temporary one was ordered. She was told that she might also have sleep apnea. She has a return appoint to see Dr. Schames on 01/26/23. She was also given something for her nose which was very uncomfortable and she has not done it. She told Dr. Schames that she was having difficulty sleeping because of the orthopedic pain and trouble getting into a comfortable position.

DEPOSITION OF RIMA BABAYAN, DATED NOVEMBER 13, 2023:

The applicant's date of birth is July 10, 1956.

Applicant's injury date is 04/14/22;09/03/19-04/18/22.

My name is Rima Babayan. I have spent approximately 1 hours time this morning with my attorney preparing for this Volume II of my deposition. I am still living at 1250 North New Hampshire Avenue, Apartment 8 in Los Angeles.

Since January when we were last together, I have not been employed in any capacity. I am still receiving temporary disability benefits from Travelers Insurance. In my first deposition I have told you that I also received quarterly 6,500 from a real estate limited partnership. No actually, because they are remodeling the building and I have not received any, as I recall. Since January of 2023, I have applied for social security benefits and I am receiving them at the present time approximately \$1,700. I am also qualified for Medicare. I qualified for Medicare after my birthday in July 2022. Whether Medicare paid for medical treatment to any part of my body I am not sure. Probably my physical doctor, Dr. Sharim. Since January 16, 2023, I have received medical treatment for the injuries that I claim have occurred while working at Forest Lawn just with Dr. Samimi, my doctor and the last month, I think, it was Concentra for my right shoulder which was through my doctor, I mean workers' comp. The doctor from Concentra, is Dr. Bianchi. Dr. Samimi is treating my both knees, right shoulder and my back. Dr. Samimi is treating left shoulder and right shoulder. Dr. Bianchi is treating the right shoulder. Since January of 2023, Dr. Samimi received gave injections in my knees. I had three-part injection in the right knee. Three times in each knee. I have received all three injections for the right knee. The last injection was in three weeks consecutive so from the first week, would be every week after that. Well, I can say it felt a difference and then it is gone back to what it was. The condition of the right knee at the present time comparable to what it was before I had the injections it is the same with the left knee. I last saw Dr. Samimi approximately at the end of October. So basically, he said I have to lose weight to get my knees changed. To get the knees changed, like whatever, have the surgery done to both knees. He made the recommendation last time that I talked to him and prior to that. In October of 2023 recollection is that Dr. Samimi told me I need a surgery to the right knee. Dr. Samimi recommended a total knee replacement. He recommended the same thing for the left knee. Dr. Samimi indicated he cannot do the procedures in the present time because of the weight. Since January of 2023, has Dr. Samimi provided treatment for the right shoulder recently with Concentra. I just received approval for my back, pain management. The doctor at Concentra, since January, has provided me with stem cell injections. Electrical stimulation and did adjustments once and also some instrument on my back and on my shoulder. The last time I saw doctor at Concentra was on Friday; it was a face to face examination. We didn't discuss the treatment because it is up to Dr. Samimi. I am scheduled for further treatment at Concentra tomorrow. The condition of the right shoulder through treatment provided by Concentra has helped with the pain and I have less pain in right shoulder compared to three months ago. Dr. Samimi received or got authorization to refer me to pain management consultation. I think Concentra was on the list. So I have submitted that to Concentra. We will see. Concentra didn't have any opening until January so they are trying to see if some other center then where I see. I have also received treatment from dentist since January of 2023. I have seen Dr. Richard Walicki in Mint Dental Lab once. Mint Dental Lab in Pasadena. I have also seen someone else associated with him for cleaning. I had a tooth that needed to be smoothed. It was chipped. So that's all he did. Dr. Samimi suggested me to lose weight in order to facilitate the (total knee) surgeries. My current weight is Two forty-six pounds, I think. I think Dr. Samimi recommended taking Ozempic, but I don't want to do that because of the side effects. I was also sent to Dr. Arbi Mirzazians. I have seen when sent there by Dr. Samimi. The purpose of the evaluation is to see occupational in his office. When I went to the doctor's office, I was given questionnaires to fill out. At the doctor's office I spent approximately two and a half, three hours. I filled out the questionnaire and then I was told to do different manual stuff and also lifting a box of whatever it was and walk with it, and also do body movements to see how much I was able to do, and also manual. Body movements I had to do with my back, my knees moving. They did bend me forward more than once and we did it three times each time. I was also given instructions while conducting this examination as to whenever I feel the pain I should stop. I was told to do the best I can and the most I can, and if I feel pain just stop Right but at some point I couldn't do it so I just stopped. I was given a copy of the report that was generated from Dr. Samimi's. at the time I was doing this evaluation on May 26, 2023 I was just give medication just my Bio relief. It is for inflammation and pain. It is an over-the-counter Holistic medication. In the last 30 days I have not done any changes. If authorized I would wish to undergo a right total knee replacement. My left knee is worse than the right knee. Dr. Samimi did discuss with me the risks of the procedure. His assistant, his P.A. Before I was hired at Forest Lawn, my date of hire is September 3, 2019, I had pain and discomfort in my neck before the date of hire. I had neck pain before I was hired. I never had an MRI of the neck before being hired at Forest Lawn, I 8 don't think so. I have testified that I had seen a chiropractor, Dr. Bouldoukian, about three times. I was employed in the year 2013 for a short time. In 2013, I think I was working with Dr. Spearman part-time. I was employed in 2013 with Applied Scholastics. I was in charge of marketing and the job did not last more than I was there I think probably just three, four months. Three months, four months. While working for Applied Scholastics, what happened is I was reading a book and my upper back I had pain and just something happened there

in the back. I did not file a claim for workers' compensation benefits against Applied Scholastics or their insurance carrier. I was off probably about two weeks or three weeks. There was no neck pain but upper back pain. I was more concerned my upper back. Because I don't see a medical report in front of you that you're reading off of. I had low back pain prior to the date of hire at Forest Lawn but with chiropractic adjustments because that's what people read. If everything goes from spine. I was having some discomfort in my low back. I went to a chiropractor before I was hired at Forest Lawn. It is Dr. Spearman. She testified that around 2013 she had adjustments while working there. She worked there for three to four months. In my entire 67 years or 60 years of life, because the reason I go to chiropractors. I did feel pain in the back at any time in my life when I was a child up to the date. I would just say yes probably. I had no right shoulder pain prior to the date of hire at Forest Lawn. I did have numbness or tingling in left or right hand prior to the date of hire at Forest Lawn. The first time I experienced any numbness or tingling in my hands in 2013 and 2014. Physiologically, the numbness and tingling is probably from my neck or my carpal tunnel at the time. For treatment of numbness, I just saw chiropractors. For complaints of numbness, I think I saw Dr. Spearman while I was working there. I did experience jaw clenching before I was hired at Forest Lawn. At the last deposition we talked briefly about a fall I had on April 5, 2022 not at work. I did not file any type of insurance claim as a result of that accident no. Just my physical doctor, Dr. Sharim Homayoun and he ordered MRIs. The doctor charges were paid by Cigna Insurance Carrier I am not sure. In the fall of April 5, 2022, I injured my left shoulder and right knee. After the fall I was just feeling pain in the back and mostly my left shoulder. EMG it is a test where they actually put little needles in your arms or legs to determine the neuro conduction. I had an EMG, in July of 2023. Other than the doctors I talked about as treaters, meaning Dr. Samimi and the doctors at Concentra, I have seen just Dr. Sharim, I think and Dr. Spearman last night. I had pain on this side. So he adjusted. Dr. Spearman gave me supplements and he adjusted my reflection on my pancreas. Since January, I have seen Dr. Spearman approximately two or three times. As a result of the specific accident at Forest Lawn of April 14, 2022, I am claiming injury to the bilateral shoulders, bilateral knees, both knees, my low back, and my dental. The doctors at Concentra and Dr. Samimi recommended me undergo left or right shoulder surgery. Dr. Samimi recommended a procedure for both shoulders. Dr. Samimi was recommending right shoulder replacement and repair of rotator cuff. Dr. Powell had recommended arthroscopic surgery on 4/14, the day I fell at Forest Lawn. None of the doctors mentioned I had a tear in the left shoulder. Including the doctor who saw me tripping and falling on the street from the crack. The only doctor that recommended I had a tear in left shoulder would be Dr. Powell. The zoom meeting with Dr. Powell took place after I fell. I fell at 8:30 and my ZOOM meeting was at 9:00. Because of the Covid. Dr. Powell recommended arthroscopic surgery at that time. Dr. Powell mentioned I assume because of my fall on the street. The one on April 5, 2022 but I knew that I had arthritis in my upper back. I have testified in the last deposition that I was hired at Forest Lawn and prescribed a nightguard by my dentist, because I was grinding my 18 teeth. None of the doctors told me what clenching of the teeth caused by. I am claiming jaw pain following the accident at Forest Lawn. I think pain in my body and at night being discomfort as far as sleeping positions. TMJ. I think that's what it was. None of the doctors told me I had TMJ before the accident at Forest Lawn. I think Dr. Sarkissian, who gave me the nightguard, probably. I don't recall. I don't remember what he said. The first deposition indicated that I was not working between approximately 2008 and 2019 because I was taking care of my mother. I did not work at all between 2008 and 2019 because my mother passed away 2017. It would be I worked at California Deluxe Window, for like a couple months in 2019 before I started in. Between 2008 and 2019, my employment was just California Deluxe Windows. I had a conversation wherein I indicated that our client was not going to pursue. Since January I have not traveled anywhere outside of the Los Angeles County area. I took a trip or vacation with my brother and his family we went to a cabin in Idyllwild for two to three days. We stayed in a cabin. We went there approximately I would say February or March maybe. I'm not sure the dates. In a couple times in the deposition, I mentioned my private doctor, Dr. Sharim Homayoun. It is the same doctor Dr. Sharim's specialty is General, I think.

RECORDS FROM LAST SUPLM

1. **MRI C SPINE W/O CONTRAST:** Dated 04/19/2013, signed by Kimberly Foust, M.D. & Patrick Kane, M.D. Impression: NO ACUTE OSSEOUS ABNORMALITY. MULTI-LEVEL DEGENERATIVE CHANGES, AS DESCRIBED ABOVE.

2. **MRI C SPINE W/O CONTRAST;** Dated 04/23/2013, signed by Maurice Hale, M.D. Impression: 4 MM DISC HERNIATIONS FROM C4-5 THROUGH C6-7 STENOSING THE SPINAL CANAL, ENCROACHING THE 3 MM BROAD-BASED C3-4 DISC PROTRUSION ELEVATING THE POSTERIOR LONGITUDINAL LIGAMENT & ENCROACHING BOTH NEUROFORAMEN. 2 MM C7-T1 DISC PROTRUSION EFFACING THE VENTRAL THECAL SAC & ENCROACHING BOTH NEUROFORAMEN.
3. **XR OF THORACIC SPINE;** Dated 11/01/2013, signed by Ricard Witten, M.D. Impression: Mild to moderate diffuse degenerative findings. No fracture or other significant appearing abnormality is detected.
4. **XR CERVICAL SPINE AP/LAT;** Dated 11/01/2013, signed by Ricard Witten, M.D. Impression: C5-C6 interbody fusion. Whether this is surgical or due to infection or some other process is uncertain from this single exam. Chronic degenerative disk disease as detailed above. No subluxation or other acute process is suspected.
5. **GYN GENERAL H&P;** Dated 12/18/2013, signed by Steven Dalati, M.D. Chief Complaint: LLQ pain. HPI: 57yo G4P2022 with LLQ pain since 4/2013. Pt noted she had finished a Kale salad when the pain started. Initially sharp, then an ache. 4/10, no noted aggravators or alleviators. Possible pain exacerbated with heavy lifting but unsure. Pain is intermittent. Radiation to the umbilicus. Assessment and Plan: 57yo woman with LLQ pain. 1) Pain: Unlikely GYN in origin. Pt is postmenopausal x 5 years with 1 episode of PMB in 2009. Pt reports D&C with good results. Since then, no issues. Pt ultrasound shows small fibroids that are unlikely to be any source of pain. Encouraged pt to start a pain diary and RTC for review and identification of pain source 2) HCM UTD via PCP.
6. **CT ABDOMEN WITH CONTRAST, CT PELVIS WITH CONTRAST; CT ABDOMEN W/O;** Dated 03/21/2014, signed by Kevin M. Spitler, M.D. & Cecilia M. Jude, M.D. Impression: Hepatic steatosis. 1.3 x 0.7 cm left adnexal fatty lesion, likely a dermoid. The uterus demonstrates a 2.4 cm mass with areas of fat attenuation, likely a lipoleiomyoma.
7. **GYN CLINIC NOTE;** Dated 06/17/2014, signed by Sonya Tat, M.D. Chief Complaint: LLQ pain. HPI: 57yo G4P2022 with LLQ pain since 4/2013. Pt noted she had finished a Kale salad when the pain started. Initially sharp, then an ache. 4/10, no noted aggravators or alleviators. Possible pain exacerbated with heavy lifting but unsure. Exacerbated by walking, position change. Pain is intermittent. Radiation superiorly. Does not want to take pain meds. Urinary frequency 10x/day; urge, has not had incontinence. Notes stream is also interrupted. Assessment and Plan: 57yo woman with LLQ pain with incidental finding of 1.3x0.7cm adnexal lesion, not seen on prior UTZ in 9/2013 1) Pain: Unlikely GYN in origin. Pt is postmenopausal x 5 years with 1 episode of PMB in 2009. Pt reports D&C with good results. Since then, no issues. Pt ultrasound shows small fibroids that are unlikely to be any source of pain. Adnexal lesion, likely not contributing to pain. If cyst is stable, Dispo from 19A to PCP for pain management. 2) L dermoid cyst -Repeat pelvic UTZ to follow-up 3) Urinary symptoms -LIA, UCx with TFU 4) HCM UTD via PCP. - Last Pap: 10/2013 nil -Last Mammo: 10/2013 ACR 2.
8. **XR FINGER PA/LAT, XR FOOT RIGHT;** Dated 08/10/2014, signed by Ricard Witten, M.D. Impression: No evidence of acute trauma or significant joint disease in the right thumb. Hallux valgus, bunion and hammertoe formation and heel spurs are prominent in the right foot. No fracture to the second toe or elsewhere is detected.
9. **CLINIC NOTE;** Dated 08/12/2014, signed by Lina M. Rodriguez, M.D. Chief Complaint: LLQ pain. HPI: 58yo G4P2022 with LLQ pain since 4/2013 and a 3cm fibroid on UTZ, and 1cm possible dermoid on CT who presents for follow up of her pain, review of repeat ultrasound. The patient reports that she noticed the pain get better, but yesterday she bent over felt pain in her LLQ for 1 minute, and then the pain resolved after she stood up. She does note a dull left sided deep pain which she "knows is from my condition." She also wants to know if she can get disability for her condition. The pain is mostly aggravated by position change/movement. Lately, she has also been feeling very tired and sad, no suicidal ideation. She wants to know if this is from the cyst in her ovary. Urinary frequency 10x/day; urge, has not had incontinence. Notes stream is also interrupted. Assessment and Plan: 57yo woman with LLQ pain with incidental finding of 1.3x0.7cm adnexal lesion, not seen on prior UTZ in 9/2013 1) Pain with 0.8cm dermoid cyst - I explained that the cyst is not likely the source of her pain. However, only physical exam finding is mild CMT

which she says reproduces the pain, so will empirically treat with doxycycline. Pt ultrasound shows small fibroids that are unlikely to be any source of pain. Given mild CMT, will empirically treat with doxycycline x 10-day course and re-evaluate with exam after repeat UTZ in 6 months to ensure no increase in size of fibroids or cyst (although stable over one year). #Fatigue: suspect related to mood. Pt denies SI/HI - CBC and TSH to rule out thyroid dysfunction and anemia, f/u PMD. 4) HCM UTD via PCP. Last Pap: 10/2013 nil. -Last Mammo: 10/2013 ACR 2.

10. **PELVIC ULTRASOUND;** Dated 09/16/2014, signed by Nisha Alle, M.D. & Michael John Nguyen, M.D. Impression: Stable appearance of c:he 3.4 cm fundal lipoleiomyoma and 1.6 cm intramural fibroid arising from the anterior uterine wall. Redemonstration of the nonspecific 4 mm left ovarian echogenic lesion, previously described as a dermoid, and slightly smaller in size on today's exam.

11. **XR ANKLE LEFT;** Dated 09/22/2014, signed by Thomas Zung, M.D. Impression: Overlying soft tissue prominence. Minimal degenerative changes of left ankle. Small left inferior calcaneal spur. No fracture, subluxation, lytic lesion or bony erosions.

12. **US.PELVIS NON O;** Dated 03/02/2015, signed by Carissa White, M.D. & Gail C. Hansen, M.D. Impression: Stable 3.3 cm fundal lipoleiomyoma. Slight interval decreases in size of the intramural anterior uterine wall fibroid, which now measures approximately 1.3 cm. Interval increase in size of the left ovarian echogenic lesion likely a dermoid, which now measures 1.5 cm. Normal blood flow is seen in the left ovary.

13. **CLINIC NOTE;** Dated 03/23/2015, signed by Lina M. Rodriguez. History: 58yo G4P2022 PMP woman with LLQ pain since 4/2013 incidental myoma & dermoid presents for follow up. She reports continued LLQ pain and burning that goes up to subcostal area and left flank for the past year and a half. Comes and goes every day, does not take medications for it, gets up to 4/10. Does not radiate to vagina or labia. Denies vaginal itching/discharge, or bleeding. States pain has gotten much better since last visit, at most 4/10 pain. In the past she was treated with doxycycline for CMT on exam. Has not been sexually active for 10 years since divorce. Has had negative testing in the last few years with no new partners since then. She has a PCP in Glendale. No bladder issues, no dysuria. Denies unintentional weight loss. PMP 10 years, no bleeding currently.

14. **SOAP NOTE;** Dated 04/28/2015, signed by Lina M. Rodriguez. Subjective: 58 y.o F rtc f/u right bunion, 2nd HT pain and L ankle post traumatic arthritis. hx of left ankle surgeries x 2. Denies new trauma. Denies getting brace from last visit. here for that. Doesn't want surgeries at this time but does want to explore options. Cannot tolerate closed toed shoe gear mainly due to HT deformity. Also has difficulty in flat type of shoe gear. Used to work selling windows and walked a lot. Today wear sandals. A/P 58 yo F with hx of prior L ankle surgeries with l ankle pain likely 2/2 posttraumatic arthritis, R HAV with bunion deformity, R 2nd HT deformity with likely predislocation syndrome. Discussed at length findings and imaging results explained to pt all tx options including conservative surgical options. explained risks, benefits and alternatives. pt wishes to continue with conservative management. asked about ankle arthroscopy and PRP. Informed pt she may need to get second opinion at OSH for PRP, facility does not offer PRP. explained likely arthritis would not improve with PRP intraarticular injection. will recommend lace up ankle brace, physical therapy per pt request taping, splinting for R bunion & HT deformity, wide toebox shoegear information dispensed. Rtc f/u in 2-3 mos after PT. DWA Dr. Wang.

15. **SOAP NOTE;** Dated 08/19/2015, signed by Lina M. Rodriguez. Subjective: 62 yo with no hx of skin cancer, here for spots on back and chest for long time. New spot on right finger for the past year. no pain or pruritus. A/P: 1) SKs, back, cherry angiomas, chest, dermatofibromas, arm and back all benign. 2) myxoid cyst can see ortho hand for removal is desired by pt. 3) xerosis. Emollients daily. Dry skin care discussed. Seen and discussed with Dr. Fitzgerald.

16. **MRI C SPINE W/O CONTRAST;** Dated 10/05/2015, signed by Gasser M. Hathout, M.D. Impression: Very severe disc space narrowing at C5-6, with near complete fusion of the C5 and C6 vertebral bodies, likely post-degenerative auto-fusion, but other: etiologies cannot be excluded. This finding was present on prior plain film examination of 2013. Moderately severe degenerative disc disease at C6-7, and moderate/moderately severe degenerative disc disease at C3-4, C4-5, and C7-T1. Straightening and slight reversal of the normal cervical lordosis.

Mild to moderate spinal canal narrowing at C5-6 due to broad-based posterior osteophyte formation. Mild spinal canal narrowing at C4-5 and C6-7. No evidence of large disc bulge gross focal disc herniation, high grade spinal canal stenosis, gross cord impingement, or gross cord signal abnormality at any level.

17. **ELECTRONEUROMYOGRAPHIC REPORT;** Dated 06/22/2016, signed by Christina Chrisman, M.D. & Nastaran Rafiei, M.D. Impression: This is an abnormal study. There is electrodiagnostic evidence of bilateral median neuropathies at the wrists (i.e. carpal tunnel syndrome), which is moderately severe bilaterally, slightly worse on the right. There is no electrodiagnostic evidence of a left cervical root lesion (e.g. radiculopathy).

18. **CT ABDOMEN WITHOUT CONTRAST;** Dated 05/03/2021, signed by Alexander Somwaru, M.D. Impression: Increased diastasis real with large, shallow, fat-containing anterior abdominal wall hernia. No bowel involvement. Hepatosplenomegaly and hepatic steatosis. Please correlate for chronic hepatocellular disease (steatohepatitis and cirrhosis) and portal venous hypertension. Small hiatal hernia with esophageal thickening that may be due to esophagitis and/or underdistension however please consider correlation with endoscopy to ensure the absence of a potential neoplasm.

19. **X-RAY OF THE LEFT SHOULDER - ONE VIEW;** Dated 04/07/2022, signed by Haroutun Abrahamian, M.D. Impression: Mild degenerative changes about the left shoulder.

20. **X-RAY OF THE, RIGHT KNEE-THREE VIEWS;** Dated 04/07/2022, signed by Haroutun Abrahamian, M.D. Impression: Medial compartment osteoarthritis with a small to moderate size joint effusion. Quadriceps tendon enthesopathy.

21. **MRI OF THE LEFT SHOULDER WITHOUT CONTRAST;** Dated 04/07/2022, signed by Haroutun Abrahamian, M.D. Impression: Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial-thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis with adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis.

22. **OFFICE VISIT;** Dated 04/14/2022, signed by Scott Powell, M.D. History: HPI: KNEE: She is a 65 years old female who presents via telemedicine and is a new patient to our office, referred for evaluation and treatment regarding her left shoulder pain and right knee pain. She reports this pain began after she sustained a fall on April 5th. The patient reports that her left shoulder pain and right knee pain have generally persisted since onset. The patient reports that she consulted her PCP, who advised her to obtain a right knee x-ray, left shoulder x-ray, and a left shoulder MRI. The patient reports that she has completed the recommended imaging. Our office has the reports and images on file at this time. Regarding her right knee, the patient presents with persistent, constant pain at the lateral aspect, rated at a baseline of 5/10 but reaching a 9/10 with stair ascension/descension and when standing from a seated position. The patient reports difficulty with weightbearing. Additionally, she reports limited ROM (with flexion) and weakness. She denies popping/clicking and numbness/tingling. Notably, the patient reports that she recently sustained a separate fall, which caused injury to her left knee. HPI: SHOULDER: Regarding her left shoulder, the patient currently presents with persistent, constant pain in the anterior aspect rated at a 7/10, as well as limited ROM (with abduction/forward elevation) and weakness. The patient reports difficulty with overhead movements and an inability to lift objects exceeding 5 lbs in weight. The patient denies night pain and instability. The patient denies taking any anti-Inflammatory medication for her right knee and left shoulder pain at this time. Plans - Knee: She was advised to take over-the-counter anti-inflammatories (NSAIDs) as needed and to apply ice to the affected area as needed. The patients' x-rays were reviewed and discussed. The patient was advised to begin a formal physical therapy program aimed at reducing pain caused by osteoarthritic changes. The patient was provided with a requisition for 6 sessions of physical therapy and advised to attend PT 2x per week for 3 weeks. Plans - Shoulder: She was advised to take over-the-counter anti-inflammatories (NSAIDs) as needed and to apply ice to the affected area as needed. The diagnosis was discussed with the patient. Non-operative versus operative treatment options were discussed. Operative treatment was described as a left shoulder arthroscopic rotator cuff repair. Non-operative treatment was described as physical therapy and/or pain management strategies, including cortisone injections. The patient has elected to pursue conservative management at this time and was provided with a requisition for 6 sessions of physical therapy. She was advised to

attend physical therapy 2x per week for 3 weeks. Our office will follow up with the patient in 4 weeks via phone to assess her progress with physical therapy. Additionally, the patient was advised to inquire about a left shoulder cortisone injection. The patient is encouraged to consult her primary care physician regarding this injection. Chief Complaint: left shoulder pain/right knee pain. Assessment: pain in right knee. Pain in left shoulder. Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic. Unilateral primary osteoarthritis, right knee. Plan: Office o/p new low 30-44 min.

RECORDS FROM RE-EVALUATION

1. **OFFICE VISIT:** Dated 07/22/2021, signed by Sarver Alnajjar, M.D. Chief Complaint/HPI: She presented with hand pain. It is located on the right. It is described as throbbing. Episodes occur in the evening and at night. The patient is a 65-year-old female who has developed a lesion on the dorsum of her right index finger that has a bluish color and is gradually increased in size causing discomfort with full flexion and extension of the finger. She also has anxiety as the size of the lesion has increased significantly recently. She denies any accident or injury other than having a vein that may have been injured when it was punctured with a needle. Diagnoses: Ganglion, finger of right hand. Prescriptions Services Performed. OFFICE/OUTPATIENT VISIT NEW X-RAY EXAM OF HAND Services Ordered. Plan: The patient wishes to have the lesion removed to confirm the pathology as well as allow for increased range of motion without discomfort. Please authorize removal of ganglion cyst versus aneurysm dorsal vein right index finger and she will be scheduled soon as authorization and clearance is obtained. The patient was advised to obtain rheumatology consult to determine the cause of the changes to her bone and whether there is any sort of inflammatory arthritis or gout present that may be causing these changes.

2. **OFFICE VISIT:** Dated 08/24/2021, signed by Matthew Nalamlieng, M.D. Chief Complaint/HPI: She presented with foot pain. It is located on the left and on the right. It is described as tenderness. Episodes occur in the evening and at night. Bilateral foot pain. She is a 85-year-old female presents for evaluation with regard to bilateral foot pain, she reports that she has different areas of pain along both of her feet, with regard to her left foot. She previously suffered from a left ankle injury that occurred over 10 years ago that resulted in open reduction internal fixation as well as subsequent removal of hardware the patient states that she now has limitation with ankle flexion range of motion and states that she has pain found along the anterior aspect of the ankle joint. With regard to her right foot the patient endorses that she has pain found along the bunion site stating that she has also associated flat feet which is painful for her and has suffered from pain and swelling found along the dorsal midfoot, she denies any specific history of injury however to the right foot as well. Diagnoses: Pain in left foot. Pain in right foot. Bunion of right foot. Post-traumatic osteoarthritis, right ankle and foot Plantar fascial fibromatosis. Post-traumatic osteoarthritis, left ankle and foot. Prescriptions Services Performed. OFFICE/OUTPATIENT VISIT NEW X-RAY EXAM OF FOOT- 3 VIEWS in a quantity of 2 X-ray Foot, {side} 3 views AP, lateral and oblique radiographs of the (side) foot were obtained at the time of the office visit. I have personally reviewed these films and interpret the radiographic findings as follows: Three-view radiographic imaging study of the left foot shows findings consistent with anterior listhesis of the anterior aspect of the talar dome as well as the dorsal aspect of the talar head, the patient also has evidence of chronic degenerative changes that are seen along this level as well as extending towards the dorsal midfoot at the bases of the metatarsals. Three-view radiographic imaging study of the right foot shows findings consistent with hallux abductus angle which is increased as well as intermetatarsal angle which is increased as well as chronic degenerative changes which are seen along the base of the third as well as fourth and second metatarsals with near complete loss of the third tarsometatarsal articulation, the patient also has prominent bony eminences which are visualized along the bilateral plantar heels as well as along the retrocalcaneal space bilaterally. Plan: Patient seen and evaluated. Findings are consistent with significant posttraumatic arthropathy found along the left anterior ankle as well as along the right midfoot. With regard to these I did discuss that she would benefit from undergoing utilization of topical anti-inflammatory medications as well as arch supports and I did discuss possibility of undergoing future excision of bone from the dorsal aspect of the midfoot as well as anterior aspect of the left ankle. Regarding her bilateral heel pain I did discuss that she would benefit from physical therapy which I will request authorization form

and gave her instruction with regard to utilization of supportive shoe gear as well as she can continue with diclofenac gel for her pain. I will see her back for follow-up in 3 months. We also discussed possibility of undergoing a right foot hallux correction by way of Lapidus arthrodesis as well as second metatarsal osteotomy and second digit hammertoe correction she would like to let me know if she would wish to proceed with surgery at the next visit.

3. **MRI OF THE LUMBAR SPINE WITHOUT CONTRAST:** Dated 05/23/2022, signed by Haroutun Abrahamian, M.D. Impression: Mild to moderate disc desiccation of L4-5 with a 3.5 mm broad-based disc protrusion and facet arthrosis causing mild central canal and neural foraminal stenosis bilaterally. Mild disc desiccation of L5-S1 with a 2 mm broad-based disc protrusion asymmetric to the right with facet arthrosis and an 8 mm complex synovial cyst in the right neural foramen causing mild cerebral canal stenosis as well as moderate right-sided and mild-to-moderate left-sided neural foraminal stenosis. Less significant findings at the remainder of the disc levels as described above. Heterogeneous marrow signal diffusely which is a nonspecific but may represent osteopenia. Pathologic process cannot basically without oncologic workup.

4. **APPLICATION FOR ADJUDICATION OF CLAIM:** Dated 01/17/2023. Employer Name: FOREST LAWN MEMORIAL PARK. Date of Birth: 07/10/1956. Occupation: PLANNING ADVISOR. Date of Injury: 04/14/2022. Injured Body Parts: 450 SHOULDERS, 420 BACK, & 513 KNEE. How Injury Occurred: AMEND APPLICATION TO ADD HER LEFT SHOULDER, SLEEP DISORDER, AND DENTAL.

5. **INITIAL REPORT IN THE FIELD OF DENTISTRY AND REQUEST FOR AUTHORIZATION:** Dated 01/17/2023, signed by David Schames, DDS. JOB DESCRIPTION: She states she worked as a Planning Advisor for Forest Lawn Memorial Park. She worked 1 0-1 2 hours per day, 7 days per week. She states her job entailed prolonged driving, walking, standing, bending forward, reaching below shoulder level, pushing, pulling, lifting up to a maximum of 25 lbs, and carrying up to a maximum of 25 lbs. CURRENT WORK STATUS: She states she has not returned to work since April 1 8, 2022. HISTORY OF INDUSTRIAL INJURY: She states that on 4/14/22, and from CT 9/3/1 9 to 4/1 8/22, she was involved in industrial injuries in the course of performing her usual and customary job duties. She reports that as a result of performing repetitive work activities such as prolonged driving, walking, standing, bending forward, reaching below shoulder level, pushing, pulling, lifting up to a maximum of 2 5 lbs, and carrying up to a maximum of 25 lbs., she developed the gradual onset of pain in her neck, shoulders, lower back and in her knees. She states in particular that on 4/1 4/22, she tripped and fell on her back, aggravating the pain in her neck, shoulders, lower back and knees. She states, however, that as a result of the slip and fall, she also developed pain in her arms, with a residual numbness sensation and weakness in her hands and fingers. She finds that in response to her industrial related orthopedic pain, she developed emotional stressors. She finds she is clenching her teeth and bracing her facial musculature in response to her orthopedic pain, and also in response to the resultant emotional stressors experienced. This has caused her to develop facial pain. She is right hand dominant. She reports that due to the industrial exposure, she has pain and weakness in her shoulders, arms, hands, and fingers. She reports these orthopedic injuries are compromising and impairing her ability to perform proper and adequate oral hygiene procedures of brushing and flossing of her teeth and gums. She states she has gained approximately 1 5 lbs since her injury. She is taking Bio relief. SUBJECTIVE COMPLAINTS: Headaches: Occasional, moderate to severe headaches in the temple, forehead, and suboccipital areas bilaterally. Headache pain described as aching. Headaches occurring about 5-10% of the time. Headache intensity of 5-8 on a Visual Analog Scale of 0 to 10. Facial Pain: Occasional, slight to moderate facial pain on the right and left sides. Facial pain described as aching. Facial pain occurring about 5-10% of the time. Facial pain intensity of 4-6 on a Visual Analog Scale of 0 to 10. Facial pain aggravated by eating hard or chewy foods. Facial pain aggravated by prolonged continuous speaking up to 30 minutes. Facial pain interfering with ability to concentrate. Facial pain causing irritability/anger. Temporomandibular Joint. With regards to the TMJ, Ms. Babayan has complaints of: Clicking noises in the right and left temporomandibular joints. Dental: Clenching and grinding her teeth and bracing her facial musculature in response to the industrial related orthopedic pain and resultant emotional stressors. Grinding her teeth at night during sleep. Difficulty in eating hard foods due to facial pain. Difficulty in eating chewy foods due to facial pain. Soreness of teeth upon waking in the morning. Soreness of face/jaw upon waking in the morning. Headaches in temple areas upon waking in the morning. Limited opening of the mouth when compared

to before the injury. Feeling of a dry mouth. Experiencing hoarseness. Feeling her mouth is dry when eating a meal. Need to sip liquids to aid in swallowing dry food. Sleep Disturbances. Feeling fatigued during the day. **DIAGNOSIS OF INDUSTRIAL RELATED CONDITIONS:** After a review of patient's history and clinical examination, the diagnoses are: Aggravated Bruxism I Clenching and Grinding of the Teeth and Bracing of the Facial Muscles of Mastication. Myalgia of the Facial Muscles of Mastication. Trigeminal Nerve Pain I Central Sensitization. Osteoarthritis of the Right and Left TMJs. Aggravated Inflammation of the Gums. **DISCUSSION:** Upon examination, I found patient presents with objective clinical findings of bruxism where patient is clenching and bracing her facial musculature. The objective findings were teeth indentations/scalloping on the lateral borders of the tongue bilaterally as well as bite mark lines on the insides of the cheeks. Patient also presents with wear of the surfaces of her teeth. Upon examination, her facial muscles of mastication, which are involved in bruxism, were found to be painful upon palpation and I objectively palpated taut bands within her facial muscles of mastication. Patient may not have been aware that she had prior episodes of bruxism which can be due to obstructions of the airway during sleep or due to a prior non-industrial habit of bruxism due to extra-pyramidal occurrences in the brain. These preexisting episodes of bruxism can be present and not necessarily cause any facial pain, headaches, or TMJ related pain. However, it is with reasonable medical probability that the industrial exposure which caused patient to have resultant orthopedic pain would have aggravated any preexisting bruxism. The scientific literature has documented that a person can have bruxism in response to pain. Patient reports she finds she is clenching her teeth and bracing her facial musculature in response to her orthopedic pain. The scientific literature has documented that pain can cause psychological distress. The scientific literature has also documented that persistent pain is extremely distressing and psychological problems may become evident if the pain lasts for a continuous period of time. Patient states her resultant facial and jaw pain have caused increased stress and anxiety. It is with reasonable medical probability that the industrial exposure which caused patient to have resultant stress would have aggravated any preexisting bruxism. The scientific literature has documented that a person can have bruxism in response to stress. Patient reports she finds she is clenching her teeth and bracing her facial musculature in response to her stress. As discussed above, the scientific literature has documented that a person can have bruxism of clenching and bracing of the facial muscles of mastication in response to pain as well as in response to stress. Therefore, it is with reasonable medical probability that patient's bruxism was aggravated on an industrial basis. Upon examination, I found patient has Myalgia of her facial muscles of mastication where palpation of the musculature evoked subjective tenderness and there were objective palpable taut bands within the musculature. An EMG, which is approved by the American Dental Association to be used as an aid in the diagnosis of Orofacial Disorders, revealed elevated muscular activity with incoordination and aberrant function of the facial musculature. The standard of care in Dentistry, as published in the Journal of the American Dental Association (143(8) September 2012 and per the AMA Guide Page 331), is that orofacial pain Quantitative Sensory Testing (QST) should be performed to determine whether Trigeminal Nerve Pain has occurred. After performing the standard of care Quantitative Sensory Testing (QST), it was objectively documented that patient facial pain has evolved into Trigeminal Nerve Pain/Central Sensitization neuropathic pain where the testing results revealed objectively-documented trigeminal nerve pain in the V3 branches of the Trigeminal Nerve which innervate the right and left TMJ areas, right and left masseter muscle areas, and right and left temporalis muscle areas. Anatomically, the spinal nerves and cervical nerves enter the brain through the Trigeminal Nucleus. In the Trigeminal Nucleus of the brain, these nerves interconnect and converge with the Trigeminal Nerve. The Trigeminal Nerve innervates the facial muscles of mastication. The scientific literature has documented that if a person has pain in other body parts and/or if a person has stress and/or if a person has developed sleep disturbances, these factors cause a person to develop facial and Temporomandibular Disorders. The scientific literature has documented that under conditions of prolonged and/or intense noxious stimulation of repeated Bruxism, myalgia of the facial masticatory muscles transforms into Trigeminal Neuropathic Pain as a result of central sensitization mechanisms and neuroplasticity, (Journal of the American Dental Association, Vol. 140 pages 1122-1124, September 2009; JADA, Vol. 140, pages 676-678, June 2009). The scientific literature has also documented that stress induces hyperalgesia/Trigeminal Nerve Pain. As will be discussed below, there are many industrial related factors which, with reasonable medical probability, at the very least, have contributed to and aggravated the inflammation of Ms. Babayan's gums. The scientific literature has documented that the inflammatory processes of gum disease cause neuroinflammation of the glial cells in the trigeminal nerve and induce Orofacial Pain and Trigeminal Nerve Pain. The most definitive noninvasive approach in determining objective changes in neural processing and responsiveness within the central nervous system in humans is the use of functional imaging techniques. I recommend patient be referred for a Functional MRI (fMRI) of her thalamus and brain regions

which will help determine the proper long term treatment patient will require for her industrially-caused headaches and facial I TMJ area pain. I also recommend patient be referred for Neurological examination and treatment as necessary on an industrial related basis. Upon examination, found patient has Osteoarthritis within the temporomandibular joints where crepitus sounds were palpated and auscultated within the right and left temporomandibular joints upon movements of the mandible. Crepitus sounds are indicative of bony surfaces rubbing against each other causing osteoarthritic remodeling and degeneration of the joints. An Ultrasonic Doppler Analysis, which is approved by the American Dental Association to be used as an aid in the diagnosis of Orofacial Disorders, verified and confirmed the crepitus within the right and left temporomandibular joints upon translational and lateral movements of the mandible. Upon oral examination, I found patient's periodontal health reveals swelling and recession of the gum tissues, which are objective findings of patient having inflammation of the gums. Even if patient had prior inflammation of the gums due to smoking, prior gastric reflux, and dental neglect, there are numerous industrial related factors that, with reasonable medical probability, at the very least, would be contributing to, aggravating, accelerating and/or lighting up any prior inflammation of the gums. As discussed above, patient states she has industrial related injuries to her shoulders, arms, hands, and fingers. Proper oral hygiene of brushing and flossing of the teeth and gums requires fine hand manipulation and manual dexterity using both hands raised up to the mouth. Given patient's industrial injuries, coupled with her indication that she experiences difficulty brushing and flossing her teeth due to facial pain, it is with reasonable medical probability that patient is not performing proper and adequate oral hygiene. Therefore, with reasonable medical probability, the inflammation of patient's gums has been contributed to by the industrial injury. Evaluation of patient's saliva reveals objective evidence of qualitative changes of the saliva where a tongue depressor sticks to the inside of her cheeks. Stress causes qualitative changes of the saliva. These qualitative changes of the saliva have been documented in the scientific literature to contribute to dental decay and inflammation of the gums. (Position Paper of the American Dental Association's Council of Scientific Affairs. Journal of the American Dental Association, Vol. 134, May 2003) The scientific literature has also documented that inflammation of the gums can be aggravated by stress, increased production of salivary amylase caused by stress and pain, GERD, a loss of sleep, and the body's increased production of cortisol due to pain. The scientific literature has also documented that bruxism aggravates inflammation of the gums. Please Note: As discussed above, the scientific literature has documented that the inflammatory processes of gum disease cause neuroinflammation of the glial cells in the trigeminal nerve and induce Orofacial Pain and Trigeminal Nerve Pain. Therefore, even if the inflammation of patient's gums is not industrial related, patient now requires treatment of her gums to help manage and relieve her facial pain.

DIFFERENTIAL DIAGNOSIS: An examining doctor's opinion for causation must be based on a reliable differential diagnosis formed after taking a history, physical examination, diagnostic tests and, if available, a review of prior medical records. I have considered this for patient. The reader must remember: Treatment is not apportioned.

TEMPORAL CONNECTION BETWEEN INDUSTRIAL EXPOSURE AND THE SUBSEQUENT INJURIES IN MY AREA OF EXPERTISE. In my discussion section above, I discussed how, with reasonable medical probability, the industrial exposure and its resultant orthopedic pain and emotional stressors have developed consequential and derivative injuries for Ms. Babayan in the area of dentistry. Even if patient had these dental problems prior to the industrial exposure, it is with reasonable medical probability that her dental problems were contributed to and aggravated on an industrial basis. While I understand that one of the arguments a person may bring up is latency of when these dental problems started to occur, one has to understand that latency is individual and depends on the intensity of exposure and predilection of the individual.

CONCLUSION: Based on the methodology used by dental physicians in the field of Dentistry, I have: 1) Shown data to support generic causation; 2) Ruled out other well-accepted risk factors in the patient; and 3) Shown a clear temporal relationship between the industrial exposure and trauma, resultant emotional stressors, and the diagnoses presented regarding patient. Based on the available data, the history provided to me by patient, my objective findings, the scientific literature, and my expertise in the field, it is my opinion that, with reasonable medical probability, patient's presenting complaints and clinical symptoms in my area of expertise were caused or aggravated on an industrial basis.

TREATMENT PLAN: Please Note: I researched the ACOEM guidelines, the MTUS guidelines, and the ODG guidelines, where, to the best of my knowledge, none of these guidelines discuss the treatment of inflammation of the gums, treatment with an Orofacial Pain Occlusal Orthotic Device, or treatment with a Nocturnal Orthopedic Repositioning Device for nighttime bruxism. Section 4604. 5(d) of the Labor Code states: "for all injuries not covered by the official utilization schedule adopted pursuant to Section 5307. 27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are recognized generally by the national medical community and scientifically based. The dental specialty of Orofacial

Pain has been established by the American Dental Association, and its specialty association has published standard of care guidelines for the assessment, diagnosis, and management of Orofacial Pain in the following text: Orofacial Pain Guidelines for Assessment, Diagnosis, and Management, Sixth Edition. Leeuw, Reny de, editor. I Klasser, Gary D., editor. American Academy of Orofacial Pain.201 8 Quintessence Publishing Co, Inc. On page 170 it states: "Conservative (ie. reversible), noninvasive treatment such as self-management instructions, behavioral modification, physical therapy, medications, and orthopedic appliances are endorsed for the initial care of nearly all TMDs." Greene CS. Managing the care of patients with temporomandibular disorders: A new guideline for care. J Am Dent Assoc 201 0; 141: 1 086-1 088 On page 1 81 of the Sixth Edition of the Orofacial Pain Guidelines for Assessment, Diagnosis, and Management published by the American Academy of Orofacial Pain, it states: "Orthopedic appliances, including interocclusal splints, orthotics, orthoses, bite guards, bite planes, night guards, or bruxism appliances, are routinely used in the treatment of TMDs. Based on current theory, removable acrylic resin appliances that cover the teeth have traditionally been used to alter occlusal relationships and to redistribute occlusal forces, to prevent wear and mobility of the teeth, to reduce bruxism and parafunction, to treat masticatory muscle pain and dysfunction, to treat painful TMJs, and to alter structural relationships in the TMJ. " Treatment Plan for patient Orofacial Pain Occlusal Orthotic Device for Daytime Use. The primary purpose of the Orofacial Pain Occlusal Orthotic Device is to relieve facial muscle, ligament, and nerve impingement. This appliance serves to maintain the stomatognathic musculature at their proper resting length, from origin to insertion, thus decreasing pain and improving function. The appliance also decreases the inter-capsular joint pressure placed upon the TMJ from clenching and bracing of the facial musculature. The appliance also protects wearing down and fracture of the teeth from the extreme pressures placed on the teeth from bruxism. This appliance is fabricated and customized in our inhouse dental laboratory with a multiple-day process inclusive. of in-person adjustments as necessary. Nocturnal Orthopedic Repositioning Device for Nighttime Use I must treat patient with a daytime Occlusal Orthotic Device for her bruxism and resultant facial pain and/or TMJ Disorder. However, the scientific literature has documented that if a person such as patient wears a regular daytime Occlusal Orthotic Device during sleep, this may cause or increase any underlying obstructions of the airway that may be present which can be dangerous and life threatening. Traditionally, dentists treat bruxism with an oral appliance, generically called a night guard appliance. However, it has been documented that when a regular bruxism night guard appliance is given to a patient to wear during sleep, this appliance can exacerbate nighttime obstructions of the airway. Therefore, the standard of care is that a patient cannot use a daytime bruxism oral appliance while sleeping, day or night. Rather, patients must use an oral sleep appliance such as a mandibular advancement or tongue-retaining appliance during sleep. The oral sleep appliance serves to not only protect from the ill effects of bruxism, but also to bring the mandible and tongue forward, thereby, promoting opening of the airway. H Journal of the California Dental Association, August 2016. Volume 44. No. 8 page 510 Therefore, the standard of care in dentistry is to also fabricate a separate highly specialized and unique Nocturnal Orthopedic Repositioning Device that not only treats bruxism that occurs during the night, but also prevents and/or manages any underlying obstructions of the airway that are present (Journal of the California Dental Association, August 201 6. Volume 44. No. 8 Page 510). This appliance is fabricated and customized in our in-house dental laboratory and is adjusted in person, as needed, over multiple weeks. The reader must understand that the Nocturnal Orthopedic Repositioning Device cannot be used during the daytime because of the inability to speak and function while it is in the mouth. Therefore, patient requires an oral appliance for daytime use as well as a separate oral sleep appliance for nighttime use. Treatments for Inflammation of the Gums Dental treatment of Scaling of the teeth and gums with fluoride and Saliva Substitutes; one time only Craniofacial Exercises Physical Medicine Modalities as needed Full mouth series radiographs Panorex. Radiological Referral for Functional MRI (fMRI) of the Thalamus and Brain. An RFA requesting this MRI will be submitted along with this report. (The benefits of which are discussed in the Chronic Pain Medical Treatment Guidelines, 8 C.C.R. 9792.20-9792.26. Pg. 48 of 127) Internal I Occupational Medicine Consultation and Monitoring Bacteria and inflammatory processes from inflammation of the gums readily enter the bloodstream and have been implicated in an increased risk of heart problems. High blood pressure, high cholesterol, stroke, arthritic conditions, kidney disease and diabetes, as well as a significantly increased risk for the development of cancer throughout the body. Therefore, patient will require monitoring throughout her lifetime with treatment as necessary on an industrial basis. Pulmonologist Evaluation. I recommend patient be referred to an Internal Medicine physician specializing in Pulmonology and/or Sleep Medicine in order to assess her sleep condition and to also determine whether she would benefit from undergoing Polysomnographic Studies to prove/disprove AOE/COE, for diagnosis purposes, to determine any impairments or apportionment (if necessary), and to recommend treatment (as necessary) on an industrial related basis.

Psychiatric/Psychological Examination and Treatment To address patient's complaints of emotional stressors in response to her industrial related facial pain. Trigeminal Neuropathic Facial Pain Examination. Patient objectively presents with industrial related facial musculature problems which this office will treat on an industrial basis. However, as discussed above, patient also presents with Trigeminal Neuropathic components to her facial pain. This facial neuropathic pain component may arise from the scientific findings that continued muscular pain and continued Bruxism, as well as stress, opioid use, and inflammation of the gums induces Trigeminal Nerve Pain/Central Sensitization. Patient requires care that should be provided by a Neurologist with expertise in Trigeminal Neuropathic Facial Pain. Duration of Treatment Frequency of Treatment 3 months 1 time per month. Estimated date of completion of treatment: March 24, 2023. Disability Status in My Area of Expertise. Patient is Temporarily Partially Disabled. Patient has not been discharged. The condition is not Permanent and Stationary. Preclusions/Work Restrictions in my Area of Expertise. Since patient suffers from Myalgia of the facial musculature, activities should be prophylactically restricted so as not to aggravate her musculature. The work restrictions are designed to avoid or prevent undue pain, avoid causing an increase in symptoms that would lead to a longer period of temporary disability, avoid causing increased permanent disability, and prevent exacerbation that would increase the need for medical care.

6. **SPORTS NEUROLOGY AND PAIN MANAGEMENT:** Dated 02/21/2023, signed by Williams, Vernon Brian, MD, Chief Complaint: Lumbar spine pain, bilateral shoulder pain. History of Present Illness: Patient is a 66-year-old female who presents today for lumbar spine pain, bilateral shoulder pain which began 4/14/2022 following a fall. It is rated as 8/10 and described as aching, shooting and incapacitating and is associated with morning stiffness. The pain is better with rest, special positioning, heat and physical therapy. Associated symptoms include locking, giving way, fatigue, tingling and radiating pain to the hands. Assessment: Lumbar pain. lumbar spondylosis. Lumbar facet arthropathy. Work related injury. Plan: Treatment goals: Reduce subjective pain intensity. Reduce/eliminate the use of ongoing health care services for primary pain complaint, and reduce the misuse, overuse, or dependency on medications (defined as the continuous use of therapeutic levels of opioids or sedative/hypnotics, or other pain medications, above the maximum recommended dose or duration, and physical or psychological dependency). Reduce the use of invasive medical procedures. Diagnostic workup: HRV, JTtech exam. Pain treatments: RFA for lumbar facet/MBBs at bilateral L4-5 and LS-S1, RFA for lumbar physical therapy with massage. We have provided prolonged education regarding home exercise program followed by demonstration and observation of therapeutic exercises and performance space. Patient was provided with digital examples of a curated program using Medbridge platform. Email: rimababayian@icloud.com; Access code: 629VL T3G. Patient education: Discussed information on body mechanics, chronic pain, disease management, low back pain, treatment goals. Questions were encouraged to stated satisfaction from the patient. Discussion: Rima Babayan is a 66-year-old female who presents to clinic today for evaluation and treatment options related to symptoms complaints. The patient has a work-related injury to her lumbar spine in 4/2022 after a slip and fall. She did have some radicular symptoms last year, but currently and over the past few months her low back symptoms have been almost exclusively axial Left>Right with some referred pain into the glutes at times. She had some PT last year with some benefit. I have personally reviewed the MRI of her lumbar spine and discussed it in detail with the patient; it does reveal multi-level facet arthropathy from L2 through S1. At this point I recommend: HRV. RFA for lumbar facet/MBBs at bilateral L4-5 and L5-S1. RFA for lumbar PT with massage. Medbridge HEP. We have provided prolonged education regarding home exercise program followed by demonstration and observation of therapeutic exercises and performance space. Patient was provided with digital examples of a curated program using Medbridge platform. Email: rimababayian@icloud.com; Access code: 629VL T3G. Follow up for JTtech exam. The patient may be a candidate for lumbar medial branch rhizotomy, SPRINT PNS. Of note, the patient had a question about the MRI, specifically reference to "heterogeneous marrow signal diffusely ... Pathologic process cannot basically without oncologic workup." Regarding this, we are deferring to her PTP as this is not related to the work injury, we are evaluating her for. VISIT DIAGNOSES: Primary lumbar pain. Lumbar spondylosis. Lumbar facet arthropathy. Work related injury.

7. **PERMANENT AND STATIONARY REPORT IN THE FIELD OF DENTISTRY BY MEANS OF TELEHEALTH:** Dated 04/25/2023, signed by David Schames, DDS. History of Present Illness: The following is a Permanent and Stationary Discharge report in my area of expertise, for patient who was evaluated and treated at our office for injuries sustained on the date(s) indicated above. Please refer to our initial report detailing the history and

physical findings, as well as the treatment program instituted. Patient was reevaluated via audio-only telehealth conference on April 14, 2022. Permission was obtained from patient for this telehealth session. Patient states she received 50% subjective overall improvement in my area of expertise, with our treatment, with regard to her facial and jaw complaint. Patient complains she continues to experience bruxism in response to her orthopedic pain and also in response to her industrial related stressors, where she is clenching/grinding her teeth and bracing her facial musculature during the day and night. At the time of our initial in-person examination, this was clinically objectively confirmed with findings of teeth indentations/scalloping of the lateral borders of the tongue bilaterally as well as bite mark lines/buccal mucosa I ridging of the insides of her cheeks bilaterally. There was wear on the surfaces of patient's teeth. Patient finds she has occasional minimal pain in her right and left facial areas. There was capsulitis found in her right and left temporomandibular joints during our initial examination. Ultrasonic Doppler Analysis performed during our initial examination verified and confirmed crepitus of the right and left temporomandibular joints upon translational and lateral movements of the mandible. At our initial in person examination, there were objectively palpated taut bands in patient's facial musculature. As EMG, which is approved by the American Dental Association to be used as an aid in the diagnosis of temporomandibular disorders, was performed at the time of the nital examination and revealed elevated muscular activity with incoordination and aberrant function of her facial musculature. Temperature Gradient Studies performed at the time of the initial examination revealed abnormal temperature readings comparing one side of her facial musculature to the other side. Quantitative Sensory Testing administered during the initial examination revealed Trigeminal Nerve Pain in the branches of patient's trigeminal nerve that innervates her right and left TMJ areas and right masseter muscle area. The sphenopalatine ganglion is a branch of the Trigeminal Nerve with the closest proximity to the Trigeminal Nerve as it exits from the brain. Anesthetizing the sphenopalatine ganglion is a direct and accessible way to block the Trigeminal Nerve. Diagnostic sphenopalatine ganglion blocks were performed and it was further documented that patient's pain is definitely Trigeminal Nerve Pain. the scientific literature has documented that under conditions of prolonged and/or intense noxious stimulation of repeated bruxism, myalgia of the facial masticatory muscles transforms into Trigeminal Neuropathic Pain as a result of central sensitization mechanisms and neuroplasticity. The scientific literature has also documented that stress induces hyperalgesia/ Trigeminal Nerve Pain. The scientific literature has also documented that the inflammatory processes of gum disease cause neuroinflammation of the glial cells in the trigeminal nerve and induce Trigeminal Nerve Pain. Patient presented during the initial in-person examination with objective findings of inflammation of her gums as determined by objectively documented swelling and recession of the gum tissues and objectively documented bacterial Biofilm deposits on the teeth and around the gums. Inflammation of the gums is due to bacteria producing inflammation and toxins under the gums which inflame and infect the gum tissues. Even if patient had prior inflammation of the gums due to preexistent smoking and dental neglect, there are numerous industrial related factors that, with reasonable medical probability, at the very least, would be contributing to, aggravating, accelerating, and/or lighting up any prior inflammation of the gums. Patient states she had industrial related injuries to her shoulders, arms, hands, and fingers. Proper oral hygiene of brushing and flossing of the teeth and gums requires fine hand manipulation and manual dexterity using both hands raised up to the mouth. Given patient's industrial injuries, coupled with her indication that she also experiences difficulties brushing and flossing her teeth due to her facial pain in, it is with reasonable medical probability, that patient is not performing proper and adequate oral hygiene. Therefore, with reasonable medical probability, patient's inflammation of the gums has been contributed to by the industrial injury. Evaluation of the saliva during initial evaluation in our office revealed objective evidence of qualitative changes of patient's saliva. Stress causes qualitative changes of the saliva. These qualitative changes of the saliva have been documented in the scientific literature to contribute to dental decay and inflammation of the gums. (Position Paper of the American Dental Association's Council of Scientific Affairs. Journal of the American Dental Association, Vol. 134, May 2003) The scientific literature has also documented that inflammation of the gums can be aggravated by stress, a loss of sleep, and the body's increased production of cortisol due to pain. The scientific literature has also documented that bruxism aggravates inflammation of the gums. Please Note: As discussed above, the scientific literature has documented that the inflammatory processes of gum disease cause neuroinflammation of the glial cells in the trigeminal nerve and induce Orofacial Pain and Trigeminal Nerve Pain. Therefore, even if the inflammation of patient's gums is not industrial related, patient now requires gum treatments to manage and relieve her industrially-aggravated facial pain. **SUBJECTIVE COMPLAINTS:** At the time of this discharge on April 14, 2022, patient had subjective complaints in my area of expertise of: Clenching of the facial musculature in response to orthopedic pain and resultant emotional stressors. Occasional minimal headaches in the

temple, forehead, and suboccipital areas. Occasional minimal right facial area pain. Occasional minimal left facial area pain. Facial pain aggravated by eating hard or chewy foods. Facial pain interferes with ability to concentrate. Facial pain causes irritability. Facial pain upon yawning, bilaterally. Headaches in temple areas upon waking in the morning. Dry mouth. Hoarseness. Amount of saliva in her mouth seems to be too little. Bleeding gums. Speech impairments of hoarseness. Cold temperatures and environments such as air-conditioning causing an increase in facial pain. **DIAGNOSIS OF INDUSTRIAL RELATED CONDITIONS:** As discussed in my initial report and after a review of patient's history, and clinical examination, and a review of medical records, patient has the following conditions in my area of expertise on an industrial basis: Aggravated Bruxism I Clenching and Grinding of the Teeth and Bracing of the Facial Muscles of Mastication. Myalgia of the Facial Muscles of Mastication. Trigeminal Nerve Pain I Central Sensitization. Osteoarthritis of the Right and Left TMJs. Aggravated Inflammation of the Gums. **DISABILITY STATUS:** Based on patient's subjective complaints, our objective findings, and according to the Work Capacity as set forth by the Workers' Compensation Appeals Board, I feel patient has reached a plateau and is considered Permanent and Stationary in my area of expertise from a pain perspective, but still requires treatment on an industrial basis. **IMPAIRMENTS PER THE AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, 5TH EDITION MASTICATION and DEGLUTITION IMPAIRMENT Section 11.4b.** Patient has occasional minimal facial muscle pain on the right and left sides of her face due to chronic bruxism of clenching and grinding of the teeth as well as clenching, grimacing and bracing her facial muscles in response to her industrial orthopedic pain and emotional stressors. The anti-depressant medication she is taking on an industrial basis also has a side effect of increasing bruxism. Patient indicates her facial muscle pain and TMJ pain is increased by 20% upon chewing and as such she has difficulty eating hard and chewy foods. Mastication of harder or chewy foods is restricted for patient because it causes an increase in her facial pain. patient has resultant dietary restrictions where her diet is limited towards semi-solid or soft foods. Per the AMA Guides to the Evaluation of Permanent Impairment Fifth Edition page 262. Patient has a 5% impairment of the whole person. **TRIGEMINAL NERVE/CRANIAL NERVE IMPAIRMENT Section 13.4 d.** The Trigeminal Nerve is Cranial Nerve V which comes directly from the brain and innervates the teeth, facial muscles of mastication (the chewing muscles), the oral cavity, and the tongue. Since the Trigeminal Nerve innervates all of the areas involved in dentistry, the Dentist is the expert of the Trigeminal Nerve. A dentist even performs surgery on the Trigeminal Nerve when performing a root canal. Trigeminal Nerve Pain arises from chronic prolonged facial muscular pain which transforms into centrally sensitized Trigeminal Nerve Pain as well as the scientific findings that repeated heavy clenching can convert into Trigeminal Nerve Pain. "Under conditions of prolonged and/or intense noxious stimulation (for example, repeated heavy parafunctional clenching or a heavy blow to the temporalis muscle) some of the ineffective synapses can become effective connections as a result of central sensitization mechanisms and neuroplasticity" (Journal of the American Dental Association, Vol. 140 pages 1122-1124, September 2009; JADA, Vol. 140, pages 676-678, June 2009; Current Concepts on Temporomandibular Disorders, Manfredini D., pages 61-85, Quintessence Publishing Co. 2010). The scientific literature has also documented that stress induces hyperalgesia I Trigeminal Nerve Pain. The scientific literature has also documented that the inflammatory processes of gum disease cause neuroinflammation of the glial cells in the trigeminal nerve and induce Trigeminal Nerve Pain. The AMA Guide discusses on page 331 that evaluation of the Trigeminal Nerve must be performed with Quantitative Sensory Testing (QST) by testing for pain, temperature, and touch. This is the standard of care for a dentist to perform, as published in the Journal of the American Dental Association (JADA 143(8). August 2012). Upon performing QST testing, it was documented that Ms. Babayan's facial pain has definitely transformed into Trigeminal Nerve Pain in that she described her pain as sharp. The sphenopalatine ganglion is a branch of the Trigeminal Nerve with the closest proximity to the Trigeminal Nerve as it exits from the brain. Anesthetizing the sphenopalatine ganglion is a direct and accessible way to block the Trigeminal Nerve. Diagnostic Sphenopalatine Ganglion Blocks were performed and it was further documented that patient's pain is definitely Trigeminal Nerve Pain. Patient has a mild uncontrolled Trigeminal Nerve Pain which may interfere in the Activities of Daily Living of eating and talking. Per the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, page 331, patient has a 7% impairment of the whole person. **WORK RESTRICTIONS:** Since patient suffers from Myalgia of the facial musculature, activities should be prophylactically restricted so as not to aggravate the musculature. These activities include: cradling a phone between the facial, neck, and shoulder musculature; avoidance of extensive talking of 20 minutes straight without taking a 10 minute rest; an improper posture due to a non-ergonomically designed environment; and comparable physical activities. Patient must also be restricted in the open labor market from cold temperatures and environments such as refrigeration coolers and direct drafts of air-conditioning, as this will increase

the Myalgia and Trigeminal Nerve Pain. Since patient is clenching/grinding her teeth and bracing her facial musculature, restrictions involving emotional stress must be given consideration. This restriction contemplates the individual avoiding undue emotional stress and strain. APPORTIONMENT: It is my opinion, based on the available evidence presented to me, the history related to me by patient, my examination findings, and diagnostic testing that, with reasonable medical probability, patient's impairments in my area of expertise are 100% related to the industrial injury. Patient was involved in a specific injury on 4/14/22 as well as Cumulative Trauma injuries from CT 9/3/19 through 4/18/22. Per the Benson decision, I am required to try to break down patient's impairments in my area of expertise to the different dates of injury. However, I cannot apportion patient's impairments in my area of expertise because her impairments in my area of expertise are inextricably intertwined. FUTURE MEDICAL CARE: Inflammation of the Gums/Treatments: Patient will require any dental treatment that has arisen, or may arise in the future, as a consequence of the Xerostomia, acidic salivary environment, or for the destructive consequences of her Bruxism. Internal/Occupational Medicine Consultation and Monitoring: Bacteria and inflammatory processes from inflammation of the gums readily enter the bloodstream and have been implicated in an increased risk of heart problems, high blood pressure, high cholesterol, stroke, arthritic conditions, kidney disease, and diabetes, as well as a significantly increased risk for the development of cancer throughout the body. Therefore, patient will require monitoring throughout her lifetime with treatment as necessary on an industrial basis. Pulmonologist Evaluation: I recommend that patient be referred to an Internal Medicine physician specializing in Pulmonology and/or Sleep Medicine in order to assess whether she would benefit from undergoing Polysomnographic Studies, to prove/disprove AOE/COE, for diagnosis purposes, to determine apportionment if necessary, and to recommend treatment as necessary on an industrial related basis. Psychological/Psychiatric Evaluation: Patient presents with a need for Psychological/Psychiatric examination and treatment as necessary on an industrial basis. Orofacial Pain/Occlusal Orthotic Device for Daytime Use: Patient was instructed to continue wearing an Occlusal Orthotic Device indefinitely due to her facial myalgia and bruxism. This appliance will require replacement as needed throughout her lifetime on an industrial related basis. Nocturnal Orthopedic Repositioning Device for Nighttime Use: Patient was instructed to continue wearing a Nocturnal Orthopedic Repositioning Device indefinitely due to her sleep bruxism. This appliance will require replacement as needed throughout her lifetime on an industrial related basis. Continued Palliative Care: In the event of future exacerbation of patient's injuries, she may require additional physical medicine modalities and therapy until the condition resolves.

8. **OFFICE VISIT:** Dated 09/14/2023, signed by Elliot Bright, PA-C & Babak Samimi, M.D. History of Present Illness: 9/13/23: The patient presents for follow up evaluation and reports mild relief of her BI LATERAL knees with the Supartz injections #3 provided on 8/3/23. She had a new QME supplemental report which was made available for review today. She is still pending appointment with pain management specialist. 8/3/23: The patient presents for follow up evaluation and would like to proceed with Supartz injection #3 for BI LATERAL knees. She had Supartz Injection # 2 for BILATERAL knees on 7/28/23 and reports mild improvement so far. 7/28/23: The patient returns for reevaluation and bilateral knee Supartz #2. She would like to also go over the left shoulder MRI. 7/20/23: The patient presents for follow-up evaluation and was approved for BILATERAL Knee Supartz injections and would like to proceed with the BILATERAL Knee Supartz #1 today due to persistent symptoms in her BILATERAL knees. She also complains of persistent symptoms in her RIGHT shoulder and BI LATERAL upper extremities. She was denied with physical therapy request for her BI LATERAL shoulders but approved for chiropractic care and Supartz injections. 6/1/23: The patient presents for follow-up evaluation and reports persistent symptoms in her BILATERAL shoulders, BILATERAL knee, and back, as well as her BILATERAL hand and wrist. She has obtained an EMG/Nerve Conduction Study, which was ordered and recommended by a QME. The request for physical therapy for her RIGHT shoulder was denied but for the LEFT shoulder is still pending. She did have the dental evaluation, which has been pending for some time. Pt c/o numbness and tingling with pain in the BILATERAL thumb, index and middle fingers. Numbness and tingling is worse w/repetitive activity. Pt awakens at night with "hand asleep" and has to shake it off. Certain activities such as driving and holding the steering wheel for a prolonged period of time cause worsening of the symptoms. 4/18/23: The patient presents for follow-up evaluation and reports persistent pain in her bilateral shoulders, bilateral knees, and back. She has been obtained LEFT shoulder MRI and has been scheduled for bilateral upper extremity EMG/NCS. She has been authorized for evaluation but not treatment of the LEFT shoulder. She has been following up with a pain management specialist. 3/2/23: The patient presents for follow up evaluation and had a recent QME visit. She reports persistent pain in her BILATERAL shoulders and BI

LATERAL knees. 1/24/23: Telemedicine Visit due to the patient suffering from current covid 19 infection. She feels moderate improvement with the bilateral knee durolane injections provided on 12/16/22; however, she still has some symptoms. She also co persistent Right shoulder symptoms. The patient returns for follow-up evaluation. She continues to have persistent bilateral knee symptoms. The previously discussed. Durolane injections were approved. Sensation is intact to light touch to the lateral, medial, dorsal and plantar aspects of the foot. EHL, TA, GS intact. Right Shoulder: Large Rotator Cuff Tear with severe atrophy. Early Degenerative joint Disease (aggravation). Left Shoulder (Not accepted industrial). Partial-Thickness Rotator Cuff Tear. AC Joint Arthrosis. Shoulder Impingement Syndrome with Tendonitis/Bursitis. Bilateral Hand (pending authorization). Carpal Tunnel Syndrome. Lumbar Spine: Multi-level Disc Herniations. Lumbar Radiculitis. Bilateral Knee: Moderate Degenerative joint Disease (aggravation). Outside x-rays of the Left Shoulder 4/7/22. Mild degenerative changes about the left shoulder. Outside x-rays of the Right Knee 4n/22. Medial compartment osteoarthritis with a small to moderate size joint effusion. Quadriceps tendon enthesopathy. UMI MRI of the Left Shoulder 4/7/22. Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial-thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis with adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis. My Interpretation: Moderate AC joint arthrosis. There is mild fatty atrophy of the supraspinatus tendon. There is a partial thickness tear at the footprint of the supraspinatus with reactive bony edema of the greater tuberosity. Outside Left Knee Series 4/18/22. There is mild generalized osteopenia. There is no evidence of acute fracture present. There is no evidence of acute fracture or dislocation. The alignment is intact. There are osteoarthritic changes of the medial and patellofemoral compartments of the knee present. Outside Right Shoulder Series 4/28/22. No evidence of fracture or dislocation. UMI MRI of the Right Shoulder 5/17/22. Full-thickness supraspinatus tendon tear with retraction by 10 mm and has mild muscle bulk/fatty atrophy. Adjacent infraspinatus and subscapularis tendinosis. High-grade partial-thickness long head of the biceps tendon tear and retraction. Mild to moderate acromioclavicular joint arthrosis with adjacent subacromial/subdeltoid bursitis. UMI MRI of the Left Knee 5/19/22. Peripheral extrusion of the medial meniscus from the joint line as well as heterogeneous signal at the anterior horn/body junction. A complex degenerative tear cannot be excluded at this site without postcontrast imaging. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment. Subchondral edema versus bone contusion of the lateral femoral condyle posterior nonweightbearing aspect. Small to moderate size joint effusion. Quadriceps tendon enthesopathy. UMI MRI of the Lumbar Spine 5/23/2. Mild to moderate disc desiccation of L4-L5 with a 3.5 mm broad-based disc protrusion and facet arthrosis causing mild central canal and neural foraminal stenosis bilaterally. Mild disc desiccation of LS-51 with a 2 mm broad-based disc protrusion asymmetric to the right with facet arthrosis and an 8 mm complex synovial cyst in the right neural foramen causing mild central canal stenosis as well as moderate right-sided and mild to moderate left-sided neural foraminal stenosis. Less significant findings at the remainder of the disc levels as described above. Heterogeneous marrow signal diffusely which is nonspecific but may represent osteopenia Pathologic process cannot basically without oncologic workup. UMI MRI of the Left Shoulder 5/24/22. Supraspinatus and infraspinatus tendinosis with a persistent 3.5 mm partial-thickness supraspinatus footprint tear without retraction or associated muscle bulk atrophy. Mild acromioclavicular joint arthrosis with adjacent subacromial/subdeltoid bursitis. Addendum: Please add to the findings and impression regarding the 3.5 mm supraspinatus tendon tear. The difference in measurement is minimal and can be related to technique. These findings are likely stable when compared to the prior exam given the inherent difference in technique. However, interval scarring may also demonstrate similar findings. Clinical correlation with symptoms is recommended. UMI MRI of the Right Knee 5/24/22. Peripheral extrusion of the medial meniscus from the joint line without a definite tear. Intrasubstance generation of the lateral meniscus at the body without a definite tear. MR arthrogram may be performed for further evaluation/characterization if clinical concern persists. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment. Quadriceps tendon enthesopathy. Mild prepatellar bursitis. My Interpretation: Moderate tricompartmental degenerative joint disease. QME Dr Sharona Drake DC 1/17/23: 67page report reviewed. States the Left shoulder should be authorized as a compensatory injury and evaluated. Also recommended were bilateral upper extremity EMG/NCS, psychiatry and dental evaluations. Westwood Open MRI scan of the Left Shoulder dated 4/18/23: Demonstrates a focal full-thickness tear involving the posterior fibers of the supraspinatus footprint on a background of mild tendinosis. Mild infraspinatus tendinosis with interstitial tears and foci myotendinous delamination. Mild subscapularis tendinosis. No evidence of fatty muscle atrophy. Mild acromioclavicular joint arthrosis. Moderate glenohumeral chondral thinning. Mild diffuse labral degeneration. Large fluid in the subcoracoid bursa. My Interpretation: There is a large full-thickness tear of the supraspinatus tendon. There is moderate flu id in

the subacromial space. EMG of the BILATERAL Upper Extremities dated 5/15/2023: Electrodiagnostic evidence of moderate RIGHT and LEFT carpal tunnel syndrome (median neuropathy at the wrist) affecting both sensory and motor fibers; right side is more affected than left. Clinical correlation is recommended. There is no electrodiagnostic evidence of any other mononeuropathy, peripheral neuropathy or entrapment neuropathy in either upper extremity. Electromyography of the bilateral upper extremities and cervical paraspinal muscles is without active or chronic denervation potentials to suggest a motor cervical radiculopathy, plexopathy or myopathic process. Please note that a negative electromyographic study does not completely rule out a possibility of a nerve involvement, clinical correlation is recommended. Plan: RIGHT SHOULDER: I had a lengthy conversation with the patient regarding treatment options, risks, and benefits. Patient expressed understanding. Ultimately, she is a candidate for a reverse total shoulder replacement. Informed Consent: All risks, benefits, and alternatives discussed at length with the pt and available family members. Risks including but not limited to death, chronic pain, infection, bleeding, blood clots, damage to surrounding tissues, worse function, implant failure or loosening, and need for further surgery. No guarantees were given or implied. All questions were answered. The patient is not a surgical candidate due to her BMI. Elevated BMI: Counseled the patient on the risks of high BMI and the importance of losing weight. A combination of proper diet and regular exercise was recommended. LEFT SHOULDER: Now recommended for evaluation and treatment by PQME on 1/17/23 AND 7/6/23 Sharon Drake DC. The patient has not had any physical therapy for the LEFT shoulder. REQUEST 12 sessions Physical Therapy: ROM, Strengthening, Stretching, Modalities. Recommend Left Shoulder Arthroscopy, Glenohumeral Debridement, Synovectomy, Subacromial Decompression, Distal Clavicle Excision, Rotator Cuff Repair, possible Biceps Tenodesis and surgery as indicated. The patient is not a surgical candidate due to her BMI. Elevated BMI: Counseled the patient on the risks of high BMI and the importance of losing weight. A combination of proper diet and regular exercise was recommended. BILATERAL HAND: Activity Modification. NSAIDs as needed and tolerated. (Pending) REQUEST DME dispensed bilateral wrist braces which are to be worn overnight at night x6 weeks. I had a lengthy conversation with the patient regarding treatment options, risks, and benefits. Patient expressed understanding. LUMBAR SPINE: Activity Modification. Apply Heat. Gentle Massage. NSAIDs. Continue Physical Therapy: Referral for a course of physical therapy for Lumbar ROM, Strengthening, Stretching, Pelvic Stabilization, Core, Modalities (massage, gentle manipulation, heat, ice, electric stimulation, ionophoresis, ultrasound, etc.). REQUEST Pain Management Specialist for evaluation and treatment including Lumbar Epidural Injection, Facet Block Injection vs other injections. BILATERAL KNEE: Activity Modification. Ultimately, Recommend Bilateral Total Knee Replacement Surgery: Pt has severe degenerative joint disease (arthritis) confirmed by x-ray and clinical exam and has failed conservative treatment including NSAIDs, RICE, Activity Modification, PT, and Steroid Injections. I recommend total knee replacement surgery to allow for improved pain and function. However, I recommend weight loss prior to considering surgery. Informed Consent: All risks, benefits, and alternatives discussed at length with the pt and available family members. Risks including but not limited to death, chronic pain, infection, bleeding, blood clots, damage to surrounding tissues, worse function, implant failure or loosening, and need for further surgery. No guarantees were given or implied. All questions were answered. The patient would like to continue with conservative measures while considering treatment options. Elevated BMI: Counseled the patient on the risks of high BMI and the importance of losing weight. A combination of proper diet and regular exercise was recommended. REQUEST Evaluation and Treatment with Dietician for weight loss. REQUEST Evaluation and Treatment with Internal medicine provider for weight loss. Per PQME: Request Psychiatry evaluation. REQUEST Dental evaluation. Work Status: TTD. Follow-up in 6 weeks.

9. **PANEL QUALIFIED MEDICAL EVALUATION WITH REVIEW OF MEDICAL RECORDS;** Dated 09/21/2023, signed by Babak Abrishami, DDS. HISTORY OF INJURY: Patient is a 67-year-old, right-handed female with a stated height of 5' 6" and a stated weight of 244 lbs. She was employed as an advanced planner by Forest Lawn Memorial Park. The applicant alleges suffering cumulative trauma from 09/03/2019 to 04/18/2022. She attributed her injuries to the nature of her job, as she was required to do physical activities while performing her usual and customary job duties. On 04/14/2022, the patient stated that she was meeting with a client, looking at properties at the park, when she slipped and fell over a muddy patch on the sloppy area of the park. She lost her balance and went down the slope a few steps. She tried to steady herself by pushing her feet on the ground but in doing so, she twisted her knees and ankles. She fell backwards, slamming on her bottom, back, and shoulders. The incident was witnessed by the client and was also reported accordingly. She was advised to go to the clinic. She felt pain in her back and left shoulder the

day after the incident. She stated that she sought medical advice four or five days later at ProHealth in Glendale, where she met Dr. Raffi Kazazian. An x-ray of her left knee and shoulder were taken. An MRI of her right knee, right shoulder, and back were taken in May 2022 at United Imaging revealing a complete rotator cuff tear in her shoulders, bicep retraction, right knee ACL tear, and L4 and LS issues to her back. She reported that she received physical therapy, massages, TENS, and ultrasound of her back, shoulders, and knees. The physical therapy helped a lot according to the patient. She was taken off work and she was not able to return to work because she lacked the capacity to lift 25-lbs objects, which was a requirement for her role as advanced planner. According to the patient, her attorney referred her to Dr. Babak Samimi at Samimi Orthopedic Group in Wilshire, who gave her injections to her knees due to painful burning sensation. The patient stated that her shoulders still hurt but a warm shower really helps to alleviate the pain. Last month, she received three injections to each knee, once a week. Recommended future treatments for the patient include right reverse shoulder surgery, left shoulder arthroscopic surgery, and complete replacement of both knees. The patient stated that approximately in July 2022, she started having jaw and myofascial pain and spasm, felt pressure on her jaw with tiredness, and woke up with headaches. She was seen by a dentist, Dr. Schames, in December 2022. She was evaluated for her jaw complaints. She was provided with two mouth guards. She started using only one of her mouth guards and experienced 20-30% improvement in three to four months and reached a plateau around 04/01/2023.

JOB DESCRIPTION: The patient worked as an advanced planner. She worked eight hours a day, six days a week. Her job duties involved making arrangements for families that were interested in pre-planning for their burial, meeting with the families, servicing them, generating leads through phone calls, door knocking, doing tabletops, kiosks at appropriate places such as shopping malls, following up on the leads, and park duties.

CURRENT WORK STATUS: The patient is currently not working. Her last day of work was on 04/18/2022.

CURRENT DENTAL COMPLAINTS: The patient reported clenching and grinding her teeth and bracing her facial musculature in response to the industrial related pain. She reported clicking and popping noises in the right and left temporomandibular joints. She experienced constant dry mouth. The patient complains of mild to moderate headaches in frontal and temporalis areas once a week that lasts for four hours. She reported jaw tiredness after speaking for 30-45 minutes and she needed to take a break. The patient stated that she has mild to moderate pain in her jaw and face 10% of the time. In the morning, when she wakes up, she has a feeling of pressure and tiredness of the teeth and jaw after wearing a night guard. She has been diagnosed with teeth grinding by Dr. Arakelian in Woodland Hills in 2018. He provided a night guard for her for the upper teeth. She also saw Dr. Maher Nakoud in Granada Hills, who did filling for her front tooth, and he provided her with a lower night guard in 2019. She found out that she was grinding her teeth more after her fall, because all the enamel of her four front teeth got worn down from all the grinding. It was recommended in July 2022 by Dr. Gogan that she should get caps placed on her teeth after she has received Invisalign. She was seen by Dr. Waliki in April 2023. Few restorations were done and Invisalign was recommended. She stated that she gets up in the morning with a feeling of sensitivity to her teeth after the grinding and clenching the night before. She also reported that she has daytime clenching. She complains of having dietary restrictions of avoiding mastication of certain foods that require prolonged chewing or opening wide, or hard or chewy foods such as carrots, nuts, raw vegetables, and hard meat because she has jaw pain and a chipped front tooth, and she is worried she might chip more teeth if she eats hard food. She cuts her food into smaller pieces. The patient additionally reported that she has sleep apnea, and she snores according to her brother. She can get an average of six to eight hours of sleep. She wakes up two times a night with a pain.

OTHER COMPLAINTS: The patient complains of mild to moderate back pain 30% of the time. The patient complains of constant bilateral shoulder pain, more on the left side. Her pain radiates to her arm on the left side, and she has spasm on the right side. The patient complains of constant mild to moderate bilateral knee pain and burning sensation. She denies having any psyche issues such as stress and anxiety.

DIAGNOSES: Tylenol. Macro b.i.d. 100 mg. Bruxism/parafunctional habit (clenching and grinding of teeth secondary to pain and stress). Right and left temporomandibular joint derangement. Mild myofascial pain. Mild capsulitis of the right temporomandibular joint: Inflammation of the right temporomandibular joint.

DISCUSSION: She demonstrated clearly having bruxism, right and left temporomandibular joint derangement, capsulitis of the right temporomandibular joint, and myofascial pain. Objective findings such as clicking and popping of the right and left temporomandibular joints during opening and closing functions of the mandible, facial and masticatory muscle pain upon palpation with objective trigger points and/or taut bands, occlusal/incisal wear, abfraction lesions, and jaw deviation during opening and closing functions of the mandible support these diagnoses. She sustained industrial injuries on 04/14/2022 and CT 09/03/2019-04/18/2022, which resulted in orthopedic pain and stress. People who have pain and stress tend to clench their teeth together which in turn can cause TMJ and myofascial pain and other issues

in the TMJ structure, such as TMJ derangement and slipped disc causing clicking and popping of the TMJ. Clenching and grinding over time also affects the TMJ and inflammation in the muscles of mastication and can cause changes in the temporomandibular joints. Some people hold tension in their mouths and muscles of mastication. This can go on all their lives without any problem. Also, some people's jaws click and pop without any bad effects. However, in some instances when there is orthopedic pain in the other areas of the body and stress, the person will clench and grind more aggressively and more frequently which places more load on the TMJ and myofascial muscles that could result in TMJ problems, and facial and masticatory muscle pain. This process usually takes months or years, depending on severity of the patient's bruxism before it becomes symptomatic. According to the medical records dated 05/05/2006, intake forms by Michael Spearman; she had difficulty chewing/clicking jaw, headaches, and dental problems. She was also provided with night guards starting in 2018 by her dentists. She has a history of bruxism dating back many years ago that had been somewhat asymptomatic. It is reasonable medical probability that she has been clenching and grinding for many years prior to her industrial injuries of 04/14/2022 and CT 09/03/2019-04/18/2022. I believe that she had been asymptomatic because she had mild bruxism in the past. However, as a result of her industrial injuries of 04/14/2022 and CT 09/03/2019-04/18/2022, she started to clench and grind more aggressively and more frequently. As a result of that, she became more symptomatic after her industrial injuries of 04/14/2022 and CT 09/03/2019-04/18/2022. She has been using a mouth guard, therefore her condition improved, and her symptoms are now very mild. I believe that as long as she continues using her mouth guard, her symptoms will remain the same. The patient stated that approximately in July 2022, she started having jaw and myofascial pain and spasm, felt pressure on her jaw with tiredness, and woke up with headaches. She was seen by a dentist, Dr. Schames, in December 2022. She was evaluated for her jaw complaints. She was provided with two mouth guards. She started using only one of her mouth guards and experienced 20-30% improvement in three to four months and reached a plateau around 04/01/2023. She is still using her mouth guard. I was being asked to disclose whether I have any professional or personal relationship with the Dental Trauma Center, Dr. Schames. I have never had and now do not have any professional or personal relationship with the Dental Trauma Center, Dr. Schames, and his staff. If I am provided with any other dental records or x-rays, or any other medical records, I will be able to review them and inform the parties if they alter any of my opinions and conclusions. After obtaining the history from and conducting examination of this patient, it would appear that the patient had incurred dental/TMJ problems as a consequence of her industrial injuries. The patient's subjective complaints are supported by my objective findings. My objective dental findings are consistent with the mechanism of her injuries.

PERMANENT AND STATIONARY STATUS: The applicant has reached permanent and stationary and MMI status from a dental, temporomandibular joint and orofacial pain perspective approximately three to four months after she was being provided with a mouth guard and her condition reached a plateau, which was on 04/01/2023.

IMPAIRMENT RATING AND RATIONALE (ORGAN SYSTEM AND WHOLE PERSON IMPAIRMENT): Pursuant to SB889, and Labor Code 4660 (b) (1), percentages of Permanent Disability shall be determined by evaluating nature of the physical injury or disfigurement, and examiner shall incorporate the description and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) Guidelines to the Evaluation of Permanent Impairment (Fifth Ed.). To accomplish this goal, the following is my summary of this patient's whole person impairment rating and rationale as it relates to the jaw/TMJ. Calculated total whole person impairment solely as it relates to the jaw/facial area is 3%. This whole person impairment rating is solely related to the jaw/TMJ area/face and is based upon the Combined Values Chart published in the 5th Edition of the AMA Guide to the Evaluation of Permanent Impairment, pages 604-605. Please defer to the primary treating physician or trier of fact to incorporate this percentage into his overall impairment rating as applicable.

DISCUSSION OF RA TIO NALE FOR IMPAIRMENT RA TING:

- a) **Mastication and Deglutition Rationale:** Mastication and Deglutition Rationale: The patient was given a 3% impairment rating regarding dietary restrictions involving mastication of food due to degenerative changes (clicking and popping) in the right and left temporomandibular joints and myofascial pain, which was found during clinical examination. This impairment rating is based primarily on the patient's jaw/TMJ condition of degenerative arthritis brought upon by chronic clenching of the teeth due to psychological responses and the orthopedic pain and stress. This patient also has dietary restrictions of avoiding mastication of certain foods that require prolonged chewing or opening wide, or hard or chewy foods.
- b) **Pain Related Impairment Rationale:** The patient was given a 0% rating regarding pain. The reason for 0% impairment is that it was best felt this patient's pain was adequately incorporated into the mastication and deglutition impairment as stated above.

PRECLUSIONS/WORK LIMITATIONS: I believe that this patient can return to her previous job as far as her dental is concerned with the following limitations: No heavy lifting. Lifting heavy

objects may cause her to clench her teeth hard and that could cause further TMJ and teeth damage, which will also increase myofascial pain. A void extensive talking of 45 minutes straight without taking a 5-minute rest. Avoid cold temperatures such as refrigeration coolers, as it will increase her myofascial pain. CAUSE OF INJURY: In my professional opinion, it is with reasonable medical probability that the diagnoses of bruxism, right and left temporomandibular joint derangement, capsulitis of the right temporomandibular joint, and myofascial pain are AOE/COE and industrial in nature. There is at least some causation that could be given to the fact that the patient was clenching and grinding more aggressively and more frequently after her industrial injuries, due to her orthopedic pain, stress, and anxiety. Excessive clenching and grinding have had a negative effect on her oral condition, teeth, TMJ, and facial muscles which therefore are at least somewhat responsible for her dental injuries. My objective dental findings are consistent with the mechanism of her injuries. APPORTIONMENT: The patient's impairments in the field of dentistry are because of her temporomandibular joint condition and myofascial pain, which are caused by excessive clenching and grinding due to orthopedic pain and stress. Based upon the information provided to me, it is reasonable medical probability that apportionment is warranted. I believe with reasonable medical probability that she has been clenching and grinding prior to her industrial injuries of 04/14/2022 and CT 09/03/2019- 04/18/2022, but remained asymptomatic. She also had other industrial and non-industrial injuries that involved orthopedic pain and stress. However, she became symptomatic after her industrial injuries of 04/14/2022 and CT 09/03/2019-04/18/2022 due to excessive pain and stress, which causes excessive clenching and grinding. Based on the factors mentioned above, my experience, examining the patient, patient's testimony, and review of her medical records provided to me indicating the duration and level of pain caused by each of her injuries, I believe with reasonable medical probability that 40% of her dental/TMJ impairments are apportioned to the industrial injury of 04/14/2022, 30% to the industrial injury of CT 09/03/2019-04/18/2022, and 30% to prior industrial and non-industrial factors and injuries. TEMPORARY DISABILITY: In my area of expertise, she had been temporarily partially disabled starting in July 2022, when she started having jaw and myofascial pain and spasm, felt pressure on her jaw with tiredness, and waking up with headaches on 04/01/2023, when she reached P&S and MMI status. My recommendations on work restrictions in this report would apply to this time period as well. In my area of expertise, she has never been temporarily totally disabled from dental standpoint. PERMANENT DISABILITY: In my area of expertise, the patient is not permanently totally disabled at this point from dental standpoint. In my area of expertise, the patient is permanently partially disabled from dental/TMJ perspective, starting the date that she reached P&S and MMI status on 04/01/2023. This patient is able to return to her usual and customary work and is able to compete in the open job market with limitations from a dental standpoint. FUTURE MEDICAL TREATMENT: This treatment plan will serve both as palliative and rid patient of pain as well as restore applicant's functional capacities. I recommend that patient continues wearing her occlusal guard, which was provided to her by Dr. Schames, to place patient's jaw in a position where her TMJ and facial muscles can get better over time, and to avoid worsening her TMJ and myofascial pain in the future. This appliance will need to be replaced every two to five years, as it wears out, for the rest of her life.

10. **PANEL QUALIFIED MEDICAL EVALUATION SUPPLEMENTAL REPORT WITH REVIEW OF MEDICAL RECORDS:** Dated 11/07/2023, signed by Babak Abrishami, DDS. HISTORY OF INJURY: Patient presented in my Los Angeles office on August 23, 2023, for a Panel Qualified Medical Evaluation. I was being provided with medical and dental records to review and issue a supplemental report. After reviewing the records, my opinions and conclusions reported in my original QME report will remain the same with no changes. There is no new information in the records provided to me that alters any of my opinions and conclusions.

DEPOSITION OF RIMA BABAYAN, DATED JANUARY 16, 2023;

The applicant's date of birth is July 10, 1956.

Applicant's injury date is 04/14/22;09/03/19-04/18/22.

My full name as Rima Babayan. She had her deposition taken before with regards to her divorce about 20 years prior to this one. She lived at 1 250 North New Hampshire A venue, Number 8, Los Angeles, California, at this time. She has been living at this address since about 02/12/22 and lived there alone. South Western A venue was still her mailing

address at this time. She was born in Rezaieh, Iran, on 07/10/56. Aside from living in California since 1977, she had lived in New York from 1975 through 1977. Her divorce with Albert Babyan was finalized in 2000 or 2003. They were married for 19 years. The patient had two sons who were financially independent of her. She was not working at this time, nor was she self-employed. She last worked on 04/18/22 at Forest Lawn. She received temporary disability workers' compensation insurance benefits from Travelers Insurance three days after 04/18/22 and she consistently received those benefits every two weeks since. She received \$3,079.42 for each check. Aside from her temporary disability benefits from Travelers, she quarterly received income from her divorce. She and her ex-husband owned 25% of an L.L.C. She receives a K1 every year. She received \$6,500 for a quarter last time. She was first hired by Forest Lawn on 09/03/19, and she worked consistently for them through her last day of work, 04/18/22. She worked as an Advanced Planner for them, and she was responsible for selling pre-need services. In April 2022, Angineh Goocherians was their office manager, David Moe was their supervisor, and Grace Chong was their regional manager. Diana Saffles was their office manager prior to Angineh. She stated that she had training for the first three months before they were sent to Glendale Forest Lawn. She stated that she spent 30% of the time in the office, and the rest was spent out in the field meeting clients, etc. Her gross income for the first four months was \$30,000, and in the last year it was \$110,000 gross. They received benefits from EDD during the pandemic from March 2020 through approximately March 2021. She did not continue to receive a salary from that period, but they were getting unemployment benefits and they still had their training, meetings, etc. She was unemployed before she started working for Forest Lawn, and her last employer prior to Forest Lawn was California Deluxe Windows. Her employment with California Deluxe Windows ended in 2008. She temporarily worked for California Deluxe Windows in 2012 for less than a year, and she again returned to work for them in 2018 or 2019 for about three or four months, but in a different division, which was Americana. She stopped working for California Deluxe Windows in 2008 when management changed. She stated that she also had to take care of her mother. She broke her left ankle when she fell in Fort Harrison hotel in Clearwater in 2005 while working in a sales position for California Deluxe Windows and she remained off work for a few months then returned to work in November 2005. No personal injury claim was filed against the hotel. She had two surgeries on her left ankle. Steel plates and screws were placed in 2005, but she had an allergic reaction to those, so she had another surgery in 2006 to take them out. Surgery was performed in Florida. Dr. Wood treated her ankle. She had physical therapy as follow-up medical treatment. She had prescriptions from the doctor when she returned. She did not sustain any work-related injuries during either of the two brief periods that she worked for California Deluxe and American, in 2012 and 2018 through 2019. She was aware that two claims were filed on her behalf by her attorney against Travelers and Forest Lawn. She had a claim that she injured her back, right shoulder, and knees in 04/14/22 while working for Forest Lawn. She believed she aggravated her left shoulder due to her fall. With regards to her second claim, she developed injuries to her back and knees, sleep problems, and dental injury from 09/03/19 through 04/18/22 due to her day-to-day work activities at Forest Lawn. She had no pain or discomfort in her knees before being hired. She had not seen a doctor with regard to her pain in both knees prior to 09/03/19. She had not taken medication for any medical condition when Forest Lawn initially hired her in September 2019. She did not have aches or back pains before being hired at Forest Lawn, but she had chiropractic adjustments with Dr. Spearment in 2013 on Fountain in Los Angeles. She stated that she worked there once a week for three or four months, and Dr. Spearment gave her adjustments. She worked as a receptionist for Dr. Spearment, and she took orders, helped customers, and was paid for her efforts. Her employment there probably ended in 2014. She did not file any legal claim against Dr. Spearment or sustain any injuries while working for Dr. Spearment. She saw Dr. Garo Bouldoukian thrice in La Crescenta for chiropractic treatment of her left shoulder. Her sleep issues began after her fall on 04/14/22 due to orthopedic pain, as she could not find a comfortable position to sleep. She had no sleeping difficulties prior to 04/14/22. She began to have low back pain in about February 2020 after their training when she had to carry tables to her car, set them up outside, and put promo pieces to meet customers. She saw Dr. Ario Gordin in Valencia for her back prior to 04/14/22. She stated that she might have told Dr. Gordin that she felt back pain from her work activities. She stated that she had set tables twice or thrice a week, before and after the pandemic, around the end of December 2019, in January 2020, and in March 2021. She stated that she did not have to lift and carry tables in March 2021 until her last day as much as she did initially. She reported her back pain to their Human Resources and Mr. Morones. Mr.

Morones offered her to go to the clinic, and she accepted his offer. She also told Mr. Morones sometime in 2021 to April 2022 that she did not want to do the tables anymore. She also added that there was another lady who had back complaints. After the conversation with Mr. Morones, very light and smaller tables were provided, which were much easier to handle. She recalled filling out a report that mainly mentioned her back pain. She believed that carrying and standing caused back pain while she was with Forest Lawn. Besides tables and banners, she also had to carry Forest Lawn bags of promos weighing about 5- 15 pounds. She was kept on the books and was paid all her benefits after her time off work due to the pandemic from March 2020 through March 2021. She did not go out to public areas during that period. She had gone to malls and shopping centers twice to thrice a week before the pandemic, and there was a year when she did not do it at all. From March 2021 through April 2022, she only had to set tables once or twice, which were lighter compared to before. Her primary form of selling for Forest Lawn from March 2021 through 04/19/22 was going door to door, seeing clients, or giving out promos. During the last year she worked, she was required to go to public areas about 10-20 times to market for Forest Lawn. She agreed that Forest Lawn publicized too the advanced planners that there was going to be an event at the Burbank Mall. She stated that the office gave them schedules for when they had to work there, when to do park duty, and when to go to the grocery shopping venue. She did not have a chair to sit down in Burbank Mall and Northridge Mall, but there was a chair at Eagle Rock. She related that she had back pain due to standing and walking all day during these sales events. She stated that some places she went to had sign-up sheets that recorded each of the events that she went to, but the YMCA was her own, so she had her own days. She stated that YMCA closed down during the pandemic, and she did not go there at all between 2021 and 2022. With regard to records, she stated that she had to flag appointments the day before or look for properties before meeting with the client. She added that if the Forest Lawn gave the appointment, they would know, but if it was her appointment, then it was her own. Between March 2021 and April 2022, she stated that properties that did not sell were in between 10-20. She agreed that not all properties were on the hillside, and some were on flat land. She worked mainly in Glendale and Hollywood Hills. She also showed properties at Glendale. She stated that she experienced pain in both knees mainly after her fall, but prior to that, she attributed her pain from walking up and down the hills. She did not go to see a doctor for her knee pain at any time before approximately March 2021. After her fall, she saw Dr. Plance who administered the platelet-rich plasma (PRP) injection to her knees. She stated she had her first PRP injection after April. She related that Dr. Plance told her it would not help because she had an ACL tear and should have surgery. She had x-rays of the right knee and left shoulder on her first fall on 04/05/22, just nine days prior to the fall on 04/14/22. Her primary doctor, Dr. Homayoun Sharim at 201 South Glendale Avenue, requested an x-ray. She also claimed that due to her day-to-day work activities, she developed some dental problems including grinding and clenching of her teeth, which she has had before, and it just worsened. She recalled first experiencing either grinding or clenching in 2018 or 2019 when she went to see a dentist, Dr. Nakoud, in Granda Hills. Before that, she had a night guard, which was given by Dr. Arakelian in Woodland Hills in 2018. A new night guard was ordered because the other one would not fit anymore and was so thick. She indicated that she was prescribed a night guard because her teeth were wearing down and she had a crack. She related that she was not continuously wearing the night guard from the first time she was prescribed it until the date of the accident on 04/14/22. She indicated she frequently used the night guard because she was uncomfortable with the one she had. She related that she still has clenching and grinding with her teeth, and she was having more pain in her mouth at this time. She indicated that the pain or discomfort in her body was causing her to clench or grind her teeth more. Within the last 12 months, she had Dr. Nakoud and Dr. Gogan/Gogon, who performed cleaning of her teeth at 321 North Larchmont. She saw Dr. Gogan two times for cleaning. The first time she saw Dr. Gogan, he took x-rays and was going to send her to a doctor to make a night guard. The last time she saw him was about 10 days ago. She stated she saw him back in June or July last year and he planned to fix the grinding of her teeth. She denied seeing other dentists besides Dr. Nakoud, Dr. Gogan, and Dr. Arakelian over the last five years. She stated she noticed an increased right-sided jaw pain between the date of hire on 09/03/19 and just prior to the specific injury on 04/14/22. She stated that some days it was hard, and some days it was fine. She indicated that even when the time of the deposition, she could feel an increase in her symptoms. She claimed that on 04/14/22 she had an appointment with Armenia, a female client. She picked Armenia up at about 8:00 a.m. from her work, which was very close to Forest Lawn. Armenia had to go back

to work at 9:00 a.m. This was her third or fourth appointment with this client in a year, showing her and her husband different properties. This time, Armenia came by herself. She picked her up because she could not drive on the freeway. And so, they went to Hollywood Hills. The night before, she was at Forest Lawn and flagging all the different properties with different price ranges for two hours. She was there until 7:00 p.m. And the next morning, she picked up Armenia and they went to Hollywood Hills. The last two places she showed Armenia were in the Peaceful Memory Section, which was the least expensive and sloppy place. They went down and Armenia look at it and indicated she did not like it as it was kind of sloppy. Armenia then looked to the right, saw a flatter place, and wanted to go there. She then got the map from the car, which was parked on the road next to where they were. Armenia stayed where they used to be while she went up and got the map and her phone. She called the office on speakerphone to find out if the property that Armenia liked was available. As she was talking to the girl, Angineh, in the office and walking down, she did not realize that she stepped into a soggy mud place. Her right foot slide down. And as she was sliding down towards the client, she tried to stop herself as she was afraid, she would hit the client if she rolled down. She pushed her feet down to stop herself and twisted her body. She fell down on her buttocks first, back and shoulder. And then she turned to her right and ended up lying down on her entire back. Angineh, who was still on the phone, asked her if she was okay. She indicated that although she was in shock and kind of teary, she continued asking Angineh if the other property was available or not. She related that at the time she fell, she was talking to two people in the office. She forgot the other person's name as she was new and the other one was Angineh. She was lying there when Armenia came up and was trying to help her. Armenia told her she had a bad fall, in which she denied. As she did not want to pull Armenia, she turned on her knees and hands and got up. She refused Angineh's offer to call security because she had to take Armenia back to the office. Armenia was worried about her job and boss, so she took Armenia back to her workplace. She went to the office and reported the accident. Diana Saffles and Angineh told her that she should go to the clinic. Next Monday, she eventually went to the clinic. She went there every two weeks starting from April 1 8th. She indicated that she was not receiving any treatment because Dr. Kazazian was just evaluating her. They were waiting for authorizations. After she was authorized to see Dr. Adamson in August 2022, she stopped seeing Dr. Kazazian. She was still under the care of Dr. Adamson for her left shoulder. She saw him about a month ago and was recommended physical therapy. She just saw Dr. Adamson once for her right shoulder and knees. She also received treatments from Dr. Samimi on 09122122 for her knees, back and right shoulder. Dr. Samimi administered Durolane injections in her knees, which was much more painful at first, and then gradually, the pain disappeared. But her pain was still the same. She also has clicking. Dr. Samimi told her that she had to wait and see if this would help every six weeks or so. She last saw Dr. Samimi in December. Workers' Compensation denied Dr. Samimi's recommendation of physical therapy. She stated that she only saw Dr. Gevokian at Pathways Medical 10730 Riverside Drive in Toluca Lake for her overall body treatments, including Vitamin C and IV therapy to remove the inflammation. She was scheduled to see Dr. Drake, a QME. She mentioned during the deposition that she had a fall on 04/05/22 and sustained injury to her left shoulder. She was crossing a pedestrian lane when she fell due to uneven asphalt. Her foot got stuck and went forward. She did not go to the emergency room or urgent care facility immediately after that fall. The day after her fall, she saw Dr. Sharim for her physical exam and blood test. She informed Dr. Sharim about her fall and complained of left shoulder pain and movement as well as right knee soreness. Dr. Sharim ordered MRI and x-ray. The next day, she got an appointment at United Medical where the MRI and x-ray were performed. She was told not to use her hand and arm. She also saw Dr. Plance, who referred her to an orthopedic surgeon, Dr. Powell at 2021 Santa Monica Boulevard, Suite E, California, 90404. Dr. Powell indicated that she might need surgery for the left shoulder. She related she misunderstood Dr. Powell's recommendation. She thought it was open surgery and later found that it was arthroscopic surgery. She stated that when she fell on the 14th, she had a scheduled Zoom meeting with Dr. Powell. That was when she was told that she would need surgery. She had injured her ankle in 2005. Over the last 15 years, she just saw her OB-GYN Dr. Lantry. She also had Cigna-HMO. She also had hiatal hernia and had colonoscopy done by Dr. Boghossian. She had cyst in her right index finger. In 2007, she went to Glendale Adventist because she had heart palpitations. She went to emergency, and she was kept overnight. She also went to Angel's Wings Medical Association for UTI. In her present condition, she believed that she was not able to return to work as an advanced planner for Forest Lawn. It was her knees, back, and shoulders that were preventing her from working as an advanced

planner. When she would pick up especially on her right shoulder and bicep, she would get spasm and she have to drop whatever she has. Since she has been off work since 04/2022, she noticed that her right shoulder and low back were worse. She stated that her left shoulder was better. She was taking biorelief, and she was taking a lot of supplements, natural supplements, stem cell supplements, and standard process supplements. She received medical treatment for the pain in her abdomen area at Olive View Medical Center in 2014. After her accident on the sidewalk, she had an MRI to her left knee on 04/07/22. She had another MRI of the left shoulder in 05/24/22. She has seen Dr. Schames in 12/2022. She stated that Dr. Schames took pictures of her mouth and teeth. She was told that she was grinding and a mouthguard or a temporary one was ordered. She was told that she might also have sleep apnea. She has a return appoint to see Dr. Schames on 01/26/23. She was also given something for her nose which was very uncomfortable and she has not done it. She told Dr. Schames that she was having difficulty sleeping because of the orthopedic pain and trouble getting into a comfortable position.

DEPOSITION OF RIMA BABAYAN, DATED NOVEMBER 13, 2023;

The applicant's date of birth is July 10, 1956.

Applicant's injury date is 04/14/22;09/03/19-04/18/22.

My name is Rima Babayan. I have spent approximately 1 hours time this morning with my attorney preparing for this Volume II of my deposition. I am still living at 1250 North New Hampshire Avenue, Apartment 8 in Los Angeles. Since January when we were last together, I have not been employed in any capacity. I am still receiving temporary disability benefits from Travelers Insurance. In my first deposition I have told you that I also received quarterly 6,500 from a real estate limited partnership. No actually, because they are remodeling the building and I have not received any, as I recall. Since January of 2023, I have applied for social security benefits and I am receiving them at the present time approximately \$1,700. I am also qualified for Medicare. I qualified for Medicare after my birthday in July 2022. Whether Medicare paid for medical treatment to any part of my body I am not sure. Probably my physical doctor, Dr. Sharim. Since January 16, 2023, I have received medical treatment for the injuries that I claim have occurred while working at Forest Lawn just with Dr. Samimi, my doctor and the last month, I think, it was Concentra for my right shoulder which was through my doctor, I mean workers' comp. The doctor from Concentra, is Dr. Bianchi. Dr. Samimi is treating my both knees, right shoulder and my back. Dr. Samimi is treating left shoulder and right shoulder. Dr. Bianchi is treating the right shoulder. Since January of 2023, Dr. Samimi received gave injections in my knees. I had three-part injection in the right knee. Three times in each knee. I have received all three injections for the right knee. The last injection was in three weeks consecutive so from the first week, would be every week after that. Well, I can say it felt a difference and then it is gone back to what it was. The condition of the right knee at the present time comparable to what it was before I had the injections it is the same with the left knee. I last saw Dr. Samimi approximately at the end of October. So basically, he said I have to lose weight to get my knees changed. To get the knees changed, like whatever, have the surgery done to both knees. He made the recommendation last time that I talked to him and prior to that. In October of 2023 recollection is that Dr. Samimi told me I need a surgery to the right knee. Dr. Samimi recommended a total knee replacement. He recommended the same thing for the left knee. Dr. Samimi indicated he cannot do the procedures in the present time because of the weight. Since January of 2023, has Dr. Samimi provided treatment for the right shoulder recently with Concentra. I just received approval for my back, pain management. The doctor at Concentra, since January, has provided me with stem cell injections. Electrical stimulation and did adjustments once and also some instrument on my back and on my shoulder. The last time I saw doctor at Concentra was on Friday; it was a face to face examination. We didn't discuss the treatment because it is up to Dr. Samimi. I am scheduled for further treatment at Concentra tomorrow. The condition of the right shoulder through treatment provided by Concentra has helped with the pain and I have less pain in right shoulder compared to three months ago. Dr. Samimi received or got authorization to refer me to pain management consultation. I think Concentra was on the list. So I have submitted that to Concentra. We will see. Concentra didn't have any opening until

January so they are trying to see if some other center then where I see. I have also received treatment from dentist since January of 2023. I have seen Dr. Richard Walicki in Mint Dental Lab once. Mint Dental Lab in Pasadena. I have also seen someone else associated with him for cleaning. I had a tooth that needed to be smoothed. It was chipped. So that's all he did. Dr. Samimi suggested me to lose weight in order to facilitate the (total knee) surgeries. My current weight is Two forty-six pounds, I think. I think Dr. Samimi recommended taking Ozempic, but I don't want to do that because of the side effects. I was also sent to Dr. Arbi Mirzazians. I have seen when sent there by Dr. Samimi. The purpose of the evaluation is to see occupational in his office. When I went to the doctor's office, I was given questionnaires to fill out. At the doctor's office I spent approximately two and a half, three hours. I filled out the questionnaire and then I was told to do different manual stuff and also lifting a box of whatever it was and walk with it, and also do body movements to see how much I was able to do, and also manual. Body movements I had to do with my back, my knees moving. They did bend me forward more than once and we did it three times each time. I was also given instructions while conducting this examination as to whenever I feel the pain I should stop. I was told to do the best I can and the most I can, and if I feel pain just stop Right but at some point I couldn't do it so I just stopped. I was given a copy of the report that was generated from Dr. Samimi's. at the time I was doing this evaluation on May 26, 2023 I was just give medication just my Bio relief. It is for inflammation and pain. It is an over-the-counter Holistic medication. In the last 30 days I have not done any changes. If authorized I would wish to undergo a right total knee replacement. My left knee is worse than the right knee. Dr. Samimi did discuss with me the risks of the procedure. His assistant, his P.A. Before I was hired at Forest Lawn, my date of hire is September 3, 2019, I had pain and discomfort in my neck before the date of hire. I had neck pain before I was hired. I never had an MRI of the neck before being hired at Forest Lawn, I 8 don't think so. I have testified that I had seen a chiropractor, Dr. Bouldoukian, about three times. I was employed in the year 2013 for a short time. In 2013, I think I was working with Dr. Spearman part-time. I was employed in 2013 with Applied Scholastics. I was in charge of marketing and the job did not last more than I was there I think probably just three, four months. Three months, four months. While working for Applied Scholastics, what happened is I was reading a book and my upper back I had pain and just something happened there in the back. I did not file a claim for workers' compensation benefits against Applied Scholastics or their insurance carrier. I was off probably about two weeks or three weeks. There was no neck pain but upper back pain. I was more concerned my upper back. Because I don't see a medical report in front of you that you're reading off of. I had low back pain prior to the date of hire at Forest Lawn but with chiropractic adjustments because that's what people read. If everything goes from spine. I was having some discomfort in my low back. I went to a chiropractor before I was hired at Forest Lawn. It is Dr. Spearman. She testified that around 2013 she had adjustments while working there. She worked there for three to four months. In my entire 67 years or 60 years of life, because the reason I go to chiropractors. I did feel pain in the back at any time in my life when I was a child up to the date. I would just say yes probably. I had no right shoulder pain prior to the date of hire at Forest Lawn. I did have numbness or tingling in left or right hand prior to the date of hire at Forest Lawn. The first time I experienced any numbness or tingling in my hands in 2013 and 2014. Physiologically, the numbness and tingling is probably from my neck or my carpal tunnel at the time. For treatment of numbness, I just saw chiropractors. For complaints of numbness, I think I saw Dr. Spearman while I was working there. I did experience jaw clenching before I was hired at Forest Lawn. At the last deposition we talked briefly about a fall I had on April 5, 2022 not at work. I did not file any type of insurance claim as a result of that accident no. Just my physical doctor, Dr. Sharim Homayoun and he ordered MRIs. The doctor charges were paid by Cigna Insurance Carrier I am not sure. In the fall of April 5, 2022, I injured my left shoulder and right knee. After the fall I was just feeling pain in the back and mostly my left shoulder. EMG it is a test where they actually put little needles in your arms or legs to determine the neuro conduction. I had an EMG, in July of 2023. Other than the doctors I talked about as treaters, meaning Dr. Samimi and the doctors at Concentra, I have seen just Dr. Sharim, I think and Dr. Spearman last night. I had pain on this side. So he adjusted. Dr. Spearman gave me supplements and he adjusted my reflection on my pancreas. Since January, I have seen Dr. Spearman approximately two or three times. As a result of the specific accident at Forest Lawn of April 14, 2022, I am claiming injury to the bilateral shoulders, bilateral knees, both knees, my low back, and my dental. The doctors at Concentra and Dr. Samimi recommended me undergo left or right shoulder surgery. Dr. Samimi recommended a procedure for both shoulders. Dr. Samimi was

recommending right shoulder replacement and repair of rotator cuff. Dr. Powell had recommended arthroscopic surgery on 4/14, the day I fell at Forest Lawn. None of the doctors mentioned I had a tear in the left shoulder. Including the doctor who saw me tripping and falling on the street from the crack. The only doctor that recommended I had a tear in left shoulder would be Dr. Powell. The zoom meeting with Dr. Powell took place after I fell. I fell at 8:30 and my ZOOM meeting was at 9:00. Because of the Covid. Dr. Powell recommended arthroscopic surgery at that time. Dr. Powell mentioned I assume because of my fall on the street. The one on April 5, 2022 but I knew that I had arthritis in my upper back. I have testified in the last deposition that I was hired at Forest Lawn and prescribed a nightguard by my dentist, because I was grinding my 18 teeth. None of the doctors told me what clenching of the teeth caused by. I am claiming jaw pain following the accident at Forest Lawn. I think pain in my body and at night being discomfort as far as sleeping positions. TMJ. I think that's what it was. None of the doctors told me I had TMJ before the accident at Forest Lawn. I think Dr. Sarkissian, who gave me the nightguard, probably. I don't recall. I don't remember what he said. The first deposition indicated that I was not working between approximately 2008 and 2019 because I was taking care of my mother. I did not work at all between 2008 and 2019 because my mother passed away 2017. It would be I worked at California Deluxe Window, for like a couple months in 2019 before I started in. Between 2008 and 2019, my employment was just California Deluxe Windows. I had a conversation wherein I indicated that our client was not going to pursue. Since January I have not traveled anywhere outside of the Los Angeles County area. I took a trip or vacation with my brother and his family we went to a cabin in Idyllwild for two to three days. We stayed in a cabin. We went there approximately I would say February or March maybe. I'm not sure the dates. In a couple times in the deposition, I mentioned my private doctor, Dr. Sharim Homayoun. It is the same doctor Dr. Sharim's specialty is General, I think.

OTHER AVAILABLE RECORDS

1. **MRI CERVICAL SPINE W/O CONTRAST:** Dated 04/23/2013, signed by Maurice Hale, M.D. Impression: 4 mm disc herniations from C4-5 through C6-7 stenosing the spinal canal, encroaching the neuroforamen and impinging. RVE roots as described aggravated by osteoarthritis and disc desiccation. 3 mm broad-based C3-4 disc protrusion elevating the posterior longitudinal ligament and encroaching both neuroforamen. 3.2 mm C7-T1 disc protrusion effacing the ventral thecal sac and encroaching both neuroforamen.
2. **X-RAY OF THE LEFT ANKLE 3 VIEWS WEIGHT BEARING:** Dated 11/01/2013, signed by Richard Witten, M.D. Impression: Mild to moderate diffuse degenerative findings. No fracture or other significant appearing abnormality is detected.
3. **XR CERVICAL SPINE AP/LAT:** Dated 11/01/2013, signed by Richard Witten, M.D. Impression: C5-C6 interbody fusion. Whether this is surgical or due to infection or some other process is uncertain from this single exam. Chronic degenerative disk disease as detailed above. No subluxation or other acute process is suspected.
4. **CT ABDOMEN WITH CONTRAST, CT PELVIS WITH CONTRAST; CT ABDOMEN W/O:** Dated 03/21/2014, signed by Cecilia M. Jude, M.D. Impression: Hepatic steatosis. 1.3 x 0.7 cm left adnexal fatty lesion, likely a dermoid. The uterus demonstrate a 2.4 cm mass with areas of fat attenuation likely a lipoleiomyoma.
5. **X-RAY OF THE FINGER PA/LAT, XR FOOT RIGHT:** Dated 08/10/2014, signed by Richard Witten, M.D. Impression: No evidence of acute trauma or significant joint disease in the right thumb. Hallux valgus, bunion and hammertoe formation and heel spurs are prominent in the right foot. No fracture to the second toe or elsewhere is detected.
6. **PELVIC ULTRASOUND:** Dated 09/06/2014, signed by Michael J. Nguyen, M.D. Impression: Stable appearance of the 3.4 cm fundal lipoleiomyoma and 1.5 cm intramural fibroid arising from the anterior uterine wall. Redemonstration of the nonspecific 4 mm left ovarian echogenic lesion, previously described as a dermoid, and slightly smaller in size on today's exam.

7. **PELVIC ULTRASOUND:** Dated 03/02/2015, signed by Gail C. Hansen, M.D. **Impression:** Stable 3.3 cm fundal lipoleiomyoma. Slight interval decrease in size of the intramural anterior uterine wall fibroid, which now measures approximately 1.3 cm. Interval increase in size of the left ovarian echogenic lesion, likely a dermoid, which now measures 1.5 cm. Normal blood flow is seen in the left ovary.

8. **MRI C SPINE W/O CONTRAST:** Dated 10/05/2015, signed by Gasser M. Hathout, M.D. **Impression:** Very severe disc space narrowing at C5-6, with near complete fusion of the C5 and C6, with near complete fusion of the C5 and C6 vertebral bodies, likely post degenerative auto-fusion, but other etiologies cannot be excluded. This finding was present on prior plain film examination of 2013. Moderately severe degenerative disc disease at C6-7, and moderate/moderately severe degenerative disc disease at C3-4, C4-5, and C7-T1. Straightening and slight reversal of the normal cervical lordosis. Mild to moderate spinal canal narrowing at C5-6 due to broad-based posterior osteophyte formation. Mild spinal canal narrowing at C4-5 and C6-7. No evidence of large disc bulge, gross focal disc herniation, high grade spinal canal stenosis, gross cord impingement, or gross cord signal abnormality at any level. Multilevel neural foraminal stenosis, most pronounced at C3-4 as described above. Clinical correlation for radiculopathy is suggested.

9. **CT ABDOMEN WITHOUT CONTRAST:** Dated 05/03/2021, signed by Alexander Somwaru, M.D. **Impression:** Increased diastasis recti with large shallow fat containing anterior abdominal wall hernia. No bowel movement. Hepatosplenomegaly and hepatic steatosis. Please correlate for chronic hepatocellular disease (steatohepatitis and cirrhosis) and portal venous hypertension. Small hiatal hernia with esophageal thickening that may be due to esophagitis and/or under distention however please consider correlation with endoscopy to ensure the absence of a potential neoplasm.

10. **X-RAY OF THE RIGHT KNEE – THREE VIEWS:** Dated 04/07/2022, signed by Haroutun Abrahamian, M.D. **Impression:** Medial compartment osteoarthritis with a small to moderate size joint effusion. Quadriceps tendon enthesopathy.

11. **X-RAY OF THE LEFT SHOULDER – ONE VIEW:** Dated 04/07/2022, signed by Haroutun Abrahamian, M.D. **Impression:** Mild degenerative changes about the left shoulder.

12. **MRI OF THE LEFT SHOULDER WITHOUT CONTRAST:** Dated 04/07/2022, signed by Haroutun Abrahamian, M.D. **Impression:** Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial-thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis with adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis.

13. **X-RAY OF THE LEFT SHOULDER WITHOUT CONTRAST:** Dated 04/08/2022, signed by Haroutun Abrahamian, M.D. **Impression:** Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial-thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis with adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis.

14. **OFFICE VISIT:** Dated 04/14/2022, signed by Scott Powell, M.D. **Subjective:** She is a 65 years old female who presents via telemedicine and is a new patient to our office, referred for evaluation and treatment regarding her left shoulder pain and right knee pain. She reports this pain began after she sustained a fall on April 5th. The patient reports that her left shoulder pain and right knee pain have generally persisted since onset. The patient reports that she consulted her PCP, who advised her to obtain a right knee x-ray, left shoulder x-ray, and a left shoulder MRI. The patient reports that she has completed the recommended imaging. Our office has the reports and images on file at this time. Regarding her right knee, the patient presents with persistent, constant pain at the lateral aspect, rated at a baseline of 5/10 but reaching a 9/10 with stair ascension/descension and when standing from a seated position. The patient reports difficulty with weight bearing. Additionally, she reports limited ROM (with flexion) and weakness. She denies popping/clicking and numbness/tingling. Notably. The patient reports that she recently sustained a separate fall, which caused injury to her left knee. HPI - Shoulder: Regarding her left shoulder, the patient currently presents with persistent, constant pain in the anterior aspect rated at a 7/10, as well as limited ROM (with abduction/forward elevation) and weakness. The patient reports difficulty with overhead movements and an inability to lift objects

exceeding 5 lbs in weight. The patient denies night pain and instability. The patient denies taking any anti-inflammatory medication for her right knee and left shoulder pain at this time. Plan: Knee: She was advised to take over-the-counter anti-inflammatories (NSAIDs) as needed and to apply ice to the affected area as needed. The patient's x-rays were reviewed and discussed. The patient was advised to begin a formal physical therapy program aimed at reducing pain caused by osteoarthritic changes. The patient was provided with a requisition for 6 sessions of physical therapy and advised to attend PT 2x per week for 3 weeks. Shoulder: She was advised to take over-the-counter anti-inflammatories (NSAIDs) as needed and to apply ice to the affected area as needed. The diagnosis was discussed with the patient. Non-operative versus operative treatment options were discussed. Operative treatment was described as a left shoulder arthroscopic rotator cuff repair. Non-operative treatment was described as physical therapy and/or pain management strategies, including cortisone injections. The patient has elected to pursue conservative management at this time and was provided with a requisition for 6 sessions of physical therapy. She was advised to attend physical therapy 2x per week for 3 weeks. Our office will follow up with the patient in 4 weeks via phone to assess her progress with physical therapy. Additionally, the patient was advised to inquire about a left shoulder cortisone injection. The patient was encouraged to consult her primary care physician regarding this injection. Chief Complaint: Left shoulder pain/right knee pain. Assessment: Pain in right knee. Pain in left shoulder. Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic. Unilateral primary osteoarthritis, right knee.

15. **DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS:** Dated 04/18/2022, signed by Raffi Kazazian, M.D. How Injury Occurred: I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited here. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. Work Status: The patient is unable to perform his usual work. The patient can return to modified work on 4/18/2022. Work relatedness: Work related injury. . Subjective: INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Treatment Plan: TREATMENT/ORDERS: WORK RELATEDNESS: WORK RELATED INJURY. Restrictions – Shoulder. Left shoulder restrictions include – No overhead work. Lifting, pushing, or pulling limitations up to 5 lbs. TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 4/28/2022. Physician/Scribe: rk. Work Status: Return to work modified duty.

16. **WORK STATUS SUMMARY:** Dated 04/18/2022, signed by Raffi Kazazian, M.D. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. Current Work Restrictions: WORK RELATEDNESS: WORK RELATED INJURY. Restrictions – Shoulder. Left shoulder restrictions include – No overhead work. lifting, pushing, or pulling limitations up to 5 lbs. Work Status: Return to work with restrictions, from 4/28/22 thru 4/28/22. Follow-Up Appointments: 4/28/22 at 10:45 AM.

17. **LEFT KNEE SERIES:** Dated 04/18/2022, signed by P. Kashfian, M.D. Impression: As above.

18. **RIGHT SHOULDER SERIES:** Dated 04/18/2022, signed by P. Kashfian, M.D. Impression: Osteoarthritic changes of the acromioclavicular joint.

19. **RIGHT SHOULDER SERIES:** Dated 04/28/2022, signed by B. Shayestehfar, M.D. Impression: No evidence of fracture or dislocation.

20. **WORK STATUS SUMMARY:** Dated 04/28/2022, signed by Raffi Kazazian, M.D. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain

of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. Current Work Restrictions: WORK RELATEDNESS: WORK RELATED INJURY. Restrictions – Shoulder. Left shoulder restrictions include – No overhead work. lifting, pushing, or pulling limitations up to 5 lbs. Work Status: Return to work with restrictions, from 4/28/22 thru 5/16/22. Follow-Up Appointments: 5/16/22 at 02:45 PM.

21. **CHART NOTE:** Dated 04/28/2022, signed by Raffi Kazazian, M.D. Diagnosis: Sprain & strain of unspecified site of knee and leg. Subjective: INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): Presenting Problem: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy. Mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28 - F/u for b/l shoulder, b/l knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall still unable to lift over 5 pounds and she remains off work since they cant accommodate. She did see Dr Scott Powell (ortho) through private insurance, he rec'd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she doesn't want to. Assessment: Sprain of unspecified site of left knee, initial encounter Strain of musc/fasc/tend at shldr/up arm, right arm, init Sprain of unspecified site of right knee, initial encounter Low back pain. Inj must/tend the rotator cuff of left shoulder, init. Plan: TREATMENT/ORDERS: RADIOLOGY/TEST ORDER (Referral): The following radiology/test was ordered: MRI Bilateral Shoulder Without Contrast. Diagnostic RADIOLOGY/TEST ORDER (Referral): The following radiology/test was ordered: Knee Without Contrast. Diagnostic RADIOLOGY/ TEST ORDER (Referral). The following radiology/test was ordered: MRI Bilateral Spine - Lumbar/Sacral Without Contrast.

22. **WORK STATUS SUMMARY:** Dated 04/28/2022, signed by Raffi Kazazian, M.D. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. Current Work Restrictions: WORK RELATEDNESS: WORK RELATED INJURY. Restrictions – Shoulder. Left shoulder restrictions include – No overhead work. lifting, pushing, or pulling limitations up to 5 lbs. Work Status: Return to work with restrictions, from 4/28/22 thru 5/16/22. Follow-Up Appointments: 5/16/22 at 02:45 PM.

23. **PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2):** Dated 04/28/2022, signed by Raffi Kazazian, M.D. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. Work Status: This patient has been instructed to return to modified work on 04/18/2022 with the following limitations or restrictions. Work relatedness: work related injury. Restrictions-shoulder. Subjective: INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): Presenting Problem: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching.

SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy. Mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28 - F/u for b/l shoulder, b/l knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall still unable to lift over 5 pounds and she remains off work since they can't accommodate. She did see Dr Scott Powell (ortho) through private insurance, he rec'd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she doesn't want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she doesn't want to do PT until she gets an MRI, and doesn't want to get CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited p.r.n. She would like to see Dr. Stenson who she was told is also in MPN for workers camp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. Treatment Plan: TREATMENT/ORDERS: RADIOLOGY/TEST ORDER (Referral): The following radiology / test was ordered: MRI Bilateral Shoulder Without Contrast. Diagnostic RADIOLOGY/TEST ORDER (Referral): The following radiology/test was ordered: Knee Without Contrast. Diagnostic RADIOLOGY/ TEST ORDER (Referral). The following radiology/test was ordered: MRI Bilateral Spine - Lumbar/Sacral Without Contrast. Diagnostic TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 5/16/2022 Physician/Scribe: rk. Work Status: Return to work modified duty. Additional instructions: Referred for an MRI.

24. **CHART NOTE:** Dated 05/16/2022, signed by Raffi Kazazian, M.D. **Diagnosis:** Sprain & strain of unspecified site of knee and leg. **Subjective:** INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." **Present Complaint:** The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): **Presenting Problem:** Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy. Mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28 - F/u for b/l shoulder, b/l knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall still unable to lift over 5 pounds and she remains off work since they cant accommodate. She did see Dr Scott Powell (ortho) through private insurance, he rec'd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she doesn't want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she doesn't want to do PT until she gets an MRI, and doesn't want to get CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited p.r.n. She would like to see Dr. Stenson who she was told is also in MPN for workers camp but today found out he is not taking new WC cases but has a Dr Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for

f/up of low back, B/L shoulder and B/L knee pain. Pain relatively changed: she can't to report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shells shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22, L/S MRI on 5/23/22 and 13/1. Knee MRI on 5/24/22. She is currently on modified duty. Assessment: Sprain of unspecified site of left knee, initial encounter Strain of musc/fasc/tend at shldr/up arm, right arm, init Sprain of unspecified site of right knee, initial encounter Low back pain. Inj must/tend the rotator cuff of left shoulder, init WORK STATUS/ASSESSMENT: Plan: TREATMENT PLAN / INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up Follow up in 2 weeks Physician/Scribe: AK. Work Status: Return to work modified duty. 5/16/22 - D/w pt current condition of low back, B/L knee and B/L shoulder condition. Advised her to proceed with rt shoulder MRI on 5/20/22, L/S MRI on 5/23/22, and B/L knee MRI on 5/24/22. Con't modified duty. F/up in 2 wks to discuss condition and to review MRI report and to discuss poss use of T-Shellz shoulder wrap.

25. **WORK STATUS SUMMARY:** Dated 05/16/2022, signed by Raffi Kazazian, M.D. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. Work Status: Return to work with restrictions, from 5/16/22 thru 5/31/22. Follow-Up Appointments: 5/31/22 at 11:00 AM.

26. **PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2):** Dated 05/16/2022, signed by Raffi Kazazian, M.D. Diagnosis: Sprain & strain of unspecified site of knee and leg. Subjective: INITIAL VISIT CONIPLA INT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): Presenting Problem: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy. Mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28 - F/u for b/l shoulder, b/l knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall still unable to lift over 5 pounds and she remains off work since they cant accommodate. She did see Dr Scott Powell (ortho) through private insurance, he rec'd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she doesn't want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she doesn't want to do PT until she gets an MRI, and doesn't want to get CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited p.r.n. She would like to see Dr Stenson who she was told is also in MPN for workers camp but today found out he is not taking new WC cases but has a Dr Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, B/L shoulder and B/L knee pain. Pain relatively changed: she can't to report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shells shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22, L/S MRI on 5/23/22 and 13/1. Knee MRI on 5/24/22. She is currently on modified duty. Assessment: Sprain of unspecified site of left knee, initial encounter Strain of musc/fasc/tend at shldr/up arm, right arm, init. Sprain of unspecified site of right knee, initial encounter Low back

pain. Inj muscl tend the rotator cuff of left shoulder, init. Work Status/Assessment: Treatment Plan: TREATAIENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up Follow up in 2 weeks Physician/Scribe: RK. Work Status: Return to work modified duty. 5/16/22 - D/w pt current condition of low back, B/L knee and B/L shoulder condition. Advised her to proceed with rt Shoulder MRI on 5/20/22. US MRI on 5/23/22, and b/l. knee MRI on 5/24/22 Con't modified duty. F/up in 2 weeks to discuss condition and to review MRI report and to discuss poss use of T-Shellz shoulder wrap.

27. **MRI OF THE RIGHT SHOULDER WITHOUT CONTRAST:** Dated 05/17/2022, signed by Haroutun Abrahamian, M.D. Impression: Full-thickness supraspinatus tendon tear with retraction by 10 mm and has mild muscle. Bulk/fatty atrophy. Adjacent infraspinatus and subscapularis tendinosis. High-grade partial-thickness tong head of the biceps tendon tear and retraction. Mild to moderate acromioclavicular joint arthrosis with adjacent subacromial/subdeltoid bursitis.

28. **MRI OF THE LEFT KNEE WITHOUT CONTRAST:** Dated 05/19/2022, signed by Haroutun Abrahamian, M.D. Impression: Peripheral extrusion of the medial meniscus from the joint line as well as heterogeneous signal at the anterior horn/body junction. A complex degenerative tear carnal be excluded at this site without post contrast imaging. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment as described above. Subchondral edema versus bone contusion of the lateral femoral condyle posterior nonweightbearing aspect. Small to moderate size joint effusion. Quadriceps tendon enthesopathy.

29. **MRI OF THE LUMBAR SPINE WITHOUT CONTRAST:** Dated 05/23/2022, signed by Haroutun Abrahamian, M.D. Impression: Mild to moderate disc desiccation of L4-L5 with a 3.5 mm broad-based disc protrusion and facet arthrosis causing mild central canal and neural foraminal stenosis bilaterally. Mild disc desiccation of L5-S1 with a 2 mm broad-based disc protrusion asymmetric to the right with facet arthrosis and an 8 mm complex synovial cyst in the right neural foramen causing mild central canal stenosis as well as moderate right-sided and mild to moderate left-sided neural foraminal stenosis. Less significant findings at the remainder of the disc levels as described above. Heterogeneous marrow signal diffusely which is nonspecific but may represent osteopenia. Pathologic process cannot basically without oncologic workup.

30. **MRI OF THE LEFT SHOULDER WITHOUT CONTRAST:** Dated 05/24/2022, signed by Haroutun Abrahamian, M.D. Impression: Supraspinatus and infraspinatus tendinosis with a persistent 3.5 mm partial-thickness supraspinatus footprint tear without retraction or associated muscle bulk atrophy. Mild acromioclavicular joint arthrosis with adjacent subacromial/subdeltoid bursitis.

31. **MRI OF THE RIGHT KNEE WITHOUT CONTRAST:** Dated 05/24/2022, signed by Haroutun Abrahamian, M.D. Impression: Peripheral extrusion of the medial meniscus from the joint line without a definite tear. Intrab实质 generation of the lateral meniscus at the body without a definite tear. MR arthrogram may be performed for further evaluation/characterization if clinical concern persists. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment. Quadriceps tendon enthesopathy. Mild prepatellar bursitis.

32. **PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2):** Dated 05/31/2022, signed by Raffi Kazazian, M.D. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. Work Status: This patient has been instructed to return to modified work on 04/18/2022 with the following limitations or restrictions. Work relatedness: work related injury. Restrictions-shoulder. Subjective: INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity

and Pain - Back. SIGNS/SYMPOTOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/I shoulder, b/I knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to get CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also in MPH for workers comp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31-F/u For LBP< b/I shoulder and b/I knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear, she will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. Treatment Plan: TREATMENT/ORDERS: ORTHOPEDIST REFERRAL: I recommend a consultation and treatment with a qualified Orthopedist. Referral Reason: lumbago, radicular symptoms. Referral Status: Regular. BACK SPECIALIST REFERRAL: I recommend a consultation and treatment with a qualified orthopedic back specialist. Referral Reason: b/I knee and bit shoulder internal derangement. Referral Status: Regular. REQUEST FOR PHYSICAL THERAPY AUTHORIZATION: I recommended physical therapy: three times weekly for three weeks. Patient Problems: Stiffness, Pain and Limited ROM. PT MEDICAL NECESSITY: Treatment Goals: Increased ROM/Flexibility, Increased Strength and Increase Function. Body Parts: Back/Lumbar & Sacral Spine, Bilateral - Upper Extremity and Bilateral - Lower Extremity. TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 6/14/2022 Physician/Scribe: rk. Work Status: Return to work modified duty. Additional Instructions: Referred to Physical Therapy and Referred to Orthopedics.

33. **CHART NOTE:** Dated 05/31/2022, signed by Raffi Kazazian, M.D. **Subjective:** INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." **Present Complaint:** The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS:

Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/l shoulder, b/l knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to get CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also in MPH for workers comp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31 - F/u For LBP< b/l shoulder and b/l knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear, she will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds.

Assessment: Sprain of unspecified site of left knee, initial encounter Strain of musc/fast/tend at shldr/up arm, right arm, init sprain of unspecified site of right knee, initial encounter Low back pain. Inj musc/tend the rotator cuff of left shoulder, init. Plan: TREATMENT ORDERS: ORTHOPEDIST REFERRAL: I recommend a consultation and treatment with a qualified Orthopedist. Referral Reason: lumbago, radicular symptoms. Referral Status: Regular. BACK SPECIALIST REFERRAL: I recommend a consultation and treatment with a qualified orthopedic back specialist. Referral Reason: b/l knee and b/l shoulder internal derangement. Referral Status: Regular. REQUEST FOR PHYSICAL THERAPY AUTHORIZATION: I recommended physical therapy: three times weekly for three weeks. Patient Problems: Stiffness, Pain and Limited ROM. PT MEDICAL NECESSITY: Treatment Goals: Increased ROM / Flexibility, Increased Strength and Increase Function. Body Parts: Back / Lumbar & Sacral Spine, Bilateral - Upper Extremity and Bilateral - Lower Extremity. TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 5/14/2022 Physician/Scribe: rk. Work Status: Return to work modified duty. Additional Instructions: Referred to Physical Therapy and Referred to Orthopedics.

34. **WORK STATUS SUMMARY:** Dated 06/13/2022, signed by Raffi Kazazian, M.D. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj musc tend the rotator cuff of left shoulder, init. Work Status: Return to work with restrictions, from 6/13/22 thru 6/27/22. Follow-Up Appointments: 6/27/22 at 11:15 AM.

35. **PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2):** Dated 06/13/2022, signed by Raffi Kazazian, M.D. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj musc tend the rotator cuff of left shoulder, init. Work Status: This patient has been instructed to return to modified work on 04/18/2022 with the following limitations or restrictions. Work relatedness: work related injury. Restrictions-shoulder. Subjective: INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property

then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/I shoulder, b/I knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to gel CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also in MPH for workers comp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't to report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31- F/u For LBP< b/l shoulder and b/I knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear. She will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. 6/13- F/u for LBP, b/I knee and b/I shoulder pain. She had prior nonwork related L shoulder injury just before the work injury and MRI confirmed no changes since prior, she even called UMI and had radiologist add an addendum to his report explaining that $5.5 > 3.5$ mm partial tear was a negligible difference and that there was no progression of tear and MRI was essentially unchanged. I discussed with her again that L shoulder injury was not considered work related for this reason, she had already been receiving care for this and CSI, PT and possible surgery was rec'd but she could not start with that ortho surgeon because she is unvax. She has been approved for PT for low back. R shoulder and b/l knee as of 6/7, she states she did not get any notification until this week. She is also pending auth to ortho spine and ortho for b/I knee and R shoulder. She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for L. shoulder although she understands this was the reason for the repeat MRI. Plan: TREATMENT PLAN INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 6/27/2022 Physician/Scribe: rk. Work Status: Return to work modified dut. Additional Instructions: Start Physical Therapy. Treatment plan: PT approved for R shoulder, b/I knee and I advised to start ASAP. Discussed case with Luis Morones from forest lawn and left message for destiny from insurance.

36. CHART NOTE: Dated 06/13/2022, signed by Raffi Kazazian, M.D. Subjective: INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the

other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching, SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/l shoulder, b/l knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. 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She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31- F/u For LBP< b/l shoulder and b/l knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear. She will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. 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She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for L. shoulder although she understands this was the reason for the repeat MRI. Assessment: Sprain of unspecified site of left knee, initial encounter Strain of must/fast/tend at shldr/up arm, right arm, init sprain of unspecified site of right knee, initial encounter Low back pain. Inj must/tend the rotator cuff of left shoulder, init. Plan: TREATMENT PLAN INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 6/27/2022 Physician/Scribe: rk. Work Status: Return to work modified dut. Additional Instructions: Start Physical Therapy. Treatment plan: PT approved for R shoulder, b/l knee and I advised to start ASAP. Discussed case with Luis Morones from forest lawn and left message for destiny from insurance.

37. **PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)**; Dated 06/27/2022, signed by Raffi Kazazian, M.D. **Diagnoses:** 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. **Work Status:** This patient has been instructed to return to modified work on 04/18/2022 with the following limitations or restrictions. Work relatedness: work related injury. Restrictions-shoulder. **Subjective:** INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. 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She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. 6/13- F/u for LBP, b/I knee and b/I shoulder pain. She had prior nonwork related L shoulder injury just before the work injury and MRI confirmed no changes since prior, she even called UMI and had radiologist add an addendum to his report explaining that $5.5 > 3.5$ mm partial tear was a negligible difference and that there was no progression of tear and MRI was essentially unchanged. I discussed with her again that L shoulder injury was not considered work related for this reason, she had already been receiving care for this and CSI, PT and possible surgery was rec'd but she could not start with that ortho surgeon because she is unvax. She has been approved for PT for low back. R shoulder and b/I knee as of 6/7, she states she did not get any notification until this week. She is also pending auth to ortho spine and ortho for b/I knee and R shoulder. She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for I. shoulder although she understands this was the reason for the repeat MRI. **Assessment:** Sprain of unspecified site of left knee, initial encounter Strain of must/fast/tend at shldr/up

arm, right arm, init sprain of unspecified site of right knee, initial encounter Low back pain. Inj must/tend the rotator cuff of left shoulder, init. 6/27 - F/u for LBP b/I knee and shoulder pain. 4-5/10, just started PT last week, used US and TENS. Did get some soreness the next day but admits to some benefit in general. Has been off from work due to inability to accommodate is currently on 5 pound lifting restrictions states that she has tried lifting 10 pounds at PT. reviewed MRI again with patient and discussed why L shoulder injury should be considered non work related since she did bring an MRI from prior non work related injury and compared with new WRI 5/24 after work fall revealed no progression of partial tear of supraspinatus, that injury was eval ty PMD and she had zoom call and PT, CSI and surgery was recommended, she is upset that for some reason she believes she was told that she shouldn't continue getting treatment for the I shoulder by PMD since she did have a fall after that injury. In regards to R shoulder injury which did appear to be new as well as L knee injury and low back pain since it appeared that she only had workup from outside injury for L shoulder and R knee with xr of each and MRI of I shoulder revealing the partial tear. MRI was subsequently done for all other body parts including LS spine, bilateral knees and shoulder, new L shoulder MRI showed no progression of tear so L shoulder injury was deemed not work 'elated, R shoulder does show full thickness supraspinatus tear and high grade partial thickness bicep tendon tear there was retraction and atrophy for both, I explained to the patient that although it was about a month since the fall, that even her previous I. shoulder injury still didn't reveal any retraction or atrophy and demonstrated acute findings which would be due to the fall outside of work. Her knee MRI did show chronic changes as well but also some prepatellar bursitis which may have been due to fall. Patient's primary issue since first visit has been her I. shoulder and this has been explained multiple times to not be related to the work injury which didn't seem to exacerbate her symptoms considerably and objectively by MRI showed no worsening. L5 spine MRI showed deg changes, mild to moderate disc bulge, greatest at 3.5mm she likely had chronic back issues which were exacerbated with the work fall but this must have partly been exacerbated due to previous fall from few weeks earlier outside of work, although we don't have records from PMD and she denies c/o any back pain to PMD. I called adjuster while patient was still in office and discussed case and agreed that upon reviewing all her medical records after release from PMD office and given a trial of PT we should have her evaluated by ortho if symptoms persist. Plan: TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 7/11/2022 Physician/Scribe: rk. Work Status: Return to work modified duty. Additional Instructions: Continue Physical Therapy.

38. **CHART NOTE:** Dated 06/27/2022, signed by Raffi Kazazian, M.D. **Subjective:** INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." **Present Complaint:** The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/I shoulder, b/I knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to gel CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also in MPH for workers comp but today found out he

is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't to report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31- F/u For LBP< b/I shoulder and b/I knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear. She will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. 6/13- F/u for LBP, b/I knee and b/I shoulder pain. She had prior nonwork related L shoulder injury just before the work injury and MRI confirmed no changes since prior, she even called UMI and had radiologist add an addendum to his report explaining that $5.5 > 3.5$ mm partial tear was a negligible difference and that there was no progression of tear and MRI was essentially unchanged. I discussed with her again that L shoulder injury was not considered work related for this reason, she had already been receiving care for this and CSI, PT and possible surgery was rec'd but she could not start with that ortho surgeon because she is unvax. She has been approved for PT for low back. R shoulder and b/I knee as of 6/7, she states she did not get any notification until this week. She is also pending auth to ortho spine and ortho for b/I knee and R shoulder. She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for I. shoulder although she understands this was the reason for the repeat MRI. Assessment: Sprain of unspecified site of left knee, initial encounter Strain of musc/fasc/tend at shldr/up arm, right arm, init sprain of unspecified site of right knee, initial encounter Low back pain. Inj musc/tend the rotator cuff of left shoulder, init. 6/27 - F/u for LBP b/I knee and shoulder pain. 4-5/10, just started PT last week, used US and TENS. Did get some soreness the next day but admits to some benefit in general. Has been off from work due to inability to accommodate is currently on 5 pound lifting restrictions states that she has tried lifting 10 pounds at PT. reviewed MRI again with patient and discussed why L shoulder injury should be considered non work related since she did bring an MRI from prior non work related injury and compared with new WRI 5/24 after work fall revealed no progression of partial tear of supraspinatus, that injury was eval ty PMD and she had zoom call and PT, CSI and surgery was recommended, she is upset that for some reason she believes she was told that she shouldn't continue getting treatment for the I shoulder by PMD since she did have a fall after that injury. In regards to R shoulder injury which did appear to be new as well as L knee injury and low back pain since it appeared that she only had workup from outside injury for L shoulder and R knee with xr of each and MRI of I shoulder revealing the partial tear. MRI was subsequently done for all other body parts including LS spine, bilateral knees and shoulder, new L shoulder MRI showed no progression of tear so L shoulder injury was deemed not work related, R shoulder does show full thickness supraspinatus tear and high grade partial thickness bicep tendon tear there was retraction and atrophy for both, I explained to the patient that although it was about a month since the fall, that even her previous I. shoulder injury still didn't reveal any retraction or atrophy and demonstrated acute findings which would be due to the fall outside of work. Her knee MRI did show chronic changes as well but also some prepatellar bursitis which may have been due to fall. Patient's primary issue since first visit has been her I. shoulder and this has been explained multiple times to not be related to the work injury which didn't seem to exacerbate her symptoms considerably and objectively by MRI showed no worsening. L5 spine MRI showed deg changes, mild to moderate disc bulge, greatest at 3.5mm she likely had chronic back issues which were exacerbated with the work fall but this must have partly been exacerbated due to previous fall from few weeks earlier outside of work, although we don't have records from PMD and she denies c/o any back pain to PMD. I called adjuster while patient was still in office and discussed case and agreed that upon reviewing all her medical records after release from PMD office and given a trial of PT we should have her evaluated by ortho if symptoms persist. Assessment: Sprain of unspecified site of left knee, initial encounter Strain of musc/fasc/tend at shldr/up arm, right arm, init Sprain of unspecified site of right knee, initial encounter Low back pain. Inj musc/tend the rotator cuff of left shoulier, init. Plan: TREATMENT PLAN / INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 7/11/2022 Physician/Scribe: rk. Work Status: Return to work modified duty. Additional Instructions: Continue Physical Therapy.

39. **PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)**: Dated 07/11/2022, signed by Raffi Kazazian, M.D. **Diagnoses:** 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. **Work Status:** This patient has been instructed to return to modified work on 04/18/2022 with the following limitations or restrictions. Work relatedness: work related injury. Restrictions-shoulder. **Subjective:** INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." **Present Complaint:** The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/l shoulder, b/l knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to gel CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also in MPH for workers comp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't to report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31- F/u For LBP< b/l shoulder and b/l knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear. She will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. 6/13- F/u for LBP, b/l knee and b/l shoulder pain. She had prior nonwork related L shoulder injury just before the work injury and MRI confirmed no changes since prior, she even called UMI and had radiologist add an addendum to his report explaining that $5.5 > 3.5$ mm partial tear was a negligible difference and that there was no progression of tear and MRI was essentially unchanged. I discussed with her again that L shoulder injury was not considered work related for this reason, she had already been receiving care for this and CSI, PT and possible surgery was rec'd but she could not start with that ortho surgeon because she is unvax. She has been approved for PT for low back. R shoulder and b/l knee as of 6/7, she states she did not get any notification until this week. She is also pending auth to ortho spine and ortho for b/l knee and R shoulder. She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for L. shoulder although she understands this was the reason for the repeat MRI. **Assessment:** Sprain of unspecified site of left knee, initial encounter Strain of must/fast/tend at shldr/up

arm, right arm, init sprain of unspecified site of right knee, initial encounter Low back pain. Inj must/tend the rotator cuff of left shoulder, init. 6/27 - F/u for LBP b/I knee and shoulder pain. 4-5/10, just started PT last week, used US and TENS. Did get some soreness the next day but admits to some benefit in general. Has been off from work due to inability to accommodate is currently on 5 pound lifting restrictions states that she has tried lifting 10 pounds at PT. reviewed MRI again with patient and discussed why L shoulder injury should be considered non work related since she did bring an MRI from prior non work related injury and compared with new WRI 5/24 after work fall revealed no progression of partial tear of supraspinatus, that injury was eval ty PMD and she had zoom call and PT, CSI and surgery was recommended, she is upset that for some reason she believes she was told that she shouldn't continue getting treatment for the I shoulder by PMD since she did have a fall after that injury. In regards to R shoulder injury which did appear to be new as well as L knee injury and low back pain since it appeared that she only had workup from outside injury for L shoulder and R knee with xr of each and MRI of I shoulder revealing the partial tear. MRI was subsequently done for all other body parts including LS spine, bilateral knees and shoulder, new L shoulder MRI showed no progression of tear so L shoulder injury was deemed not work 'elated, R shoulder does show full thickness supraspinatus tear and high grade partial thickness bicep tendon tear there was retraction and atrophy for both, I explained to the patient that although it was about a month since the fall, that even her previous I. shoulder injury still didn't reveal any retraction or atrophy and demonstrated acute findings which would be due to the fall outside of work. Her knee MRI did show chronic changes as well but also some prepatellar bursitis which may have been due to fall. Patient's primary issue since first visit has been her I. shoulder and this has been explained multiple times to not be related to the work injury which didn't seem to exacerbate her symptoms considerably and objectively by MRI showed no worsening. L5 spine MRI showed deg changes, mild to moderate disc bulge, greatest at 3.5mm she likely had chronic back issues which were exacerbated with the work fall but this must have partly been exacerbated due to previous fall from few weeks earlier outside of work, although we don't have records from PMD and she denies c/o any back pain to PMD. I called adjuster while patient was still in office and discussed case and agreed that upon reviewing all her medical records after release from PMD office and given a trial of PT we should have her evaluated by ortho if symptoms persist. 7/11- fit' for R shoulder, V knee and low back pain. R shoulder is 5/10, pain with elevation and limited oath. Has been lifting up to 10 pounds at PT which is helping. She has b/I knee pain medially with some instability. LBP is 5/10 as well and radiates down LLE. She is pending authorization for ortho surgery, she had already seen ortho for L shoulder which she had injured just prior to this work related injury. Plan: TREATMENT ORDERS; REQUEST FOR PHYSICAL THERAPY AUTHORIZATION: I recommended physical therapy: two times weekly for three weeks. Patient Problems: Stiffness, Pain and limited ROM. PT MEDICAL NECESSITY: Treatment Goals: Increased ROM/Flexibility and Increased Strength. Body Parts: Back/Lumbar & Sacral Spine, Right - Upper Extremity and Bilateral - Lower Extremity. TREATAIENT PLAN I INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 7/25/2022 Physician/Scribe: rk. Work Status: Return to work modified dull. Additional Instructions: Continue Physical Therapy. Discussed case with Jean Dominguez field case mgr, she will d/w adjuster. I believe at this point its reasonable to have patient evals by ortho for R shoulder and b/I knee, although she has findings of chronic injury on mri she did have a significant fall which may have acute/exacerbated condition. I also believe she should be seen by ortho spine due to persistent LBP with radicular symptoms. Patient will c/w PT for now and restrictions will be changed to 10 pounds. Plan: TREATMENT/ORDERS: REQUEST FOR PHYSICAL THERAPY AUTHORIZATION: I recommended physical therapy: two times weekly for three weeks. Patient Problems: Stiffness, Pain and Limited ROM. PT MEDICAL NECESSITY: Treatment Goals: Increased ROM/Flexibility and Increased Strength. Body Parts: Back/Lumbar & Sacral Spine, Right - Upper Extremity and Bilateral - Lower Extremity. TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 7/25/2022 Physician/Scribe: rk. Work Status: Return to work modified duty. Additional Instructions: Continue Physical Therapy. Discussed case with Jean Dominguez field case mgr, she will d/w adjuster. Believe at this point its reasonable to have patient eval's by ortho for R shoulder and b/I knee, although she has findings of chronic injury on mri she did have a significant fall which may have acutely exacerbated condition. I also believe she should be seen biortho spine due to persistent LBP with radicular symptoms patient will c/w PT for now and restrictions will be changed to 10 pounds.

40. **CHART NOTE:** Dated 07/11/2022, signed by Raffi Kazazian, M.D. **Subjective:** INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property

was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/l shoulder, b/l knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he rec'd NSAID, ice, CSI, PT and possible arthroscopic surgery. 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Has been off from work due to inability to accommodate is currently on 5 pound lifting restrictions states that she has tried lifting 10 pounds at PT. reviewed MRI again with patient and discussed why L shoulder injury should be considered non work related since she did bring an MRI from prior non work related injury and compared with new WRI 5/24 after work fall revealed no progression of partial tear of supraspinatus, that injury was eval ty PMD and she had zoom call and PT, CSI and surgery was recommended, she is upset that for some reason she believes

she was told that she shouldn't continue getting treatment for the I shoulder by PMD since she did have a fall after that injury. In regards to R shoulder injury which did appear to be new as well as L knee injury and low back pain since it appeared that she only had workup from outside injury for L shoulder and R knee with xr of each and MRI of I shoulder revealing the partial tear. MRI was subsequently done for all other body parts including LS spine, bilateral knees and shoulder, new L shoulder MRI showed no progression of tear so L shoulder injury was deemed not work related, R shoulder does show full thickness supraspinatus tear and high grade partial thickness bicep tendon tear there was retraction and atrophy for both, I explained to the patient that although it was about a month since the fall, that even her previous I. shoulder injury still didn't reveal any retraction or atrophy and demonstrated acute findings which would be due to the fall outside of work. Her knee MRI did show chronic changes as well but also some prepatellar bursitis which may have been due to fall. Patient's primary issue since first visit has been her I. shoulder and this has been explained multiple times to not be related to the work injury which didn't seem to exacerbate her symptoms considerably and objectively by MRI showed no worsening. L5 spine MRI showed deg changes, mild to moderate disc bulge, greatest at 3.5mm she likely had chronic back issues which were exacerbated with the work fall but this must have partly been exacerbated due to previous fall from few weeks earlier outside of work, although we don't have records from PMD and she denies c/o any back pain to PMD. I called adjuster while patient was still in office and discussed case and agreed that upon reviewing all her medical records after release from PMD office and given a trial of PT we should have her evaluated by ortho if symptoms persist. 7/11- fit' for R shoulder, V knee and low back pain. R shoulder is 5/10, pain with elevation and limited oath. Has been lifting up to 10 pounds at PT which is helping. She has b/I knee pain medially with some instability. LBP is 5/10 as well and radiates down LLE. She is pending authorization for ortho surgery, she had already seen ortho for L shoulder which she had injured just prior to this work related injury. Assessment: Sprain of unspecified site of left knee, initial encounter Strain of musc/fasc/tend at shldr/up arm, right arm, init. Sprain of unspecified site of right knee, initial encounter Low back pain. Inj muse/tend the rotator cuff of left shoulder, init.

41. **PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2):** Dated 07/28/2022, signed by Raffi Kazazian, M.D. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. Work Status: This patient has been instructed to return to modified work on 04/18/2022 with the following limitations or restrictions. Work relatedness: work related injury. Restrictions-shoulder. Subjective: INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/I shoulder, b/I knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to gel CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also

in MPH for workers comp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes workers comp cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31-F/u For LBP< b/I shoulder and b/I knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear. She will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. 6/13- F/u for LBP, b/I knee and b/I shoulder pain. She had prior nonwork related L shoulder injury just before the work injury and MRI confirmed no changes since prior, she even called UMI and had radiologist add an addendum to his report explaining that $5.5 > 3.5$ mm partial tear was a negligible difference and that there was no progression of tear and MRI was essentially unchanged. I discussed with her again that L shoulder injury was not considered work related for this reason, she had already been receiving care for this and CSI, PT and possible surgery was rec'd but she could not start with that ortho surgeon because she is unvax. She has been approved for PT for low back. R shoulder and b/l knee as of 6/7, she states she did not get any notification until this week. She is also pending auth to ortho spine and ortho for b/I knee and R shoulder. She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for I. shoulder although she understands this was the reason for the repeat MRI. 6/27 - F/u for LBP b/I knee and shoulder pain. 4-5/10, just started PT last week, used US and TENS. Did get some soreness the next day but admits to some benefit in general. Has been off from work due to inability to accommodate is currently on 5 pound lifting restrictions states that she has tried lifting 10 pounds at PT. reviewed MRI again with patient and discussed why L shoulder injury should be considered non work related since she did bring an MRI from prior non work related injury and compared with new WRI 5/24 after work fall revealed no progression of partial tear of supraspinatus, that injury was eval ty PMD and she had zoom call and PT, CSI and surgery was recommended, she is upset that for some reason she believes she was told that she shouldn't continue getting treatment for the I shoulder by PMD since she did have a fall after that injury. In regards to R shoulder injury which did appear to be new as well as L knee injury and low back pain since it appeared that she only had workup from outside injury for L shoulder and R knee with xr of each and MRI of I shoulder revealing the partial tear. MRI was subsequently done for all other body parts including LS spine, bilateral knees and shoulder, new L shoulder MRI showed no progression of tear so L shoulder injury was deemed not work related, R shoulder does show full thickness supraspinatus tear and high grade partial thickness bicep tendon tear there was retraction and atrophy for both, I explained to the patient that although it was about a month since the fall, that even her previous I. shoulder injury still didn't reveal any retraction or atrophy and demonstrated acute findings which would be due to the fall outside of work. Her knee MRI did show chronic changes as well but also some prepatellar bursitis which may have been due to fall. Patient's primary issue since first visit has been her I. shoulder and this has been explained multiple times to not be related to the work injury which didn't seem to exacerbate her symptoms considerably and objectively by MRI showed no worsening. L5 spine MRI showed deg changes, mild to moderate disc bulge, greatest at 3.5mm she likely had chronic back issues which were exacerbated with the work fall but this must have partly been exacerbated due to previous fall from few weeks earlier outside of work, although we don't have records from PMD and she denies c/o any back pain to PMD. I called adjuster while patient was still in office and discussed case and agreed that upon reviewing all her medical records after release from PMD office and given a trial of PT we should have her evaluated by ortho if symptoms persist. 7/11- fit' for R shoulder, V knee and low back pain. R shoulder is 5/10, pain with elevation and limited oath. Has been lifting up to 10 pounds at PT which is helping. She has b/I knee pain medially with some instability. LBP is 5/10 as well and radiates down LLE. She is pending authorization for ortho surgery, she had already seen ortho for L shoulder which she had injured just prior to this work related injury. 7/28- F/u for R shoulder b/I knee and lbp. Symptoms persist, tried lifting 20 pounds and symptoms worsened. Has been off work, doing PT, had 4 addition sessions approved. Per pt adjuster told her that congress is still reviewing records to see if

they will accept, she found out that the surgeon she wanted to see has been off from work due to medical condition trying to see same surgeon for knee and shoulder now. Plan: TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 8/12/2022 Physician/Scribe: rk. Work Status: Return to work modified duty. Additional Instructions: Continue Physical Therapy. Treatment Plan: Pending ortho spine and ortho appt for R shoulder and b/l knee.

42. **CHART NOTE:** Dated 07/28/2022, signed by Raffi Kazazian, M.D. **Subjective:** INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." **Present Complaint:** The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/I shoulder, b/I knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to gel CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also in MPH for workers comp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't to report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31- F/u For LBP< b/I shoulder and b/I knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear. She will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. 6/13- F/u for LBP, b/I knee and b/I shoulder pain. She had prior nonwork related L shoulder injury just before the work injury and MRI confirmed no changes since prior, she even called UMI and had radiologist add an addendum to his report explaining that $5.5 > 3.5$ mm partial tear was a negligible difference and that there was no progression of tear and MRI was essentially unchanged. I discussed with her again that L shoulder injury was not considered work related for this reason, she had already been receiving care for this and CSI, PT and possible surgery was rec'd but she could not start with that ortho surgeon because she is unvax. She has been approved for PT for low back. R shoulder and b/l knee as of 6/7, she states she did not get any notification until this week. She is also pending auth to ortho spine and ortho for b/I knee and R shoulder. She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for I. shoulder although she

understands this was the reason for the repeat MRI. 6/27 - F/u for LBP b/l knee and shoulder pain. 4-5/10, just started PT last week, used US and TENS. Did get some soreness the next day but admits to some benefit in general. Has been off from work due to inability to accommodate is currently on 5 pound lifting restrictions states that she has tried lifting 10 pounds at PT. reviewed MRI again with patient and discussed why L shoulder injury should be considered non work related since she did bring an MRI from prior non work related injury and compared with new MRI 5/24 after work fall revealed no progression of partial tear of supraspinatus, that injury was eval by PMD and she had zoom call and PT, CSI and surgery was recommended, she is upset that for some reason she believes she was told that she shouldn't continue getting treatment for the I shoulder by PMD since she did have a fall after that injury. In regards to R shoulder injury which did appear to be new as well as L knee injury and low back pain since it appeared that she only had workup from outside injury for L shoulder and R knee with xr of each and MRI of I shoulder revealing the partial tear. MRI was subsequently done for all other body parts including LS spine, bilateral knees and shoulder, new L shoulder MRI showed no progression of tear so L shoulder injury was deemed not work 'elated', R shoulder does show full thickness supraspinatus tear and high grade partial thickness bicep tendon tear there was retraction and atrophy for both, I explained to the patient that although it was about a month since the fall, that even her previous I. shoulder injury still didn't reveal any retraction or atrophy and demonstrated acute findings which would be due to the fall outside of work. Her knee MRI did show chronic changes as well but also some prepatellar bursitis which may have been due to fall. Patient's primary issue since first visit has been her I. shoulder and this has been explained multiple times to not be related to the work injury which didn't seem to exacerbate her symptoms considerably and objectively by MRI showed no worsening. L5 spine MRI showed deg changes, mild to moderate disc bulge, greatest at 3.5mm she likely had chronic back issues which were exacerbated with the work fall but this must have partly been exacerbated due to previous fall from few weeks earlier outside of work, although we don't have records from PMD and she denies c/o any back pain to PMD. I called adjuster while patient was still in office and discussed case and agreed that upon reviewing all her medical records after release from PMD office and given a trial of PT we should have her evaluated by ortho if symptoms persist. 7/11- fit' for R shoulder, V knee and low back pain. R shoulder is 5/10, pain with elevation and limited oath. Has been lifting up to 10 pounds at PT which is helping. She has b/l knee pain medially with some instability. LBP is 5/10 as well and radiates down LLE. She is pending authorization for ortho surgery, she had already seen ortho for L shoulder which she had injured just prior to this work related injury. 7/28- F/u for R shoulder b/l knee and lbp. Symptoms persist, tried lifting 20 pounds and symptoms worsened. Has been off work, doing PT, had 4 addition sessions approved. Per pt adjuster told her that congress is still reviewing records to see if they will accept, she found out that the surgeon she wanted to see has been off from work due to medical condition trying to see same surgeon for knee and shoulder now. Assessment: Sprain of unspecified site of left knee, init encounter Strain of musc/fasci tend at shldr/up arm, right arm, init Sprain of unspecified site of right knee, initial encounter Low back pain. Inj musc/tend the rotator cuff of left shoulder, init Plan: TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 8/12/2022 Physician/Scribe: rk. Work Status: Return to work modified dut. Additional Instructions: Continue Physical Therapy. Treatment Plan: Pending ortho spine and ortho appt for R shoulder and b/l knee.

43. **APPLICATION FOR ADJUDICATION OF CLAIM:** Dated 08/10/2022. Employer Name: FOREST LAWN MEMORIAL PARK. Date of Birth: 07/10/1956. Occupation: PLANNING ADVISOR. Date of Injury: CT: 09/03/2019-04/18/2022. Injured Body Parts: 420 BACK and 145 TEETH. How Injury Occurred: CUMULATIVE TRAUMA ADDITIONAL BODY PARTS LUMBAR SPINE, SLEEPING DISORDER, DENTAL.

44. **PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2):** Dated 08/12/2022, signed by Raffi Kazazian, M.D. Diagnoses: 1) Sprain of unspecified site of left knee, initial encounter. 2) Strain of musc/fasci tend at shldr/up arm, right arm, init. 3) Sprain of unspecified site of right knee, initial encounter. 4) Low back pain. 5) Inj muscl tend the rotator cuff of left shoulder, init. Work Status: This patient has been instructed to return to modified work on 04/18/2022 with the following limitations or restrictions. Work relatedness: work related injury. Restrictions-shoulder. Subjective: INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s):

PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. **SIGNS/SYMPOTMS:** Pain and Swelling. **LOCATION:** Knee, Lower back and Shoulder. **QUALITY:** Aching. **SEVERITY:** Patient rates their pain as 5 on a scale of 0 to 10. **DURATION:** 4 Days. **TIMING:** Constant. **CONTEXT/MECHANISM:** Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. **AGGRAVATING FACTORS:** Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/I shoulder, b/I knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to gel CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also in MPH for workers comp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't to report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31- F/u For LBP< b/I shoulder and b/I knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear. She will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. 6/13- F/u for LBP, b/I knee and b/I shoulder pain. She had prior nonwork related L shoulder injury just before the work injury and MRI confirmed no changes since prior, she even called UMI and had radiologist add an addendum to his report explaining that $5.5 > 3.5$ mm partial tear was a negligible difference and that there was no progression of tear and MRI was essentially unchanged. I discussed with her again that L shoulder injury was not considered work related for this reason, she had already been receiving care for this and CSI, PT and possible surgery was rec'd but she could not start with that ortho surgeon because she is unvax. She has been approved for PT for low back. R shoulder and b/l knee as of 6/7, she states she did not get any notification until this week. She is also pending auth to ortho spine and ortho for b/I knee and R shoulder. She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for I. shoulder although she understands this was the reason for the repeat MRI. **Assessment:** Sprain of unspecified site of left knee, initial encounter Strain of must/fast/tend at shldr/up arm, right arm, init sprain of unspecified site of right knee, initial encounter Low back pain. Inj must/tend the rotator cuff of left shoulder, init. 6/27 - F/u for LBP b/I knee and shoulder pain. 4-5/10, just started PT last week, used US and TENS. Did get some soreness the next day but admits to some benefit in general. Has been off from work due to inability to accommodate is currently on 5 pound lifting restrictions states that she has tried lifting 10 pounds at PT. Reviewed MRI again with patient and discussed why L shoulder injury should be considered non work related since she did bring an MRI from prior non work related injury and compared with new WRI 5/24 after work fall revealed no progression of partial tear of supraspinatus, that injury was eval ty PMD and she had zoom call and PT, CSI and surgery was recommended, she is upset that for some reason she believes she was told that she shouldn't continue getting treatment for the I shoulder by PMD since she did have a fall after that injury. In regards to R shoulder injury which did appear to be new as well as L knee injury and low back pain since it appeared that she only had workup

from outside injury for L shoulder and R knee with xr of each and MRI of I shoulder revealing the partial tear. MRI was subsequently done for all other body parts including LS spine, bilateral knees and shoulder, new L shoulder MRI showed no progression of tear so L shoulder injury was deemed not work related, R shoulder does show full thickness supraspinatus tear and high grade partial thickness bicep tendon tear there was retraction and atrophy for both, I explained to the patient that although it was about a month since the fall, that even her previous I. shoulder injury still didn't reveal any retraction or atrophy and demonstrated acute findings which would be due to the fall outside of work. Her knee MRI did show chronic changes as well but also some prepatellar bursitis which may have been due to fall. Patient's primary issue since first visit has been her I. shoulder and this has been explained multiple times to not be related to the work injury which didn't seem to exacerbate her symptoms considerably and objectively by MRI showed no worsening. L5 spine MRI showed deg changes, mild to moderate disc bulge, greatest at 3.5mm she likely had chronic back issues which were exacerbated with the work fall but this must have partly been exacerbated due to previous fall from few weeks earlier outside of work, although we don't have records from PMD and she denies c/o any back pain to PMD. I called adjuster while patient was still in office and discussed case and agreed that upon reviewing all her medical records after release from PMD office and given a trial of PT we should have her evaluated by ortho if symptoms persist. 7/11- fit' for R shoulder, V knee and low back pain. R shoulder is 5/10, pain with elevation and limited oath. Has been lifting up to 10 pounds at PT which is helping. She has b/I knee pain medially with some instability. LBP is 5/10 as well and radiates down LLE. She is pending authorization for ortho surgery, she had already seen ortho for L shoulder which she had injured just prior to this work related injury. 7/28- F/u for R shoulder b/I knee and lbp. Symptoms persist, tried lifting 20 pounds and symptoms worsened. Has been off work, doing PT, had 4 addition sessions approved. Per pt adjuster told her that congress is still reviewing records to see if they will accept, she found out that the surgeon she wanted to see has been off from work due to medical condition trying to see same surgeon for knee and shoulder now. 8/12 - F/u For R shoulder, b/i knee and low back pain. Pain is 5/10, PT has helped. She has finally been approved to see Dr. Ashford for spine and Dr. Adamson for b/I knee and R shoulder she was also gonna see Dr. Adamson for L shoulder which is not work related. Appt with ortho spine is 9/15. She would like to try more PT. has been doing chiro on her own (he doesn't take workers comp). Plan: TREATMENT/ORDERS: REQUEST FOR PHYSICAL THERAPY AUTHORIZATION: I recommended physical therapy: Two times weekly for two weeks. Patient Problems: Stiffness and Pain. PT MEDICAL NECESSITY: Treatment Goals: increased ROM/Flexibility and Increased Strength. Body Parts: Back/Lumbar & Sacral Spine, Right - Upper Extremity and Bilateral - Upper Extremity. TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 9/16/2022 Physician/Scribe: rk. Work Status: Return to work modified duty. Additional Instructions: Continue Physical Therapy.

45. CHART NOTE: Dated 08/12/2022, signed by Raffi Kazazian, M.D. Subjective: INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/I shoulder, b/I knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want

to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to gel CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also in MPH for workers comp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't to report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31- F/u For LBP< b/l shoulder and b/l knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear. She will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. 6/13- F/u for LBP, b/I knee and b/I shoulder pain. She had prior nonwork related L shoulder injury just before the work injury and MRI confirmed no changes since prior, she even called UMI and had radiologist add an addendum to his report explaining that $5.5 > 3.5$ mm partial tear was a negligible difference and that there was no progression of tear and MRI was essentially unchanged. I discussed with her again that L shoulder injury was not considered work related for this reason, she had already been receiving care for this and CSI, PT and possible surgery was rec'd but she could not start with that ortho surgeon because she is unvax. She has been approved for PT for low back. R shoulder and b/l knee as of 6/7, she states she did not get any notification until this week. She is also pending auth to ortho spine and ortho for b/I knee and R shoulder. She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for I. shoulder although she understands this was the reason for the repeat MRI. Assessment: Sprain of unspecified site of left knee, initial encounter Strain of must/fast/tend at shldr/up arm, right arm, init sprain of unspecified site of right knee, initial encounter Low back pain. Inj must/tend the rotator cuff of left shoulder, init. 6/27 - F/u for LBP b/I knee and shoulder pain. 4-5/10, just started PT last week, used US and TENS. Did get some soreness the next day but admits to some benefit in general. Has been off from work due to inability to accommodate is currently on 5 pound lifting restrictions states that she has tried lifting 10 pounds at PT. Reviewed MRI again with patient and discussed why L shoulder injury should be considered non work related since she did bring an MRI from prior non work related injury and compared with new WRI 5/24 after work fall revealed no progression of partial tear of supraspinatus, that injury was eval ty PMD and she had zoom call and PT, CSI and surgery was recommended, she is upset that for some reason she believes she was told that she shouldn't continue getting treatment for the I shoulder by PMD since she did have a fall after that injury. In regards to R shoulder injury which did appear to be new as well as L knee injury and low back pain since it appeared that she only had workup from outside injury for L shoulder and R knee with xr of each and MRI of I shoulder revealing the partial tear. MRI was subsequently done for all other body parts including LS spine, bilateral knees and shoulder, new L shoulder MRI showed no progression of tear so L shoulder injury was deemed not work 'elated, R shoulder does show full thickness supraspinatus tear and high grade partial thickness bicep tendon tear there was retraction and atrophy for both, I explained to the patient that although it was about a month since the fall, that even her previous I. shoulder injury still didn't reveal any retraction or atrophy and demonstrated acute findings which would be due to the fall outside of work. Her knee MRI did show chronic changes as well but also some prepatellar bursitis which may have been due to fall. Patient's primary issue since first visit has been her I. shoulder and this has been explained multiple times to not be related to the work injury which didn't seem to exacerbate her symptoms considerably and objectively by MRI showed no worsening. L5 spine MRI showed deg changes, mild to moderate disc bulge, greatest at 3.5mm she likely had chronic back issues which were exacerbated with the work fall but this must have partly been exacerbated due to previous fall from few weeks earlier outside of work, although we don't have records from PMD and she denies c/o any back pain to PMD. I called adjuster while patient was still in office and discussed case and agreed that upon reviewing all her medical records after release from PMD office and given a trial of PT we should have her evaluated by ortho if symptoms persist. 7/11- fit' for R shoulder, V knee and low back

pain. R shoulder is 5/10, pain with elevation and limited oath. Has been lifting up to 10 pounds at PT which is helping. She has b/l knee pain medially with some instability. LBP is 5/10 as well and radiates down LLE. She is pending authorization for ortho surgery, she had already seen ortho for L shoulder which she had injured just prior to this work related injury. 7/28- F/u for R shoulder b/l knee and lbp. Symptoms persist, tried lifting 20 pounds and symptoms worsened. Has been off work, doing PT, had 4 addition sessions approved. Per pt adjuster told her that congress is still reviewing records to see if they will accept, she found out that the surgeon she wanted to see has been off from work due to medical condition trying to see same surgeon for knee and shoulder now. 8/12 - F/u For R shoulder, b/l knee and low back pain. Pain is 5/10, PT has helped. She has finally been approved to see Dr. Ashford for spine and Dr. Adamson for b/l knee and R shoulder she was also gonna see Dr. Adamson for L shoulder which is not work related. Assessment: Sprain of unspecified site of left knee, initial encounter Strain of musc/fasc/tend at shldr/up arm, right arm, init Sprain of unspecified site of right knee, initial encounter Low back pain. Inj muse/tend she rotator cuff of left shoulder, init Plan: TREATMENT/ORDERS: REQUEST FOR PHYSICAL THERAPY AUTHORIZATION: I recommended physical therapy: Two times weekly for two weeks. Patient Problems: Stiffness and Pain. PT MEDICAL NECESSITY: Treatment Goals: increased ROM/Flexibilty and Increased Strength. Body Parts: Back/Lumbar & Sacral Spine, Right - Upper Extremity and Bilateral - Upper Extremity. TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 9/16/2022 Physician/Scribe: rk. Work Status: Return to work modified duty. Additional Instructions: Continue Physical Therapy.

46. **HISTORY & PHYSICAL REPORT:** Dated 08/15/2022, signed by Gregory J. Adamson, M.D. Chief Complaint: Left shoulder pain. History: The patient is a right-hand dominant 66-year-old woman who presents today for an evaluation of her left shoulder. On 04/05/2022, she was walking on the sidewalk. Her foot got stuck in a portion of uneven ground, and caused her to fall onto her left shoulder. On 04/15/2022, she fell again while at work. Since then, she has had moderate throbbing pain in her shoulder. It has recently begun to radiate down her arm. She has pain at night, localized over her deltoid region that is positional in nature. She has limitation with range of motion. She has difficulty raising her left arm above her head, especially in the morning. Her pain is exacerbated by activity, cold, and movement. She has been using heat and natural pain killers with some relief. She has gone to the chiropractor two to three times now in an effort to decrease her pain. Impression: Bursal-sided partial thickness rotator cuff tear, left shoulder. Treatment Plan: We discussed the implications of a rotator cuff tear in detail. Over time, a rotator cuff tear may stay the same or increase in size. With time, atrophic changes will develop, which are irreversible. With an arthroscopic repair, we discussed 95% get complete or near complete pain relief. 80% get back 80% or more of their premorbid function. Without surgery, 50% will progress in size and symptomatology. Presently, given the small size of the partial thickness rotator cuff tear, I recommend that she attend a trial course of formalized physical therapy. We will plan to see her back in 4 weeks for repeat clinical evaluation of her left shoulder.

47. **HISTORY & PHYSICAL REPORT:** Dated 08/15/2022, signed by Gregory J. Adamson, M.D. History: The patient is a 66-year-old female. Assessment/Plan: Left rotator cuff tear. Impression: Bursal-sided partial thickness rotator cuff tear, left shoulder.

48. **HISTORY & PHYSICAL REPORT:** Dated 09/06/2022, signed by Gregory J. Adamson, M.D. History: The patient is a 66-year-old female. Assessment/Plan: Tear of right supraspinatus tendon. Impression: Small tear in the supraspinatus with associated early atrophic changes, right shoulder.

49. **CHART NOTE:** Dated 09/09/2022, signed by Raffi Kazazian, M.D. Subjective: INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." Present Complaint: The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPTOMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS:

Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/l shoulder, b/l knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he recd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to gel CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also in MPH for workers comp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't to report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31- F/u For LBP< b/I shoulder and b/I knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear. She will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. 6/13- F/u for LBP, b/I knee and b/I shoulder pain. She had prior nonwork related L shoulder injury just before the work injury and MRI confirmed no changes since prior, she even called UMI and had radiologist add an addendum to his report explaining that $5.5 > 3.5$ mm partial tear was a negligible difference and that there was no progression of tear and MRI was essentially unchanged. I discussed with her again that L shoulder injury was not considered work related for this reason, she had already been receiving care for this and CSI, PT and possible surgery was rec'd but she could not start with that ortho surgeon because she is unvax. She has been approved for PT for low back. R shoulder and b/l knee as of 6/7, she states she did not get any notification until this week. She is also pending auth to ortho spine and ortho for b/I knee and R shoulder. She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for I. shoulder although she understands this was the reason for the repeat MRI. Assessment: Sprain of unspecified site of left knee, initial encounter Strain of musc/fast/tend at shldr/up arm, right arm, init sprain of unspecified site of right knee, initial encounter Low back pain. Inj musc/tend the rotator cuff of left shoulder, init. 6/27 - F/u for LBP b/I knee and shoulder pain. 4-5/10, just started PT last week, used US and TENS. Did get some soreness the next day but admits to some benefit in general. Has been off from work due to inability to accommodate is currently on 5 pound lifting restrictions states that she has tried lifting 10 pounds at PT. Reviewed MRI again with patient and discussed why L shoulder injury should be considered non work related since she did bring an MRI from prior non work related injury and compared with new WRI 5/24 after work fall revealed no progression of partial tear of supraspinatus, that injury was eval ty PMD and she had zoom call and PT, CSI and surgery was recommended, she is upset that for some reason she believes she was told that she shouldn't continue getting treatment for the I shoulder by PMD since she did have a fall after that injury. In regards to R shoulder injury which did appear to be new as well as L knee injury and low back pain since it appeared that she only had workup from outside injury for L shoulder and R knee with xr of each and MRI of I shoulder revealing the partial tear. MRI was subsequently done for all other body parts including LS spine, bilateral knees and shoulder, new L shoulder MRI showed no progression of tear so L shoulder injury was deemed not work related, R shoulder does show full thickness supraspinatus tear and high grade partial thickness bicep tendon tear there was retraction and atrophy for both, I explained to the patient that although it was about a month since the fall, that

even her previous L. shoulder injury still didn't reveal any retraction or atrophy and demonstrated acute findings which would be due to the fall outside of work. Her knee MRI did show chronic changes as well but also some prepatellar bursitis which may have been due to fall. Patient's primary issue since first visit has been her L. shoulder and this has been explained multiple times to not be related to the work injury which didn't seem to exacerbate her symptoms considerably and objectively by MRI showed no worsening. L5 spine MRI showed deg changes, mild to moderate disc bulge, greatest at 3.5mm she likely had chronic back issues which were exacerbated with the work fall but this must have partly been exacerbated due to previous fall from few weeks earlier outside of work, although we don't have records from PMD and she denies c/o any back pain to PMD. I called adjuster while patient was still in office and discussed case and agreed that upon reviewing all her medical records after release from PMD office and given a trial of PT we should have her evaluated by ortho if symptoms persist. 7/11- fit' for R shoulder, V knee and low back pain. R shoulder is 5/10, pain with elevation and limited oath. Has been lifting up to 10 pounds at PT which is helping. She has b/l knee pain medially with some instability. LBP is 5/10 as well and radiates down LLE. She is pending authorization for ortho surgery, she had already seen ortho for L shoulder which she had injured just prior to this work related injury. 7/28- F/u for R shoulder b/l knee and lbp. Symptoms persist, tried lifting 20 pounds and symptoms worsened. Has been off work, doing PT, had 4 addition sessions approved. Per pt adjuster told her that congress is still reviewing records to see if they will accept, she found out that the surgeon she wanted to see has been off from work due to medical condition trying to see same surgeon for knee and shoulder now. 8/12 - F/u For R shoulder, b/l knee and low back pain. Pain is 5/10, PT has helped. She has finally been approved to see Dr. Ashford for spine and Dr. Adamson for b/l knee and R shoulder she was also gonna see Dr. Adamson for L shoulder which is not work related. apt with ortho spine is 9/15 - she would like to try more PT. has been doing chiro on her own (he doesn't take workers comp). 9/9- F/u for R shoulder, b/l knee and LBP. Has been seeing Dr Adamson for knees and shoulder she has initial apt with Dr. Ashford for spine next week wansi to Ow PT at congress. Assessment: Sprain of unspecified site of left knee, init 31 encounter Strain of musc/fascitend at shldr/up arm, right arm, init Sprain of unspecified site of right knee, initial encounter Low back pain. Inj musc/tend the rotator cuff of left shoulder, init Plan: TREATMENT PLAN/INSTRUCTIONS: PATIENT FOLLOW-UP APPOINTMENT: Work Comp Follow-up on 9/23/2022 Physician/Scribe: rk. Work Status: Return to work modified duty. Additional Instructions: Continue Physical Therapy and Continue Orthopedics.

50. **HISTORY & PHYSICAL REPORT:** Dated 09/12/2022, signed by Gregory J. Adamson, M.D. History: The patient is seen today in a follow up for her left shoulder. Since last seen, she has been experiencing occasional moderate pain and discomfort. She has been attending formalized physical therapy and states that it is helpful. She has been exercising with Theraband at physical therapy. She has also tried laser therapy, and states that it is helpful. Impression: Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder. Treatment Plan: She will continue with formalized physical therapy. We will plan to see her back in 4 weeks for repeat clinical evaluation.

51. **HISTORY & PHYSICAL REPORT:** Dated 09/12/2022, signed by Gregory J. Adamson, M.D. History: The patient is a 66-year-old female. Assessment/Plan: Left rotator cuff tear. Impression; Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder.

52. **HISTORY & PHYSICAL REPORT:** Dated 09/15/2022, signed by Roy F. Ashford, M.D. History: I had the pleasure of seeing patient in my office for an initial consultation. Patient words: I am new to Dr. Ashford (workers comp) I am here due to lower back pain radiating to both legs. The patient is a 66 year old female. She presents to the clinic as a new patient for evaluation of her low back pain radiating to both legs. She previously had a lumbar MRI scan that is available for review. This is worker's compensation. The patient reports while at work showing property to her client. She had went back to grab some paperwork due to the client was interested in another property, as she was walking back she had step into a mud puddle which caused her to slip landing onto her back. Injury occurred on 04/14/2022. At the beginning of her injury she was unable to walk. Recently she has noticed pain with sitting. Today she denies any numbness in the shin or calf. There is no muscle weakness. The leg radiculopathy today has resolved. Assessment/Plan: LIFESTYLE EDUCATION REGARDING DIET (98960) Routine (0). MRI scan of the lumbar spine obtained on 05/23/2022 were reviewed. This demonstrates a mild bugle t IA-5 and L3-4. Overall dimension of the canal is wide open. The foramen is wide open. There is no evidence of stenosis. L2-3 is open. There is evidence

of thickened ligaments but is open at L3-4. No stenosis at L4-5. Disc degenerations at the right facet joint at L4-5. Mild stenosis in the lateral recess at L4-5 and L5-S1. Lumbar strain. Degenerative disc, lumbar. The current problem demonstrates no direct neurologic involvement. I find only signs of strained muscles. There is nothing significant on x-ray other than age related degenerative changes as expected. I do not think that an MRI would allow more insight on the problem. If things change neurologically, I would consider getting an MRI later. Physical therapy and a good home exercise program will help start a habit of regular exercise, warm-ups, and stretching. I have explained different approaches for exercise, discussed resources such as health clubs, YMCAs, and pools in the area. I do not like long term use of medications for this, but anti-inflammatories certainly can provide early benefits. Careful behaviors, attention to posture, avoidance of heavy lifting and proper mechanics have all been stressed. Today the patient obtained an order to start physical therapy focusing on core stabilization.

53. **DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS:** Dated 09/15/2022, signed by Roy F. Ashford, M.D. **Subjective Complaints/Interim History:** I had the pleasure of seeing patient in my office for an initial consultation. Patient words: I am new to Dr. Ashford (workers comp) I am here due to lower back pain radiating to both legs. The patient is a 66 year old female. She presents to the clinic as a new patient for evaluation of her low back pain radiating to both legs. She previously had a lumbar MRI scan that is available for review. This is worker's compensation. The patient reports while at work showing property to her client. She had went back to grab some paperwork due to the client was interested in another property, as she was walking back she had step into a mud puddle which caused her to slip landing onto her back. Injury occurred on 04/14/2022. At the beginning of her injury she was unable to walk. Recently she has noticed pain with sitting. Today she denies any numbness in the shin or calf. There is no muscle weakness. The leg radiculopathy today has resolved. **Diagnosis/Treatment Plan:** Lumbar strain. How to Access Health Information Online using Patient Portal and 3rd Party Apps Overweight for height (E66.3). **Assessment:** LIFESTYLE EDUCATION REGARDING DIET (98960) Routine (0). MRI scan of the lumbar spine obtained on 05/23/2022 were reviewed. This demonstrates a mild bugle t IA-5 and L3-4. Overall dimension of the canal is wide open. The foramen is wide open. There is no evidence of stenosis. L2-3 is open. There is evidence of thickened ligaments but is open at L3-4. No stenosis at L4-5. Disc degenerations at the right facet joint at L4-5. Mild stenosis in the lateral recess at L4-5 and L5-S1. **Assessment:** Lumbar strain. Degenerative disc, lumbar. **Plan:** The current problem demonstrates no direct neurologic involvement. I find only signs of strained muscles. There is nothing significant on x-ray other than age related degenerative changes as expected. I do not think that an MRI would allow more insight on the problem. If things change neurologically, I would consider getting an MRI later. Physical therapy and a good home exercise program will help start a habit of regular exercise, warm-ups, and stretching. I have explained different approaches for exercise, discussed resources such as health clubs, YMCAs, and pools in the area. I do not like long term use of medications for this, but anti-inflammatories certainly can provide early benefits. Careful behaviors, attention to posture, avoidance of heavy lifting and proper mechanics have all been stressed. Today the patient obtained an order to start physical therapy focusing on core stabilization.

54. **OFFICE VISIT:** Dated 09/15/2022, signed by Elliot Bright PA-C. & Babak Samimi, M.D. **History:** Patient words: I am new to Dr. Ashford (workers comp) I am here due to lower back pain radiating to both legs. The patient is a 66 year old female. Note: She presents to the clinic as a new patient for evaluation of her low back pain radiating to both legs. She previously had a lumbar MRI scan that is available for review. This is worker's compensation. The patient reports while at work showing property to her client. She had went back to grab some paperwork due to the client was interested in another property, as she was walking back she had step into a mud puddle which caused her to slip landing onto her back. Injury occurred on 04/14/2022. At the beginning of her injury she was unable to walk. Recently she has noticed pain with sitting. Today she denies any numbness in the shin or calf. There is no muscle weakness. The leg radiculopathy today has resolved. **Assessment/Plan:** Lumbar strain. How to Access Health Information Online using Patient Portal and 3rd Party Apps Overweight for height (E66.3). LIFESTYLE EDUCATION REGARDING DIET (98960); Routine 0. MRI scan of the lumbar spine obtained on 05/23/2022 were reviewed. This demonstrates a mild bugle at L4-5 and L3-4. Overall dimension of the canal is wide open. The foramen is wide open. There is no evidence of stenosis. L2-3 is open. There is evidence of thickened ligaments but is open at L3-4. No stenosis at L4-5. Disc degenerations at the right facet joint at L4-5. Mild stenosis in the lateral recess at L4-5 and L5-S1. **Assessment:** Lumbar strain. Degenerative disc, lumbar. **Plan:** The current problem demonstrates no direct neurologic involvement. I find only signs of strained muscles. There is nothing significant on x-ray other than age

related degenerative changes as expected. I do not think that an MRI would allow more insight on the problem. If things change neurologically, I would consider getting an MRI later. Physical therapy and a good home exercise program will help start a habit of regular exercise, warm-ups, and stretching. I have explained different approaches for exercise, discussed resources such as health clubs, YMCAs, and pools in the area. I do not like long term use of medications for this, but anti-inflammatories certainly can provide early benefits. Careful behaviors, attention to posture, avoidance of heavy lifting and proper mechanics have all been stressed. Today the patient obtained an order to start physical therapy focusing on core stabilization.

55. **OFFICE VISIT:** Dated 09/22/2022, signed by Elliot Bright PA-C. & Babak Samimi, M.D. **Subjective:** On 4/14/22, the patient slipped and fell on her job site on some mud. She felt pain in her bilateral shoulders, bilateral knees, and low back. She reported the incident to her employer and was evaluated shortly after. She was taken off work after a few days and received some physical therapy which provided mild improvement of her symptoms; however, no resolution. MRI's were obtained and the patient presents for orthopedic evaluation. Pt do LOW BACK PAIN. Patient Denies Paresthesias and Motor Weakness Patient denies any bowel or bladder incontinence. Pt has difficulty sleeping at night and finding a comfortable position due to the pain. Pt do low back pain that is WORSE w/prolonged sitting and standing or with repetitive bending. Pain is WORSE after sitting for a period of time and then trying to get up, feeling stiffness, pain and limited flexibility. Pt do Bilateral Shoulder Pain, Weakness and Decreased Motion. Pain is located in the anterior and lateral aspects of the shoulder. Pain worse w/ overhead activity and lifting objects. Pt is unable to sleep on the side of the affected shoulder due to pain. Pt do shoulder weakness and decreased ROM that affects ADLs. Pt do Bilateral Shoulder Pain, Weakness and Decreased Motion.. Pain is located in the anterior and lateral aspects of the shoulder. Pain worse w/ overhead activity and lifting objects. Pt is unable to sleep on the side of the affected shoulder due to pain. Pt do shoulder weakness and decreased ROM that affects ADLs. The pt do bilateral knee pain. Pain located in the anterior and medial aspect of the knee. Pain worse with activities such as prolonged walking, stairs, kneeling or crouching Pt do locking, catching, clicking. Pt do grinding and pain in the knee worse with stairs. Pt do swelling in the knee. Pt has difficulty getting up from a seated position without pain and has stiffness in the knee. **Assessment:** Right shoulder. Large rotator cuff tear. Early degenerative joint disease (aggravation). Left shoulder (unclear authorization). Partial-thickness rotator cuff tear. AC joint arthrosis. Shoulder impingement syndrome with tendonitis/bursitis. Bilateral Knee: Moderate Degenerative Joint Disease (aggravation). Lumbar Spine: Multi-level Disc Herniations Lumbar Radiculitis. Outside x-rays of the Left Shoulder 4/7/22. Mild degenerative changes about the left shoulder. Outside x-rays of the Right Knee 4/7/22. Medial compartment osteoarthritis with a small to moderate size joint effusion. Quadriceps tendon enthesopathy. MRI of the Left Shoulder 4/7/22. Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial-thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis with adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis. My Interpretation: Moderate AC joint arthrosis. There is mild fatty atrophy of the supraspinatus tendon. There is a partial thickness tear at the footprint of the supraspinatus with reactive bony edema of the greater tuberosity. Outside Left Knee Series 4/18/22. There is mild generalized osteopenia. There is no evidence of acute fracture present. There is no evidence of acute fracture or dislocation. The alignment is intact. There are osteoarthritic changes of the medial and patellofemoral compartments of the knee present. Outside Right Shoulder Series 4/28/22. No evidence of fracture or dislocation. MRI of the Right Shoulder 5/17/22. Full-thickness supraspinatus tendon tear with retraction by 10 mm and has mild muscle bulk/fatty atrophy. Adjacent infraspinatus and subscapularis tendinosis. High-grade partial-thickness long head of the biceps tendon tear and retraction. Mild to moderate acromioclavicular joint arthrosis with adjacent subacromial/subdeltoid bursitis. MRI of the Left Knee 5/19/22. Peripheral extrusion of the medial meniscus from the joint line as well as heterogeneous signal at the anterior horn/body junction. A complex degenerative tear cannot be excluded at this site without post contrast imaging. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment. Subchondral edema versus bone contusion of the lateral femoral condyle posterior nonweightbearing aspect. Small to moderate size joint effusion. Quadriceps tendon enthesopathy. MRI of the Lumbar Spine 5/23/2. Mild to moderate disc desiccation of L4-L5 with a 3.5 mm broad-based disc protrusion and facet arthrosis causing mild central canal and neural foraminal stenosis bilaterally. Mild disc desiccation of L5-S1 with a 2 mm broad-based disc protrusion asymmetric to the right with facet arthrosis and an 8 mm complex synovial cyst in the right neural foramen causing mild central canal stenosis as well as moderate right-sided and mild to moderate left-sided neural foraminal stenosis. Less significant findings at the remainder of the disc levels as described above. Heterogeneous marrow signal diffusely which is nonspecific but may represent osteopenia

Pathologic process cannot basically without oncologic workup. MRI of the Left Shoulder 5/24/22. Supraspinatus and infraspinatus tendinosis with a persistent 3.5 mm partial-thickness supraspinatus footprint tear without retraction or associated muscle bulk atrophy. Mild acromioclavicular joint arthrosis with adjacent subacromial/subdeltoid bursitis. Addendum: Please add to the findings and impression regarding the 3.5 mm supraspinatus tendon tear. The difference in measurement is minimal and can be related to technique. These findings are likely stable when compared to the prior exam given the inherent difference in technique. However, interval scarring may also demonstrate similar findings. Clinical correlation with symptoms is recommended. MRI of the Right Knee 5/24/22. Peripheral extrusion of the medial meniscus from the joint line without a definite tear. Intrasubstance generation of the lateral meniscus at the body without a definite tear. MR arthrogram may be performed for further evaluation/characterization if clinical concern persists. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment. Quadriceps tendon enthesopathy. Mild prepatellar bursitis. My Interpretation: Moderate tricompartmental degenerative joint disease. Causation/Apportionment: Based on my best medical judgement, lack of evidence to the contrary and based on reasonable medical probability, the following conclusions have been made: The patient sustained an industrial related injury. Apportionment will be calculated at the time the patient reaches MMI. Plan: I request authorization to evaluate and treat the patient's left shoulder on an industrial basis as she is authorized for Right shoulder and Bilateral knee as well as the low back. These injuries involved the mechanism she was causing these accepted injuries would have caused or at least aggravated the Left shoulder symptoms as well. For the Bilateral Shoulder: REQUEST additional 12 sessions Physical Therapy: Shoulder ROM, Strengthening, Stretching, Modalities. I had a lengthy conversation with the patient regarding treatment options, risks, and benefits. Patient expressed understanding. Ultimately, recommended RIGHT Reverse Total Shoulder Replacement Surgery: Pt has severe degenerative joint disease and an irreparable rotator cuff tear (rotator cuff arthropathy) confirmed by x-ray and clinical exam and has failed conservative treatment including NSAIDs, RICE, Activity Modification, and PT. I recommend reverse total shoulder replacement to allow for improved pain and function. Ultimately, Recommend Left Shoulder Arthroscopic Surgery: Pt has a Rotator Cuff Tear and Impingement confirmed by MRI and clinical exam and has failed conservative treatment including NSAIDs, RICE, Activity Modification, and Therapy. Therefore, I recommend arthroscopic surgery for rotator cuff repair, subacromial decompression, glenohumeral debridement, and possible Mumford procedure, and surgery as indicated. Risks and benefits discussed. The patient expressed understanding. Informed Consent: All risks, benefits, and alternatives discussed at length with the pt and available family members. Risks including but limited to death, chronic pain, infection, bleeding, blood clots, damage to surrounding tissues, worse function, malunion, nonunion, need for further surgery. No guarantees were given or implied. All questions were answered and informed consent obtained and signed by the pt and witness. Medical Clearance: Pt will need medical clearance to ensure health optimization prior to proceeding with surgery. A medical clearance form was given to the pt for the PMD to sign. Consider injection with cortisone. The patient is apprehensive about cortisone injections as she is prediabetic. For the Bilateral Knee: Activity Modification. REQUEST 12 sessions of Physical Therapy: Knee ROM, Strengthening, Stretching, Gait Training, Modalities. I had a lengthy conversation with the patient regarding treatment options, risks, and benefits. Patient expressed understanding. Consider injection with cortisone vs. viscosupplementation. Again, the patient is apprehensive about cortisone injection due to prediabetes. Ultimately, Recommend Bilateral Total Knee Replacement Surgery: Pt has severe degenerative joint disease (arthritis) confirmed by x-ray and clinical exam and has failed conservative treatment including NSAIDs, RICE, Activity Modification, PT, and Steroid Injections. I recommend total knee replacement surgery to allow for improved pain and function. Informed Consent: All risks, benefits, and alternatives discussed at length with the pt and available family members. Risks including but limited to death, chronic pain, infection, bleeding, blood clots, damage to surrounding tissues, worse function, implant failure or loosening, and need for further surgery. No guarantees were given or implied. All questions were answered and informed consent obtained and signed by the pt and witness. Medical Clearance: Pt will need medical clearance to ensure health optimization prior to proceeding with surgery. A medical clearance form was given to the pt for the PMD to sign. The patient would like to continue with conservative measures while considering treatment options. For the Lumbar Spine: Activity Modification. Apply Heat. Gentle Massage. NSAIDs. REQUEST 12 sessions of Physical Therapy: Referral for a course of physical therapy for Lumbar ROM, Strengthening, Stretching, Pelvic Stabilization, Core, Modalities (massage, gentle manipulation, heat, ice, electric stimulation, iontophoresis, ultrasound, etc.). REQUEST referral to Pain Management Specialist for evaluation and treatment including Lumbar Epidural Injection, Facet Block Injection vs other injections. Elevated BMI: Counseled the patient

on the risks of high BMI and the importance of losing weight. A combination of proper diet and regular exercise was recommended. Work Status: TTD. Follow up in 6 weeks.

56. **CHART NOTE:** Dated 09/26/2022, signed by Raffi Kazazian, M.D. **Subjective:** INITIAL VISIT COMPLAINT: "I was with a client, I showed her the location of the property then I went to the car to get map of the other location next a few feet away, while she waited there. Coming back I called the office to make sure the property was available as I was on the phone, I stepped into mud and lost my control it was sloppy , I tried to stop it but I fell into the mud on my right side and landed first on my side and back." **Present Complaint:** The patient is a 65 year old female, presenting for a new patient visit with the following condition(s): PRESENTING PROBLEM: Injury, Injury - Lower Extremity, Injury - Multiple Body Part, Injury - Upper Extremity and Pain - Back. SIGNS/SYMPOTMS: Pain and Swelling. LOCATION: Knee, Lower back and Shoulder. QUALITY: Aching. SEVERITY: Patient rates their pain as 5 on a scale of 0 to 10. DURATION: 4 Days. TIMING: Constant. CONTEXT/MECHANISM: Fell and Slipped. She states while on phone she stepped in mud, slipped and fell on R side. AGGRAVATING FACTORS: Bending, Lifting and Walking. She reports pain in bilateral shoulder, bilateral knees and low back. She had a non work related injury 4/7 fell hurt her L shoulder and R knee, had XR which showed R knee medial compartment osteoarthritis, with small to moderate size joint effusion, quad tendon enthesopathy mild deg changes L shoulder, MRI was done of L shoulder showed moderate supraspinatus and infraspinatus tendinosis with a 5.5mm partial thickness supraspinatus footprint tear anteriorly, mild ac joint arthrosis with mild to moderate subacromial/subdeltoid bursitis, subcoracoid bursitis. 4/28: F/u for b/l shoulder, b/l knee and low back pain. "Everything hurts" 6-8/10 pain. Limited rom mainly in L shoulder. She understands that she had an injury 4/5 unrelated to work but everything including L shoulder is worse after work related fall. Still unable to lift over 5 pounds and she remains off work since they cannot accommodate. She did see Dr. Scott Powell (ortho through private insurance, he rec'd NSAID, ice, CSI, PT and possible arthroscopic surgery. She was unable to see him in office due to her not being vaccinated, she does not want to see him anymore because of this. When I asked about what she thought about his treatment plan she states she does not want to do PT until she gets an MRI, and does not want to gel CSI she would like to do PRP. She initially thought arthroscopic surgery is an open surgery and declined but now she is rethinking this option because of pain and limited ROM. She would like to see Dr. Stenson who she was told is also in MPH for workers comp but today found out he is not taking new WC cases but has a Dr. Lee in same office who takes we cases. She has been communicating with adjuster Jenny Gallegos and nurse case mgt Destiny. 5/16/22 - Here for f/up of low back, bit shoulder and B/L knee pain. Pain is relatively changed: she can't to report pain. She states she has had PRP inj to her shoulder without significant improvement and was informed by the physician that it is not likely to improve her condition. She states she has an authorization to see another orthopedic specialist. She would like to know if she should be using a T-Shellz shoulder wrap as her son was using it. She has her rt shoulder MRI scheduled on 5/20/22. L/S MRI on 5/23/22 and 13/L knee MRI on 5/24/22. She is currently on modified duty. 5/31- F/u For LBP< b/l shoulder and b/l knee pain. Had MRI for all body parts. L shoulder MRI was compared to prior and showed no worsening of partial tear. She will c/w L shoulder treatment per PMD since this was prior to work injury. She does report PRP injections x2 to L shoulder and R knee with outside (private pay), she believes the injections improved the partial tear of supraspinatus on L from 5.5 mm to 3.5mm. She is still not interested in steroid inj or surgery for now, she also does not want to start PT until she sees ortho through workers comp, it is noted that she had a zoom visit for non-work related L shoulder injury with private ortho. She has tried to contact congress medical for appt. She states she is unable to lift more than 5 pounds. 6/13- F/u for LBP, b/l knee and b/l shoulder pain. She had prior nonwork related L shoulder injury just before the work injury and MRI confirmed no changes since prior, she even called UMI and had radiologist add an addendum to his report explaining that $5.5 > 3.5$ mm partial tear was a negligible difference and that there was no progression of tear and MRI was essentially unchanged. I discussed with her again that L shoulder injury was not considered work related for this reason, she had already been receiving care for this and CSI, PT and possible surgery was rec'd but she could not start with that ortho surgeon because she is unvax. She has been approved for PT for low back. R shoulder and b/l knee as of 6/7, she states she did not get any notification until this week. She is also pending auth to ortho spine and ortho for b/l knee and R shoulder. She has been communicating with Destiny from insurance. She also is upset because from her understanding she was not supposed to continue treatment with her PMD for L shoulder although she understands this was the reason for the repeat MRI. **Assessment:** Sprain of unspecified site of left knee, initial encounter Strain of musc/fast/tend at shldr/up arm, right arm, init sprain of unspecified site of right knee, initial encounter Low back pain. Inj musc/tend the rotator cuff of left shoulder, init. 6/27 - F/u for LBP b/l knee and shoulder

pain. 4-5/10, just started PT last week, used US and TENS. Did get some soreness the next day but admits to some benefit in general. Has been off from work due to inability to accommodate is currently on 5 pound lifting restrictions states that she has tried lifting 10 pounds at PT. Reviewed MRI again with patient and discussed why L shoulder injury should be considered non work related since she did bring an MRI from prior non work related injury and compared with new MRI 5/24 after work fall revealed no progression of partial tear of supraspinatus, that injury was eval ty PMD and she had zoom call and PT, CSI and surgery was recommended, she is upset that for some reason she believes she was told that she shouldn't continue getting treatment for the I shoulder by PMD since she did have a fall after that injury. In regards to R shoulder injury which did appear to be new as well as L knee injury and low back pain since it appeared that she only had workup from outside injury for L shoulder and R knee with xr of each and MRI of I shoulder revealing the partial tear. MRI was subsequently done for all other body parts including LS spine, bilateral knees and shoulder, new L shoulder MRI showed no progression of tear so L shoulder injury was deemed not work related, R shoulder does show full thickness supraspinatus tear and high grade partial thickness bicep tendon tear there was retraction and atrophy for both, I explained to the patient that although it was about a month since the fall, that even her previous I. shoulder injury still didn't reveal any retraction or atrophy and demonstrated acute findings which would be due to the fall outside of work. Her knee MRI did show chronic changes as well but also some prepatellar bursitis which may have been due to fall. Patient's primary issue since first visit has been her I. shoulder and this has been explained multiple times to not be related to the work injury which didn't seem to exacerbate her symptoms considerably and objectively by MRI showed no worsening. L5 spine MRI showed deg changes, mild to moderate disc bulge, greatest at 3.5mm she likely had chronic back issues which were exacerbated with the work fall but this must have partly been exacerbated due to previous fall from few weeks earlier outside of work, although we don't have records from PMD and she denies c/o any back pain to PMD. I called adjuster while patient was still in office and discussed case and agreed that upon reviewing all her medical records after release from PMD office and given a trial of PT we should have her evaluated by ortho if symptoms persist. 7/11- fit' for R shoulder, V knee and low back pain. R shoulder is 5/10, pain with elevation and limited oath. Has been lifting up to 10 pounds at PT which is helping. She has b/l knee pain medially with some instability. LBP is 5/10 as well and radiates down LLE. She is pending authorization for ortho surgery, she had already seen ortho for L shoulder which she had injured just prior to this work related injury. 7/28- F/u for R shoulder b/l knee and lbp. Symptoms persist, tried lifting 20 pounds and symptoms worsened. Has been off work, doing PT, had 4 addition sessions approved. Per pt adjuster told her that congress is still reviewing records to see if they will accept, she found out that the surgeon she wanted to see has been off from work due to medical condition trying to see same surgeon for knee and shoulder now. 8/12 - F/u For R shoulder, b/l knee and low back pain. Pain is 5/10, PT has helped. She has finally been approved to see Dr. Ashford for spine and Dr. Adamson for b/l knee and R shoulder she was also gonna see Dr. Adamson for L shoulder which is not work related. appt with ortho spine is 9/15 - she would like to try more PT. has been doing chiro on her own (he doesn't take workers comp). 9/9- F/u for R shoulder, b/l knee and LBP. Has been seeing Dr Adamson for knees and shoulder she has initial appt with Dr. Ashford for spine next week wants to c/w PT at congress. 9/27/22 – the patient was called via tele-medicine with no answer, left message, will try again in 24 hours. Assessment: TREATMENT PLAN/INSTRUCTIONS: The patient was called via tele-medicine with no answer, left message, will try again in 24 hours.

57. SOAP NOTE: Dated 11/03/2022, signed by Elliot Bright PA-C. & Babak Samimi, M.D. History: The patient returns for follow up evaluation. She continues to have ongoing right shoulder symptoms and has lots of questions regarding possible surgery, the severity of her pain in multiple areas, and broke down in tears regarding her condition and frustration. She is under the care of Dr. Adamson at Congress for her left shoulder since it is not accepted industrial. Assessment: Right shoulder. Large rotator cuff tear with severe atrophy. Early degenerative joint disease (aggravation). Left shoulder (not accepted industrial). Partial thickness rotator cuff tear. AC joint arthrosis. Shoulder impingement syndrome with tendonitis/bursitis. Lumbar spine: multilevel disc herniations. Lumbar radiculitis. Outside x-rays of the left shoulder 4/7/22. Mild degenerative changes about the left shoulder. Outside x-rays of the right knee 4/7/22. Mild compartment osteoarthritis with a small to moderate size joint effusion. Quadriceps tendon enthesopathy. MRI of the left shoulder 4/7/22. Moderate supraspinatus and infraspinatus tendinosis with a 5.5 mm partial thickness supraspinatus footprint tear anteriorly. Mild acromioclavicular joint arthrosis with adjacent mild to moderate subacromial/subdeltoid bursitis. Subcoracoid bursitis. Moderate AC joint arthrosis. There is mild fatty atrophy of the supraspinatus tendon. There is a partial thickness tear at the footprint of the supraspinatus with reactive

bony edema of the greater tuberosity. Outside left knee series 4/18/22. There is mild generalized osteopenia. There is no evidence of acute fracture present. There is no evidence of acute fracture or dislocation. The alignment is intact. There are osteoarthritic changes of the medial and patellofemoral compartments of the knee present. Outside right shoulder series 4/28/22. No evidence of fracture or dislocation. MRI of the right shoulder 5/17/22. Full thickness supraspinatus tendon tear with retraction by 10 mm and has mild muscle bulk/fatty atrophy. Adjacent infraspinatus and subscapularis tendinosis. High-grade partial thickness long head of the biceps tendon tear and retraction. Mild to moderate acromioclavicular joint arthrosis with adjacent subacromial/subdeltoid bursitis. MRI of the left knee 5/19/22. Peripheral extrusion of the medial meniscus from the joint line as well as heterogeneous signal at the anterior horn body junction. A complex degenerative tear cannot be excluded at this site without post contrast imaging. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment. Subchondral edema versus bone contusion of the lateral femoral condyle posterior nonweightbearing aspect. Small to moderate size joint effusion. Quadriceps tendon enthesopathy. MRI of the lumbar spine 5/23/22. MILD TO MODERATE DISC DESSICATION OF L4-L5 WITH A 3.5 MM BROAD-BASED DISC PROTRUSION AND FACET ARTHROSIS CAUSING MILD CENTRAL CANAL AND NEURAL FORAMINAL STENOSIS BILATERALLY. MILD DISC DESICCATION OF L5-S1 with a 2 mm broad based disc protrusion asymmetric to the right with facet arthrosis and an 8 mm complex synovial cyst in the right neural foramen causing mild central canal stenosis as well as moderate right-sided and mild to moderate left-sided neural foramina stenosis. Less significant findings at the remainder of the disc levels as described above. Heterogeneous marrow signal diffusely which is nonspecific but may represent osteopenia. Pathologic process cannot basically without oncologic workup. MRI of the left shoulder 5/24/22. Supraspinatus and infraspinatus tendinosis with a persistent 3.5 mm partial thickness supraspinatus footprint tear without retraction or associated muscle bulk atrophy. Mild acromioclavicular joint arthrosis with supraspinatus tendon tear. The difference in measurement is minimal and can be related to technique. These findings are likely stable when compared to the prior exam given the inherent difference in technique. However, interval scarring may also demonstrate similar findings. Clinical correlation with symptoms is recommended. MRI of the right knee 5/24/22. Peripheral extrusion of the medial meniscus from the joint line without a definite tear. Intrasubstance generation of the lateral meniscus at the body without a definite tear. MR arthrogram may be performed for further evaluation/characterization if clinical concern persists. Tricompartmental osteoarthritis and chondromalacia most pronounced about the medial compartment. Quadriceps tendon enthesopathy. Mild prepatellar bursitis. Moderate tricompartmental degenerative joint disease. Plan: For the right shoulder additional PT has been denied. I had a lengthy conversation with the patient regarding treatment options, risks, and benefits. Patient expressed understanding. Recommended RIGHT reverse total shoulder replacement surgery. Patient has severe DJD and an irreparable rotator cuff tear (RCA) confirmed by x-ray and clinical exam and has failed conservative treatment including NSAIDs, RICE, Activity modification and PT. I recommend reverse total shoulder replacement to allow for improved pain and function. However, due to her young age and obesity I believe she should wait and do it when her condition worsens. In the meantime, she can consider cortisone injections which she declined. For the left shoulder. She is under the care of Dr. Adamson and recommended she follow up with him through her PVT insurance. For the bilateral knee: activity modification. Consider injection with cortisone vs. viscosupplementation. Again, the patient is apprehensive about cortisone injection due to the prediabetes and associated risks. REQUEST bilateral knee durolane injection. Patient has clinically relevant knee pain due to degenerative changes confirmed on x-rays. Patient has failed conservative treatment including Tylenol, Prescription strength NSAIDs, therapy and activity modification. Patient is a candidate for viscosupplementation of the knee. Additional PT has been denied. I had a lengthy conservation with the patient regarding treatment options, risks, and benefits. Patient expressed understanding. Ultimately, recommend bilateral total knee replacement surgery. Patient has severe DJD (arthritis) confirmed by x-ray and clinical exam and has failed conservative treatment including NSAIDs, RICE, Activity modification, PT and steroid injections. I recommend total knee replacement surgery to allow for improved pain and function. However, I recommend weight loss prior to considering surgery. The patient would like to continue conservative measures while considering treatment options. For the lumbar spine activity modification. Apply heat. Gentle massage. NSAIDs. Continue PT. referral for a course of physical therapy for lumbar ROM, strengthening, stretching, pelvic stabilization, core, modalities (massage, gentle manipulation, heat, ice, electric stimulation, iontophoresis, ultrasound etc.). Pending pain management specialist for evaluation and treatment including lumbar epidural injection, facet block injection vs other injections. Elevated BMI. Counseled patient on risk of high BMI and importance of losing weight. A combination of proper diet and regular exercise was recommended. Work status TTD. RTC in 6 weeks.

RECORDS PERTAINING THE 1ST SUPPLEMENTAL REPORT:

1. **NCV/EMG REPORT:** Dated 05/15/2023, signed by Komal Dhingsa, M.D. Impression: Abnormal Study. Electrodiagnostic evidence of moderate RIGHT and LEFT carpal tunnel syndrome (median neuropathy at the wrist) affecting both sensory and motor fibers; right side is more affected than left. Clinical correlation is recommended. There is no electrodiagnostic evidence of any other mononeuropathy, peripheral neuropathy or entrapment neuropathy in either upper extremity. Electromyography of the bilateral upper extremities and cervical paraspinal muscles is without active or chronic denervation potentials to suggest a motor cervical radiculopathy, plexopathy or myopathic process. Please note that a negative electromyographic study does not completely rule out a possibility of a nerve involvement, clinical correlation is recommended.

2. **WORK CAPACITY EVALUATION REPORT FOR QUALIFIED MEDICAL EVALUATION:** Dated 05/26/2023, signed by Arbi Mirzaians, D.C. History: As per AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. By answering the questions below it is anticipated that this functional capacity evaluation will assist in addressing issues which may have complicated this case. Some examples of common concerns wherein a functional capacity evaluation is beneficial is in cases when the patient has been absent from the work force for a prolonged period of time, there have been unsuccessful attempts to return the worker to their usual and customary duties, prolonged absence from the work force, conflicting medical reports exist as to the work status of this patient, there are significant injuries that require detailed exploration for work precautions or modified duties, the concern exists whether if a considered surgery will provide functional improvement as compared to the patient's preoperative physical capacity, whether if the injured worker should be considered a qualified injured worker, and to address what the injured worker's abilities are in an effort to encourage a return to work philosophy. The AMA Guides 5th Edition states on page 14, "The ADA defines disability as a physical or mental impairment that substantially limits one or more of the major life activities of an individual; a record of impairment; or being regarded as having an impairment. A person needs to meet only one of the three criteria in the definition to gain the ADA's protection against discrimination. The physician's input often is essential for determining the first two criteria and valuable for determining the third." It is stated on page 15, "The person must be presently, or perceived to be (not potentially or hypothetically), substantially limited in order to demonstrate a disability. It is difficult to determine if an impairment "substantially limits" a major life activity. An impairment's nature, extent, duration, impact, and effect on the individual are all considerations in assessing the "substantiality" of the limitations. For some major life activities, such as work, the physician may provide an opinion on the medical impairment's limitations. However, as indicated by the recent Supreme Court ruling, how much a limitation of a major life activity results in a determination of disability depends on the interaction between the remaining functional abilities and the possible types of accommodation being sought. It is the physician's responsibility to determine if the impairments results in functional imitations. The physician is responsible for informing the employer about an individual's abilities and limitations. It is the employer's responsibility to identify and determine if reasonable accommodations are possible to enable the individual's performance of essential job activities." On page 18 of the Guides to the Evaluation of Permanent Impairment, 5th Edition, it states, "In some cases, physicians may be asked to assess the medical impairment's impact on the individual's ability to work. In the latter case, physicians need to understand the essential functions of the occupation and specific job, as well as how the medical condition interacts with the occupational demands. In many cases, the physician may need to obtain additional expertise to define functional abilities and limitations, as well as vocational demands." Summary: In consideration of the reader, for purposes of convenience, the ultimate conclusions of this evaluation are presented here. The remainder of the report shall document the special testing performed, and numerous other assessment tools used to arrive at the following conclusions/recommendations. The patient's behavior and comments regarding activities of daily living, subjective reports of pain, perceived functional tolerance, and objective findings on the date of evaluation have all been taken into consideration. The patient's abilities are also compared to the job demands as described by the DOT as well as the patient's willingness to participate in testing. It is considered that the patient's subjective reports of pain and disability may be considered reliable. Throughout the Functional Capacity Evaluation, reliability of pain and disability ratings was assessed using the following tests and observations: Appropriate disability questionnaires, Ransford Pain Drawing (not scored, used as drawing only), pain ratings using the Visual Analog Scale and Functional Pain Scale, Repetitive Movement Tests, Musculoskeletal Evaluation. These

findings and intensity levels are then compared to the patient's shown physical abilities during the day of testing. Overall reports of pain and disability rating findings were good. Multiple criteria are used to determine extent of exerted effort to include Isometric Grip Effort testing and the analysis of the coefficients of variation, Bell Curve Analysis, demonstration of CTP (Competitive Test Performance), the willingness to participate in testing and musculoskeletal signs of strain to include biomechanical changes. It can be safely concluded that patient displayed good physical effort. The following restrictions are based on limitation of capacity, risk of harm and subjective examinee tolerance for the activity in question per ACOEM Guidelines, as well as patient effort. If it is noted above that it was felt that full effort was not exerted, it is deferred to the referring physician to use clinical correlation to adopt or alter the recommended restrictions. Sitting The patient should not sit for periods of time lasting greater than 95 minutes without a change in position or the ability to rest and stretch Standing The patient should not stand for periods of time lasting greater than 35 minutes without a change in position or the ability to rest and stretch Carrying No carrying greater than 6 pounds over a length of 30 feet maximum Lifting No Lifting More Than 6 lbs (Occasional lifting 0-30% of the work day) Bending Avoid Repetitive Bending Crouching Avoid Repetitive Crouching Stairs Avoid Repetitive Use of Stairs Grades Avoid Work on Steep Grades Overhead Work Avoid Repetitive Activities At or Above Shoulder Level The final decision is deferred to the QME. The injured worker at this time DOES NOT appear to meet the essential demands of a funeral planner. Vocational Rehabilitation could be indicated, but obviously, a final decision must be deferred to the referring physician. TITLE(s): DIRECTOR, FUNERAL (personal ser.) alternate titles: manager, funeral home; mortician; undertaker Arranges and directs funeral services: Coordinates activities of workers to remove body to mortuary for embalming. Interviews family or other authorized person to arrange details, such as preparation of obituary notice, selection of urn or casket, determination of location and time of cremation or burial, selection of PALLBEARERS (personal ser.), procurement of official for religious rites, and transportation of mourners. Plans placement of casket in parlor or chapel and adjusts lights, fixtures, and floral displays. Directs PALLBEARERS (personal ser.) in placement and removal of casket from hearse. Closes casket and leads funeral cortège to church or burial site. Directs preparations and shipment of body for out-of-state burial. May prepare body for interment. Patient's scored a disability score of 63%. The patient's Upper Extremity Functional Scale Score was 91%. Patient's scored a disability score of 93%. The patient was unable to continue due to fatigue and tingling in the right hand. Recommendations/Plan: The patient also complained of neck, low back, and left elbow and hand pain. The patient complained of lumbar spine pain and increased fatigue and pain in the left hand. The following observations were made regarding this patient: The patient was unable to continue even after taking a 4 minute break due to increased mid, low back, and bilateral shoulder pain. The patient also complained of fatigue in the shoulders, hands, and knees. The patient's performance was significantly affected as she stopped momentarily to rest. The patient reported increased low back, left hand, and left elbow, left shoulder pain. The patient reported pain of 3-4 /10. The patient rubbed her left hand and lumbar spine upon completion of testing. Unable to continue due to low back, left shoulder pain, as well as fatigue. Lifting: The demonstrated capabilities of patient upon lifting at the above indicated ranges, displays the ability to lift a load of 6 pounds from floor to knuckle level. Carrying: Patient demonstrated the ability to carry 6 pounds with both hands over a distance of 30 feet with maintained proper posture without any noted signs of distress or overload. Sitting and/or Standing Tolerance: Patient's ability to tolerate sitting and/or standing was evaluated during the entire functional capacity evaluation including the intake and interview process and using distraction based testing such as the Purdue Pegboard in its standardized setting. Patient displayed the ability to sit for 95 minutes without any noted disturbance during the day of testing. Her longest period of static standing was for 35 minutes during the day of testing.

RECORDS PERTAINING THE 2ND SUPPLEMENTAL REPORT:

NCV/EMG REPORT: Dated 05/15/2023, signed by Komal Dhingsa, M.D. Impression: Abnormal Study. Electrodiagnostic evidence of moderate RIGHT and LEFT carpal tunnel syndrome (median neuropathy at the wrist) affecting both sensory and motor fibers; right side is more affected than left. Clinical correlation is recommended. There is no electrodiagnostic evidence of any other mononeuropathy, peripheral neuropathy or entrapment neuropathy in either upper extremity. Electromyography of the bilateral upper extremities and cervical paraspinal muscles is without active or chronic denervation potentials to suggest a motor cervical radiculopathy, plexopathy or myopathic

process. Please note that a negative electromyographic study does not completely rule out a possibility of a nerve involvement, clinical correlation is recommended.

WORK CAPACITY EVALUATION REPORT FOR QUALIFIED MEDICAL EVALUATION; Dated 05/26/2023, signed by Arbi Mirzaians, D.C. History: As per AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. By answering the questions below it is anticipated that this functional capacity evaluation will assist in addressing issues which may have complicated this case. Some examples of common concerns wherein a functional capacity evaluation is beneficial is in cases when the patient has been absent from the work force for a prolonged period of time, there have been unsuccessful attempts to return the worker to their usual and customary duties, prolonged absence from the work force, conflicting medical reports exist as to the work status of this patient, there are significant injuries that require detailed exploration for work precautions or modified duties, the concern exists whether if a considered surgery will provide functional improvement as compared to the patient's preoperative physical capacity, whether if the injured worker should be considered a qualified injured worker, and to address what the injured worker's abilities are in an effort to encourage a return to work philosophy. The AMA Guides 5th Edition states on page 14, "The ADA defines disability as a physical or mental impairment that substantially limits one or more of the major life activities of an individual; a record of impairment; or being regarded as having an impairment. A person needs to meet only one of the three criteria in the definition to gain the ADA's protection against discrimination. The physician's input often is essential for determining the first two criteria and valuable for determining the third." It is stated on page 15, "The person must be presently, or perceived to be (not potentially or hypothetically), substantially limited in order to demonstrate a disability. It is difficult to determine if an impairment "substantially limits" a major life activity. An impairment's nature, extent, duration, impact, and effect on the individual are all considerations in assessing the "substantiality" of the limitations. For some major life activities, such as work, the physician may provide an opinion on the medical impairment's limitations. However, as indicated by the recent Supreme Court ruling, how much a limitation of a major life activity results in a determination of disability depends on the interaction between the remaining functional abilities and the possible types of accommodation being sought. It is the physician's responsibility to determine if the impairments results in functional limitations. The physician is responsible for informing the employer about an individual's abilities and limitations. It is the employer's responsibility to identify and determine if reasonable accommodations are possible to enable the individual's performance of essential job activities." On page 18 of the Guides to the Evaluation of Permanent Impairment, 5th Edition, it states, "In some cases, physicians may be asked to assess the medical impairment's impact on the individual's ability to work. In the latter case, physicians need to understand the essential functions of the occupation and specific job, as well as how the medical condition interacts with the occupational demands. In many cases, the physician may need to obtain additional expertise to define functional abilities and limitations, as well as vocational demands." Summary: In consideration of the reader, for purposes of convenience, the ultimate conclusions of this evaluation are presented here. The remainder of the report shall document the special testing performed, and numerous other assessment tools used to arrive at the following conclusions/recommendations. The patient's behavior and comments regarding activities of daily living, subjective reports of pain, perceived functional tolerance, and objective findings on the date of evaluation have all been taken into consideration. The patient's abilities are also compared to the job demands as described by the DOT as well as the patient's willingness to participate in testing. It is considered that the patient's subjective reports of pain and disability may be considered reliable. Throughout the Functional Capacity Evaluation, reliability of pain and disability ratings was assessed using the following tests and observations: Appropriate disability questionnaires, Ransford Pain Drawing (not scored, used as drawing only), pain ratings using the Visual Analog Scale and Functional Pain Scale, Repetitive Movement Tests, Musculoskeletal Evaluation. These findings and intensity levels are then compared to the patient's shown physical abilities during the day of testing. Overall reports of pain and disability rating findings were good. Multiple criteria are used to determine extent of exerted effort to include Isometric Grip Effort testing and the analysis of the coefficients of variation, Bell Curve Analysis, demonstration of CTP (Competitive Test Performance), the willingness to participate in testing and musculoskeletal signs of strain to include biomechanical changes. It can be safely concluded that patient displayed good physical effort. The following restrictions are based on limitation of capacity, risk of harm and subjective examinee tolerance for the activity in question per ACOEM Guidelines, as well as patient effort. If it is noted above that it was felt that full effort was not exerted, it is deferred to the referring physician to use clinical correlation to adopt or alter the recommended

restrictions. Sitting The patient should not sit for periods of time lasting greater than 95 minutes without a change in position or the ability to rest and stretch Standing The patient should not stand for periods of time lasting greater than 35 minutes without a change in position or the ability to rest and stretch Carrying No carrying greater than 6 pounds over a length of 30 feet maximum Lifting No Lifting More Than 6 lbs (Occasional lifting 0-30% of the work day) Bending Avoid Repetitive Bending Crouching Avoid Repetitive Crouching Stairs Avoid Repetitive Use of Stairs Grades Avoid Work on Steep Grades Overhead Work Avoid Repetitive Activities At or Above Shoulder Level The final decision is deferred to the QME. The injured worker at this time DOES NOT appear to meet the essential demands of a funeral planner. Vocational Rehabilitation could be indicated, but obviously, a final decision must be deferred to the referring physician. TITLE(s): DIRECTOR, FUNERAL (personal ser.) alternate titles: manager, funeral home; mortician; undertaker Arranges and directs funeral services: Coordinates activities of workers to remove body to mortuary for embalming. Interviews family or other authorized person to arrange details, such as preparation of obituary notice, selection of urn or casket, determination of location and time of cremation or burial, selection of PALLBEARERS (personal ser.), procurement of official for religious rites, and transportation of mourners. Plans placement of casket in parlor or chapel and adjusts lights, fixtures, and floral displays. Directs PALLBEARERS (personal ser.) in placement and removal of casket from hearse. Closes casket and leads funeral cortege to church or burial site. Directs preparations and shipment of body for out-of-state burial. May prepare body for interment. Patient's scored a disability score of 63%. The patient's Upper Extremity Functional Scale Score was 91%. Patient's scored a disability score of 93%. The patient was unable to continue due to fatigue and tingling in the right hand. Recommendations/Plan: The patient also complained of neck, low back, and left elbow and hand pain. The patient complained of lumbar spine pain and increased fatigue and pain in the left hand. The following observations were made regarding this patient: The patient was unable to continue even after taking a 4 minute break due to increased mid, low back, and bilateral shoulder pain. The patient also complained of fatigue in the shoulders, hands, and knees. The patient's performance was significantly affected as she stopped momentarily to rest. The patient reported increased low back, left hand, and left elbow, left shoulder pain. The patient reported pain of 3-4 /10. The patient rubbed her left hand and lumbar spine upon completion of testing. Unable to continue due to low back, left shoulder pain, as well as fatigue. Lifting: The demonstrated capabilities of patient upon lifting at the above indicated ranges, displays the ability to lift a load of 6 pounds from floor to knuckle level. Carrying: Patient demonstrated the ability to carry 6 pounds with both hands over a distance of 30 feet with maintained proper posture without any noted signs of distress or overload. Sitting and/or Standing Tolerance: Patient's ability to tolerate sitting and/or standing was evaluated during the entire functional capacity evaluation including the intake and interview process and using distraction based testing such as the Purdue Pegboard in its standardized setting. Patient displayed the ability to sit for 95 minutes without any noted disturbance during the day of testing. Her longest period of static standing was for 35 minutes during the day of testing.

Please be advised. I reserve the right to issue a supplemental report (upon written request), should any additional information be made available to me subsequent to this report and should such information cause me to substantially change my opinion on any of the issues.

DISCUSSION

I am in receipt of a supplemental report request dated August 06, 2024, asking me to review and comment on new medical records sent. I originally evaluated this injured worker, Rima Babayan, a now 68-year-old right-handed, female, for the purpose of a comprehensive qualified medical evaluation on January 17, 2023, following selection of my name from a state panel list (number 7531564). I then issued two supplemental reports dated May 26, 2023, and July 06, 2023, and re-evaluated the patient on January 18, 2024 and issued a third supplemental report dated March 18, 2024.

Then I was deposed on July 26, 2024, when it was agreed for me to review new records, and "issue a supplemental report addressing the issue of causation of injury and/or apportionment per labor Code section 4663".

Defense attorney, Steven H. Wax, Esq. provided a letter of instruction dated August 06, 2024, stating the following:

"Dear Dr. Drake:

Please recall that office represents Travelers Insurance Company, workers' compensation insurance carrier for Forest Lawn Memorial Park Association.

It was a pleasure to meet you at your cross-examination of July 26, 2024.

At that time, you noted records that were to be reviewed in your March 18, 2024 report, had not been received.

I am enclosing for your review the following records:

- Transcript of applicant's Vol I deposition dated 1/16/23
- Transcript of applicant's Vol II deposition dated 11/13/23
- Vital Health Medical Group
- Dr. Donald Plance:
- Dr. Michael Spearman
- LA County Olive View UCLA Medical Center
- LA County Mid Valley Comprehensive Health Center
- Dr. Gregory Adamson
- Dr. Scott Powell

These records detail medical treatment obtained by the applicant prior to her date of employment, September 3, 2019, and prior to the specific date of injury of April 14, 2022. Please pay special attention to the records of Dr. Donald Plance which contains an MRI of the cervical spine conducted on 5/16/2016 and extensive treatment to the left shoulder and neck.

These records go to the issue of causation and/or apportionment of disability. Please review these records in light of your examination findings and please issue a supplemental report addressing the issue of causation of injury and/or apportionment per labor Code section 4663. Please note, the case law does allow for apportionment of pre-existing pathology even in the absence of disability".

At this point, after thanking the parties for this opportunity, I would go through the records suggested by the defense counsel.

-Transcript of applicant's Vol I deposition dated 1/16/23: During her deposition, Ms. Babayan indicated, that she has filed two claims, for the time working for Forest Lawn; she injured her back, right shoulder, and knees in 04/1 4/22 while working for Forest Lawn. She believed she aggravated her left shoulder due to her fall. With regards to her second claim, she developed injuries to her back and knees, sleep problems, and dental injury from 09/03/19 through 04/1 8/22 due to her day-to-day work activities at Forest Lawn. She had no pain or discomfort in her knees before being hired. She had not seen a doctor with regard to her pain in both knees prior to 09/03/19. She had not taken medication for any medical condition when Forest Lawn initially hired her in September 2019. She did not have aches or back pains before being hired at Forest Lawn, but she had chiropractic adjustments with Dr. Spearment in 2013 on Fountain in Los Angeles. She stated she worked there once a week for three or four months, and Dr. Spearment gave her adjustments. She worked as a receptionist for Dr. Spearment, and she took orders, helped customers, and was paid for her efforts. Her employment there probably ended in 2014. She did not file any legal claim against Dr. Spearment or sustain any injuries while working for Dr. Spearment. Did not have low back pain before being hired by Forest Lawn. Low back pain started after our training I went to the center of Glendale Forest Lawn, and when I started doing tabletops, meaning I had to carry the tables to my car and set it up outside and put promo pieces to meet customers.

-Transcript of applicant's Vol II deposition dated 11/13/23: Before I was hired at Forest Lawn, my date of hire is September 3, 2019, I had pain and discomfort in my neck before the date of hire. I had neck pain before I was hired. In 2013, I think I was working with Dr. Spearman part-time. I was employed in 2013 with Applied Scholastics. I was in charge of marketing and the job did not last more than I was there I think probably just three, four months. Three months, four months. While working for Applied Scholastics, what happened is I was reading a book and my upper back I had pain and just something happened there in the back. I did not file a claim for workers' compensation benefits against Applied Scholastics or their insurance carrier. I was off probably about two weeks or three weeks. There was no neck pain but upper back pain. I had low back pain prior to the date of hire at Forest Lawn. I was having some discomfort in my low back. I went to a chiropractor before I was hired at Forest Lawn. It is Dr. Spearman. She testified that around 2013 she had adjustments while working there. I had no right shoulder pain prior to the date of hire at Forest Lawn. I did have numbness or tingling in left or right hand prior to the date of hire at Forest Lawn. The first time I experienced any numbness or tingling in my hands in 2013 and 2014. Physiologically, the numbness and tingling is probably from my neck or my carpal tunnel at the time. For treatment of numbness, I just saw chiropractors. For complaints of numbness, I think I saw Dr. Spearman while I was working there. I knew that I had arthritis in my upper back. Before the fall at Forest Lawn, did any doctor indicate that you had any type of a tear in your left shoulder? No.

-Vital Health Medical Group: I am not certain which report the defense counsel is directing me to, here. But no records pertaining to prior pathology or underlying issues regarding her bilateral knees, bilateral shoulders, or lower back were reviewed in these records.

-Dr. Donald Plance: The defense counsel kindly asked me the following: "Please pay special attention to the records of Dr. Donald Plance which contains an MRI of the cervical spine conducted on 5/16/2016 and extensive treatment to the left shoulder and neck".

However, unfortunately I believe the exact report that the defense counsel may be referring to has not been included in the records and was unavailable for me to review at this time. On that note, I was not able to find any other records, signed by Dr. Plance or other treating physicians, showing that Ms. Babayan had extensive treatments to her neck and the left Shoulder. However, I found this piece of record approximately from that timeline, showing that the patient was complaining of neck pain, radiating to shoulders. Another word, she was complaining of cervical radiculopathy, which of course is different than shoulder symptomatology or dysfunction (as she is claiming now), and was referred to PT and EMG/NCS was ordered, as well.

Here is the note I mentioned above. ADULT PRIMARY CARE OUTPT PROVIDER NOTE; Dated 05/03/2016, signed by Nastaran Rafiei, M.D. & Jungeun Karen Kim, NP. Chief Complaint: MRI f/up. History of Present Illness: Patient is a 59 y/o male here for SD appt for MRI result (done in'101512015) which was ordered by Dr. Phan inBl28l2015 (PCP:Chan): H/O chronic neck pain since 2013; pain radiating down to shoulders and arms; hands numbness and tingling sensation; no known injury; pt declines any pain meds; wants to have "nerve study" pt is also requesting blood tests. Assessment/Plan: Cervical radiculopathy. Pt declines any pain meds; referred to PT. Ordered EMG/NCS; keep appt as scheduled on 717116; ordered labs. Ordered: ALT, Blood, Routine collect, 05/03/16, Lab Collect, Cervical radiculopathy, Order for future visit, Print Label By Order Location, HUD PC.

In the Medical records of Dr. Donlad Plance, DO, on May 24, 2013, he wrote, "Ms. Babayan is being treated in my office for a degenerative cervical spine, which has caused her considerable pain over the last several weeks. She was treated from 4/24 - 5/24/2013. She has no complaints, no pain, and can return to work without restrictions on 5/27/2013".

Obviously, according to this report, the patient was complaining of neck pain and was being treated. Her cervical issues are not part of her claim now. Her neck pain may have had roots in her degenerative disease, and then she was returned to her normal work duties without any restrictions as of 05/27/2013. Again, I am not certain if this is the

report that the defense counsel is referring to, but I did not see any other report among the available reviewed records, that might be showing any prior underlying pathology or symptomatology with the body parts concerning the patient's claims at Forest Lawn,

In the deposition records of Ms. Babayan, the defense counsel refers to a report from Dr. Plance reporting the following: "In the Medical records of Dr. Donlad Plance, indicated that the patient underwent an MRI study of the cervical spine (done on April 23, 2013). He also notes in his records that you were taken off work and you were still off work as of April 23, 2013".

Please note that this specific report was not available for me to review either.

-Dr. Michael Spearman: (Pg. 295 of new records available). Although again, I am not certain which report the defense counsel is referring to, however, I am looking at a handwriting note from Dr. Spearman, DC. issued on July 30, 2014. Dr. Spearman wrote, "she had L(left) lower abdominal pain complaints, and x-rays done a year ago, showed degenerative disc disease. Following abdominal pain resolved. Numbness and tingling in hands, less but present. Degenerated neck disks could account for fingers or hands tingling. She did get wrist adjustment".

-LA County Olive View UCLA Medical Center: I am not certain which report the defense counsel is pointing to here, either. However, there is an EMG report, dated 6/22/2016. REASON FOR VISIT DX, was Radiculopathy, of cervical region. No records pertaining to any prior underlying pathology or symptomatology regarding her bilateral knees, bilateral shoulders, or lower back were reviewed in these records.

-LA County Mid Valley Comprehensive Health Center: I am not certain which record the defense counsel is asking me to look at.

-Dr. Gregory Adamson: Again, the defense counsel did not indicate which report to focus on. A report that was issued by Dr. Adamson, on 9/12/2022, indicated that the patient suffered from Left rotator cuff tear (M75.102). Impression: Rotator cuff tendinopathy with small bursal-sided partial thickness rotator cuff tear, left shoulder. The following plans were recommended for the patient: "Pt Education -How to Access Health Information Online using Patient Portal and 3rd Party Apps: discussed with patient and provided Information. LIFESTYLE EDUCATION REGARDING DIET".

-Dr. Scott Powell: There are a few reports from Dr. Scott Powell, MD., and I am not certain which report the defense counsel is asking me to look at. Looking at a report issued on 04/14/2022 by Dr. Powell, the following is seen: "Rima Babayan is a 65 years old female who presents via telemedicine and is a new patient to our office. referred for evaluation and treatment regarding her left shoulder pain and right knee pain. She reports this pain began after she sustained a fall on April 5th. The patient reports that her left shoulder pain and right knee pain have generally persisted since onset. The patient denies taking any anti-inflammatory medication for her right knee and left shoulder pain at this time. X-Ray of the Left Shoulder - One View: IMPRESSION: 1. Mild degenerative changes about the left shoulder. X-Ray of the Right Knee, Three Views: IMPRESSION: 1. Medial compartment osteoarthritis with small to moderate joint effusion. 2. Quadriceps tendon enthesopathy.

What stands out throughout this report is the presence of Degenerative Changes/ Osteoarthritis.

Other records that were available for me to review include:

(pg. 158 of new records). There is a piece of record, without any Department, or Doctor's name, nor any date of service. It may be from 12/05/2017, signed by Maria Estela Castro, NP., if we look at another paper that is before it, however, I am not certain. The patient made an office visit that day, indicating that she had a fall 3 days prior and was suffering from low back pain. The treatment plan was to: "DICLOFENAC 3%; APPLY AS NEEDED; Qty: 0;

Refills: 0 LIDOCAINE 5% OINTMENT; APPLY AS NEEDED; Qty: 0; Refills: 0 ORDERED MRI OF THE WHOLE SPINE FOR FURTHER EVALUATION OF PAIN". However, no follow-up records, were available to review.

(Pg. 286 of new records). There is what seems like a "Chiropractic Analysis", dated "7 May 06". There is no doctor's signature. In this piece of record, under the indication, "CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS", patient has marked "low back pain", and under "Joint Pain/Stiffness", she has marked "Walking problems". There were no treatment plans, or recommendations indicated. No further information was provided either. Frankly, there were no other records from this timeline (2006) available to review.

The medical records available for my review, included several cervical spine MRI studies. However, there were no prior MRI studies of the lumbar spine available for my review. Therefore, there without any prior MRI studies of the lumbar spine, we have no basis for comparison of prior pathology.

The only available MRI study of the lumbar spine is in fact MRI OF THE LUMBAR SPINE WITHOUT CONTRAST; Dated 05/23/2022, signed by Haroutun Abrahamian, M.D., with the following impressions: "Mild to moderate disc desiccation of L4-5 with a 3.5 mm broad-based disc protrusion and facet arthrosis causing mild central canal and neural foraminal stenosis bilaterally. Mild disc desiccation of L5-S1 with a 2 mm broad-based disc protrusion asymmetric to the right with facet arthrosis and an 8 mm complex synovial cyst in the right neural foramen causing mild cerebral canal stenosis as well as moderate right-sided and mild-to-moderate left-sided neural foraminal stenosis. Less significant findings at the remainder of the disc levels as described above. Heterogeneous marrow signal diffusely which is a nonspecific but may represent osteopenia. Pathologic process cannot basically without oncologic workup".

In this MRI study of the lumbar spine, again there is evidence of degenerative disease/facet arthrosis.

In light of all these records available for me to review, including the new records that the defense counsel asked me to review, also considering patient's own admission during her depositions taken on 01/16/2023 as well as 11/13/2023, it is evident that Ms. Babayan suffered from neck pain, and upper back pain before her employment at Forest Lawn. She said, she was having "some discomfort" in her lower back in about 2013, and that was the reason she received chiropractic adjustments from Dr. Spearman, while being employed by Dr. Spearman. She testified that she had no shoulder pain or knee pain prior to her employment with Forest Lawn. And there's no indication to the contrary, and no reason to draw a different conclusion, at this time.

Another undeniable fact is the presence of degenerative disc disease/arthritis in her discs and joints, prior to her claimed industrial injuries at Forest Lawn.

The defense counsel in his letter writes, "These records go to the issue of causation and/or apportionment of disability. Please review these records in light of your examination findings and please issue a supplemental report addressing the issue of causation of injury and/or apportionment per labor Code section 4663. Please note, the case law does allow for apportionment of pre-existing pathology even in the absence of disability".

Labor Code 4663 indicates that "A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries".

Therefore, apportionment/causation question is to be addressed in terms of any pre-existing disability, pathology, or non-industrial causation prior to the claimed industrial injuries in question.

As established before, in this report, as well as all my other reports, Ms. Babayan's Degenerative Joint Disease, has been a factor causing her prior pain and symptoms in her neck, and upper back and "some discomfort" in the lower back. And there is little reasonable doubt and high degree of medical probability, that the subject's history of prior degenerative changes, is to some degree contributory/causative factor to the level of her impairments/disabilities. Therefore, with all that said, the 80/20 apportionment would reasonably appear to be an accurate and fair representation in this case. 80% of her disabilities (for her bilateral shoulders, bilateral knees, and lumbar spine) is apportioned to her industrial injuries, and 20% apportionment is considered for her underlying degenerative joint disease.

I hope the above information has been helpful to you and if I can provide you with any necessary further information, please, feel free to contact my office at your convenience.

AFFIRMATIONS

It should be noted that all phases of the evaluation, record reviewed, related activities, report generation, and opinions contained herein were conducted and reached solely by myself, without the delegation of tasks to or participation of other parties. All opinions and conclusions delineated in this report, are my own, unless otherwise indicated and stipulated. I certify by my signature that this report is the work product of myself and express exclusively my professional opinions, findings and conclusions on the matters discussed herein. In compliance with recent worker's 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 that I have indicated I received from others. As to that information, I declare under the 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 further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.4 with regard to the evaluation of this patient or the preparation of this report. I verify under penalty of perjury that the total time I spent on the following activities is true and correct:

Review of records & Preparation of report 10 hrs.
Total time spent on this case: 10 hrs.

I hope the above information has been helpful to you and if I can provide you with any necessary further information please, feel free to call me at your convenience.

Respectfully submitted,



Sharona Drake, D.C., Q.M.E.

Doctor of Chiropractic

Qualified Medical Evaluator

Dated this 18th day of August 2024.

County where executed: Los Angeles County

CC:

TRAVELES INSURANCE: JUSTIN WILLIAMSON

LAW OFFICE OF: PEARLMAN BROWN & WAX: STEVEN H. WAX, ESQ.

LAW OFFICES OF: BARKHORDARIAN LAW: MAILHUONG TA, ESQ.



SHARONA DRAKE, D.C., Q.M.E.

19528 Ventura Blvd., Suite 640; Tarzana, CA 91356 phone:(818)232-7020 fax:(888)809-9734

DATE OF SERVICE: AUGUST 18, 2024

TRAVELES INSURANCE

ATTENTION: JUSTIN WILLIAMSON
P.O.BOX 660055
DALLAS, TX 75266

DEFENSE ATTORNEY

LAW OFFICE OF: PEARLMAN BROWN & WAX
ATTENTION: STEVEN H. WAX, ESQ.
15910 VENTURA BLVD. 18TH FLOOR
ENCINO, CA 91436

APPLICANT ATTORNEY

LAW OFFICES OF: BARKHORDARIAN LAW
ATTENTION: MAILHUONG TA, ESQ.
6047 BRISTOL PKWY.
CULVER CITY, CA 90230

Claimant Name: RIMA BABAYAN
Employer: FOREST LAWN MEMORIAL PARK
Date of Birth: JULY 10, 1956
Soc. Sec. No.: 053-56-6484
Claim Number: FWH9561; UNASSIGNED
WCAB / EAMS Number: ADJ 16541440; ADJ16541008
Injury Date (s): 04 / 14 / 2022; CT. 09 / 03 / 2019 - 04 / 18 / 2022

CHIROPRACTIC PANEL QME SUPPLEMENTAL BILLING

A Qualified Medical Evaluation has been requested for the above-named claimant. The billing of this report, as detailed below, meets the standard of *the ML 203-95 billing*.

ML 203 Billing Standard:

$$\text{ML-PRR} \quad 447\text{pages} - 50\text{pages} = 397 \text{ pages} \quad 397 \text{ pgs.} \times \$3.00 = \$1,191.00 \quad \$1,191.00 + \$650.00 = 1,841.00$$

Total due and payable : \$1,841.00

PLEASE MAKE CHECK PAYABLE TO: SHARONA DRAKE, D.C., Q.M.E.
19528 Ventura Blvd., Suite 640
Tarzana, CA 91356
(TAX ID #: 27-4916916)

**PROOF OF SERVICE BY MAIL (1013 A, 2015.5 C.C.P.)
STATE OF CALIFORNIA-COUNTY OF LOS ANGELES**

I, the undersigned, am employed in the County of Los Angeles and the state of California. I am over eighteen years of age and not a party to the within action. I served the parties to this action below on behalf of SHARONA DRAKE, D.C., Q.M.E. on the **Claimant: RIMA BABAYAN Claim Number: FWH9561**

by placing a true copy thereof enclosed in a sealed envelope with postage thereof fully prepaid, in the United States Mail.

-Petition for Reconsideration.

-Initial / P & S / **Supplemental Q.M.E. report** / A.M.E report / Q.M.E. report (dated: August 18, 2024).

-Q.M.E. Billing (dated: August 18, 2024).

-Itemization of Charges for \$ _____.

-All Itemized Bills and Green Lien for \$ _____.

-Declaration of Readiness to Proceed (dated:) .

-Notice of Representation / Demand for Documents (dated:) .

-Correspondence letter (dated:) .

-Request to be added to Official Address Record (dated:) .

-Request of Prior Medical Records including Results of All Diagnostic Studies related to DOI:

-Q.M.E. Apportionment Notice Form.

-Workers Compensation Patient Questionnaire.

List all parties to whom document was mailed:

TRAVELES INSURANCE
ATTENTION: JUSTIN WILLIAMSON
P.O.BOX 660055
DALLAS, TX 75266

LAW OFFICE OF: PEARLMAN BROWN & WAX
ATTENTION: STEVEN H. WAX, ESQ.
15910 VENTURA BLVD. 18TH FLOOR
ENCINO, CA 91436

LAW OFFICES OF: BARKHORDARIAN LAW
ATTENTION: MAILHUONG TA, ESQ.
6047 BRISTOL PKWY.
CULVER CITY, CA 90230

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

Mailed this 10th day of October 2024.

SIGNED:

Claimant Name: **RIMA BABAYAN**
Employer: **FOREST LAWN MEMORIAL PARK**
Date of Birth: **JULY 10, 1956**
Soc. Sec. No: **053-56-6484**
Claim Number: **FWH9561; UNASSIGNED**
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