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PATIENT'S NAME	Julien Olivier
ADDRESS	25791 Rana Dr. Valencia, Ca 91355
DATE OF BIRTH	06/27/1967
EMPLOYER	Los Angeles County Sheriff's Dept
ADDRESS	29330 The Old Road Castaic, Ca 91384
INSURANCE CO.	Sedgwick
ADDRESS	PO Box 7052 Pasadena, Ca 91384
CLAIM #	121-02891-A
ADJUSTOR	Linda Whitcomb
PHONE #	800-782-5888
APPLICANT ATTORNEY	Lonne Treger Helquist of Sherman & Staussner
ADDRESS	14555 Sylvan St. Vann Nuys, Ca 91411
PHONE #	818-788-1700
DEFENSE ATTORNEY	Gray & Prouty
ADDRESS	530 Camino Mercado Ste. 538 Arroyo Grande, Ca 93420
DATE OF TELEMEDICINE VISIT	03/29/2023
DATE OF INJURY	CT: 11/07/1990 - 12/15/2020

Secondary Treating Physician's Progress Report

The patient had a telemedicine visit for treatment of his work related injury. I spent 40 minutes in contact with the patient and providing this report.

HISTORY OF INJURY

The patient developed pain in the plantar heels and arches of both feet during the course of his employment as a Los Angeles County Sheriff. He is a 31 year veteran who recently retired and spent his career doing arduous and sometimes dangerous work with periods of prolonged standing and walking while wearing heavy protective equipment and heavy and stiff officers boots. He developed heel pain initially in 2001. He eventually sought medical treatment from a treating podiatrist who prescribed exercises and told the patient the condition will probably go away in six months which is not good advice for police officers. The patient continued to have moderate to severe intermittent pain with periods of remission in both plantar heels over the course of the next 15 years. He has orthopedic injuries to multiple body parts including shoulders, neck, lower back and knees and has received treatment including physical therapy and has been waiting to be referred to podiatrist for the last two years and has now been approved for a podiatric evaluation and treatment on 01/30/23. I reviewed previous medical records. I have records from the primary treating orthopedist Phillip Conwisar, MD, beginning on 03/29/21. He has been evaluated for intermittent moderate pain in the left shoulder, right-hand, neck, lower back and bilateral knees. He has pain with burning sensations in the heels and arches of both feet that can range from slight to severe depending on his level of weight-bearing activities. The patient did heavy work on his feet as a jail deputy, patrol officer, drill instructor, duty sergeant and custody/jail Lieutenant. He wore heavy protective equipment that can weight over 50 pounds with duty belt and weapons. The examination of both feet revealed pain on compression of the plantar heels bilaterally. X-rays of both feet demonstrated plantar calcaneal Spurs. The patient had MRI examinations on 10/21/21 of the cervical and lumbar spine and both knees. The cervical spine showed central cord stenosis with lumbar disc osteophyte at C-5-C6 and C6-C7. The lumbar spine demonstrated a significant disk protuberance at L5-S1. The MRI of both knees demonstrated patellofemoral degenerative joint disease with a partial lateral meniscus tear on the left. The diagnosis is lumbar strain/sprain with disc disease at L5-S1. There were shoulder labral tears bilateral as well as internal derangement of both knees. He had a diagnosis of plantar fasciitis bilaterally and a referral was recommended to a treating podiatrist with my name mentioned for the preferred referral. The patient was sent for an EMG/NCS study of the upper extremities with Kamran Hakimian, MD, on 10/28/21. There was no entrapment neuropathy found. The patient had an AME orthopedic evaluation by David Heskiaoff, MD, on 10/20/22. The patient had constant pain in both feet as well as the lower back. He had limitations in activities of daily living including moderate difficulty walking one block. He had difficulty with prolonged sitting and moderate difficulty traveling by car for one hour. He had moderate to severe pain in both feet. The pain interfered with his mood. He was also not able to walk around the house to perform any household chores. He had been doing icing and stretching of both feet. Previous x-rays demonstrated plantar calcaneal Spurs. Dr. Heskiaoff reviewed notes from a treating podiatrist Joung Lee, DPM dated 08/07/06. The patient had bilateral heel pain with the diagnosis of plantar fasciitis. The patient was to use ice and do stretching exercises. He recommended plantar fascial night splints. There was no follow-up. The patient remained on full duty. The diagnosis was lumbar strain, sprain of the shoulders and hands, internal derangement of the knees and plantar fasciitis bilaterally. A recommendation

was made for a podiatric consultation. The patient received physical therapy under the supervision of Dr. Conwisar and he continued to request a podiatric evaluation and was seeing the patient monthly from 06/24/22 through 11/23/22. The last notes were from 11/23/22. The patient was having severe pain in both feet that had been getting gradually worse and had not yet been approved for this podiatric consultation. Dr. Conwisar again strongly requested this consultation. I performed an evaluation and management service on 01/30/23. The patient presently has slight to moderate constant pain during ambulation in the right plantar heel and slight intermittent pain in the left plantar heel. He has moderate pain when first rising from a sitting position and the pain varies depending on his level of weight-bearing activities. The condition has gotten to this level over the last six months. He retired from his occupation in September 2022 and has not been wearing the heavy work-boots but the patient must stay off his feet to avoid pain. He has pain in his left great toe. He has had a bunion for several years and the first metatarsal prominence gets irritated with prolonged standing and walking and he wears Athletic shoes with a stretchable upper to avoid shoe compression. The patient has always been involved in physical fitness and was a regular runner along with general exercise routines. He could no longer run at his present level of disability. He has limitations in activities of daily living. He is presently undergoing physical therapy for his shoulders and lower back. He has had MRIs of his lumbar spine and bilateral knees that has shown and L5-S1 protruding lumbar disc as well as degenerative joint disease in the patellofemoral joint bilaterally. There is a meniscal injury in the left knee. The examination revealed pain on compression of the mid plantar heel on the right and along the course of the plantar fascia in the right arch. There is pain in the right plantar arch on maximum passive ankle joint dorsiflexion. There is no present pain on compression of the left heel. There is an enlarged medial eminence of the first metatarsal left characteristic of a bunion. There is slight tenderness on dorsal compression of the first metatarsal head. There is a callus below the second metatarsal on the left indicating a transfer of weight due to the bunion deformity. There is abnormal excessive subtalar joint pronation in stance bilaterally. The x-rays revealed an increase in the intermetatarsal angle and HAV angle on the left characteristic of a bunion deformity. There was a large well marginated plantar calcaneal spurs bilaterally. There was a dropped navicular in relation to the first metatarsal indicating abnormal pronation bilaterally. The diagnosis was 1) plantar fasciitis bilateral, 2) hallux abductovalgus with bunion left, 3) chronic pain right foot. I found the condition to be AOE/COE with no apportionment to a pre-existing condition. The condition was not permanent and stationary and the patient required additional medical treatment. He required custom molded foot orthotics and the patient presented on 02/22/23 for an orthotic work-up. He presented with slight to moderate constant pain during ambulation in the right plantar heel and slight intermittent pain in the left plantar heel. The biomechanical examination revealed a severe fully compensated subtalar varus bilateral with a moderate fully compensated forefoot varus bilateral. The patient was casted for custom molded foot orthotics and returned on 03/15/23 for dispensing. The patient will break in the orthotics gradually. I spoke to the patient for a follow-up.

WORK HISTORY

The patient has been a Los Angeles County Sheriff since 1990. He has had many different assignments and for the last seven years has been a lieutenant in the county jail system. There are periods of continuous was standing and walking while wearing 30 pounds of protective equipment and carrying a war bag of equipment and firearms. There is occasional running and altercations with inmates. There is occasional bending, stooping, kneeling and squatting. He wears stiff and heavy officers' boots. He retired from his occupation in September 2022.

SUBJECTIVE COMPLAINTS

The patient States that he is doing much better with the use of the custom orthotics. He has slight intermittent pain in the right plantar heel and arch. He expressed the need for a second set of orthotics.

DIAGNOSIS

M72.2 Plantar fasciitis bilaterally
M20.12 Hallux abductovalgus with bunion left
M25.571 Chronic pain right foot

TREATMENT

I request the second set of custom orthotics. As a first responder, the patient requires keeping one pair in his officers' boots and one pair in his every day athletic shoes. The patient will return for dispensing and a permanent and stationary report.

CAUSATION

The condition is a result of the cumulative trauma of the patients occupation and the condition is AE/COE.

APPORTIONMENT

Although the abnormal pronation is a factor in the pathology of the condition, absent the work trauma, the patient would not have likely develop his present level of disability. And, I find that the work injury is 100% responsible for the patient's disability.

WORK STATUS

The patient is presently retired from his occupation.

PERMANENT AND STATIONARY

The condition is not permanent and stationary and the patient requires additional medical treatment. The patient will be permanent and stationary at the next visit.

IMPAIRMENT RATING

An impairment rating can be addressed when the patient reaches maximum medical improvement.

DECLARATION

Pursuant to labor code for 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 the information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true”.

Pursuant to labor code 5703(a)(2)

“I declare under penalty of perjury that this report is true and correct and to the best of my knowledge and that I have not violated Labor Code # 139.3 and the contents of this report are true and correct to the best knowledge of the physician.”

EXECUTED AT

Northridge, CA

NAME

Arthur Fass DPM

CAL. LIC.#

E2475

SIGNATURE:

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Secondary Treating Physician's Progress Report

The patient returned for treatment of his work related injury. I spent 40 minutes face-to-face with the patient and 40 minutes providing this report.

HISTORY OF INJURY

The patient developed pain in the plantar heels and arches of both feet during the course of his employment as a Los Angeles County Sheriff. He is a 31 year veteran who recently retired and spent his career doing arduous and sometimes dangerous work with periods of prolonged standing and walking while wearing heavy protective equipment and heavy and stiff officers boots. He developed heel pain initially in 2001. He eventually sought medical treatment from a treating podiatrist who prescribed exercises and told the patient the condition will probably go away in six months which is not good advice for police officers. The patient continued to have moderate to severe intermittent pain with periods of remission in both plantar heels over the course of the next 15 years. He has orthopedic injuries to multiple body parts including shoulders, neck, lower back and knees and has received treatment including physical therapy and has been waiting to be referred to podiatrist for the last two years and has now been approved for a podiatric evaluation and treatment on 01/30/23. I reviewed previous medical records. I have records from the primary treating orthopedist Phillip Conwisar, MD, beginning on 03/29/21. He has been evaluated for intermittent moderate pain in the left shoulder, right-hand, neck, lower back and bilateral knees. He has pain with burning sensations in the heels and arches of both feet that can range from slight to severe depending on his level of weight-bearing activities. The patient did heavy work on his feet as a jail deputy, patrol officer, drill instructor, duty sergeant and custody/jail Lieutenant. He wore heavy protective equipment that can weight over 50 pounds with duty belt and weapons. The examination of both feet revealed pain on compression of the plantar heels bilaterally. X-rays of both feet demonstrated plantar calcaneal Spurs. The patient had MRI examinations on 10/21/21 of the cervical and lumbar spine and both knees. The cervical spine showed central cord stenosis with lumbar disc osteophyte at C-5-C6 and C6-C7. The lumbar spine demonstrated a significant disk protuberance at L5-S1. The MRI of both knees demonstrated patellofemoral degenerative joint disease with a partial lateral meniscus tear on the left. The diagnosis is lumbar strain/sprain with disc disease at L5-S1. There were shoulder labral tears bilateral as well as internal derangement of both knees. He had a diagnosis of plantar fasciitis bilaterally and a referral was recommended to a treating podiatrist with my name mentioned for the preferred referral. The patient was sent for an EMG/NCS study of the upper extremities with Kamran Hakimian, MD, on 10/28/21. There was no entrapment neuropathy found. The patient had an AME orthopedic evaluation by David Heskiaoff, MD, on 10/20/22. The patient had constant pain in both feet as well as the lower back. He had limitations in activities of daily living including moderate difficulty walking one block. He had difficulty with prolonged sitting and moderate difficulty traveling by car for one hour. He had moderate to severe pain in both feet. The pain interfered with his mood. He was also not able to walk around the house to perform any household chores. He had been doing icing and stretching of both feet. Previous x-rays demonstrated plantar calcaneal Spurs. Dr. Heskiaoff reviewed notes from a treating podiatrist Joung Lee, DPM dated 08/07/06. The patient had bilateral heel pain with the diagnosis of plantar fasciitis. The patient was to use ice and do stretching exercises. He recommended plantar fascial night splints. There was no follow-up. The patient remained on full duty. The diagnosis was lumbar strain, sprain of the shoulders and hands, internal derangement of the knees and plantar fasciitis bilaterally. A recommendation

was made for a podiatric consultation. The patient received physical therapy under the supervision of Dr. Conwisar and he continued to request a podiatric evaluation and was seeing the patient monthly from 06/24/22 through 11/23/22. The last notes were from 11/23/22. The patient was having severe pain in both feet that had been getting gradually worse and had not yet been approved for this podiatric consultation. Dr. Conwisar again strongly requested this consultation. I performed an evaluation and management service on 01/30/23. The patient presently has slight to moderate constant pain during ambulation in the right plantar heel and slight intermittent pain in the left plantar heel. He has moderate pain when first rising from a sitting position and the pain varies depending on his level of weight-bearing activities. The condition has gotten to this level over the last six months. He retired from his occupation in September 2022 and has not been wearing the heavy work-boots but the patient must stay off his feet to avoid pain. He has pain in his left great toe. He has had a bunion for several years and the first metatarsal prominence gets irritated with prolonged standing and walking and he wears Athletic shoes with a stretchable upper to avoid shoe compression. The patient has always been involved in physical fitness and was a regular runner along with general exercise routines. He could no longer run at his present level of disability. He has limitations in activities of daily living. He is presently undergoing physical therapy for his shoulders and lower back. He has had MRIs of his lumbar spine and bilateral knees that has shown and L5-S1 protruding lumbar disc as well as degenerative joint disease in the patellofemoral joint bilaterally. There is a meniscal injury in the left knee. The examination revealed pain on compression of the mid plantar heel on the right and along the course of the plantar fascia in the right arch. There is pain in the right plantar arch on maximum passive ankle joint dorsiflexion. There is no present pain on compression of the left heel. There is an enlarged medial eminence of the first metatarsal left characteristic of a bunion. There is slight tenderness on dorsal compression of the first metatarsal head. There is a callus below the second metatarsal on the left indicating a transfer of weight due to the bunion deformity. There is abnormal excessive subtalar joint pronation in stance bilaterally. The x-rays revealed an increase in the intermetatarsal angle and HAV angle on the left characteristic of a bunion deformity. There was a large well marginated plantar calcaneal spurs bilaterally. There was a dropped navicular in relation to the first metatarsal indicating abnormal pronation bilaterally. The diagnosis was 1) plantar fasciitis bilateral, 2) hallux abductovalgus with bunion left, 3) chronic pain right foot. I found the condition to be AOE/COE with no apportionment to a pre-existing condition. The condition was not permanent and stationary and the patient required additional medical treatment. He required custom molded foot orthotics and the patient presented on 02/22/23 for an orthotic work-up. He presented with slight to moderate constant pain during ambulation in the right plantar heel and slight intermittent pain in the left plantar heel. The biomechanical examination revealed a severe fully compensated subtalar varus bilateral with a moderate fully compensated forefoot varus bilateral. The patient was casted for custom molded foot orthotics and returns today for dispensing.

WORK HISTORY

The patient has been a Los Angeles County Sheriff since 1990. He has had many different assignments and for the last seven years has been a lieutenant in the county jail system. There are periods of continuous was standing and walking while wearing 30 pounds of protective equipment and carrying a war bag of equipment and firearms. There is occasional running and altercations with inmates. There is occasional bending, stooping, kneeling and squatting. He wears stiff and heavy officers' boots. He retired from his occupation in September 2022.

SUBJECTIVE COMPLAINTS

The patient presents for dispensing of custom orthotics.

OBJECTIVE FINDINGS

The orthotics appeared to fit well.

DIAGNOSIS

M72.2 Plantar fasciitis bilaterally
M20.12 Hallux abductovalgus with bunion left
M25.571 Chronic pain right foot

TREATMENT

The patient will break in the orthotics gradually. The devices are maximally supportive with a deep heel cup and wide profile and can only fit into boots or athletic shoes. He will likely require a second pair of custom orthotics to fit in more casual and dress shoes. The patient will return in two weeks to determine the effects of the treatment.

CAUSATION

The condition is a result of the cumulative trauma of the patients occupation and the condition is AE/COE.

APPORTIONMENT

Although the abnormal pronation is a factor in the pathology of the condition, absent the work trauma, the patient would not have likely develop his present level of disability. And, I find that the work injury is 100% responsible for the patient's disability.

WORK STATUS

The patient is presently retired from his occupation.

PERMANENT AND STATIONARY

The condition is not permanent and stationary and the patient requires additional medical treatment.

IMPAIRMENT RATING

An impairment rating can be addressed when the patient reaches maximum medical improvement.

DECLARATION

Pursuant to labor code for 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 the information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true”.

Pursuant to labor code 5703(a)(2)

“I declare under penalty of perjury that this report is true and correct and to the best of my knowledge and that I have not violated Labor Code # 139.3 and the contents of this report are true and correct to the best knowledge of the physician.”

EXECUTED AT

Northridge, CA

NAME

Arthur Fass DPM

CAL. LIC.#

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SIGNATURE:

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PHONE #	818-788-1700
DEFENSE ATTORNEY	Gray & Prouty
ADDRESS	530 Camino Mercado Ste. 538 Arroyo Grande, Ca 93420
DATE OF VISIT	01/30/2023
DATE OF INJURY	CT: 11/07/1990 - 12/15/2020

Secondary Treating Physician's Initial Report

The patient was referred by the primary treating orthopedist Phillip Conwisar, MD, for this podiatric consultation. I spent one hour face-to-face with the patient, two hours reviewing medical records and two hours providing this report.

HISTORY OF INJURY

The patient developed pain in the plantar heels and arches of both feet during the course of his employment as a Los Angeles County Sheriff. He is a 31 year veteran who recently retired and spent his career doing arduous and sometimes dangerous work with periods of prolonged standing and walking while wearing heavy protective equipment and heavy and stiff officers boots. He developed heel pain initially in 2001. He eventually sought medical treatment from a treating podiatrist who prescribed exercises and told the patient the condition will probably go away in six months which is not good advice for police officers. The patient continued to have moderate to severe intermittent pain with periods of remission in both plantar heels over the course of the next 15 years. He has orthopedic injuries to multiple body parts including shoulders, neck, lower back and knees and has received treatment including physical therapy and has been waiting to be referred to podiatrist for the last two years and has now been approved for this evaluation and treatment.

MEDICAL RECORDS

I have records from the primary treating orthopedist Phillip Conwisar, MD, beginning on 03/29/21. He has been evaluated for intermittent moderate pain in the left shoulder, right-hand, neck, lower back and bilateral knees. He has pain with burning sensations in the heels and arches of both feet that can range from slight to severe depending on his level of weight-bearing activities. The patient did heavy work on his feet as a jail deputy, patrol officer, drill instructor, duty sergeant and custody/jail Lieutenant. He wore heavy protective equipment that can weight over 50 pounds with duty belt and weapons. The examination of both feet revealed pain on compression of the plantar heels bilaterally. X-rays of both feet demonstrated plantar calcaneal Spurs. The patient had MRI examinations on 10/21/21 of the cervical and lumbar spine and both knees. The cervical spine showed central cord stenosis with lumbar disc osteophyte at C-5-C6 and C6-C7. The lumbar spine demonstrated a significant disk protuberance at L5-S1. The MRI of both knees demonstrated patellofemoral degenerative joint disease with a partial lateral meniscus tear on the left. The diagnosis is lumbar strain/sprain with disc disease at L5-S1. There were shoulder labral tears bilateral as well as internal derangement of both knees. He had a diagnosis of plantar fasciitis bilaterally and a referral was recommended to a treating podiatrist with my name mentioned for the preferred referral. The patient was sent for an EMG/NCS study of the upper extremities with Kamran Hakimian, MD, on 10/28/21. There was no entrapment neuropathy found. The patient had an AME orthopedic evaluation by David Heskiaoff, MD, on 10/20/22. The patient had constant pain in both feet as well as the lower back. He had limitations in activities of daily living including moderate difficulty walking one block. He had difficulty with prolonged sitting and moderate difficulty traveling by car for one hour. He had moderate to severe pain in both feet. The pain interfered with his mood and walking around the house doing household chores. He had been doing icing and stretching of both feet. Previous x-rays demonstrated plantar calcaneal Spurs. Dr. Heskiaoff reviewed notes from a treating podiatrist Joung Lee, DPM dated 08/07/06. The patient had bilateral heel pain

with the diagnosis of plantar fasciitis. The patient was to use ice and do stretching exercises. He recommended plantar fascial night splints. There was no follow-up. The patient remained on full duty. The diagnosis was lumbar strain, sprain of the shoulders and hands, internal derangement of the knees and plantar fasciitis bilaterally. A recommendation was made for a podiatric consultation. The patient received physical therapy under the supervision of Dr. Conwisar and he continued to request a podiatric evaluation and was seeing the patient monthly from 06/24/22 through 11/23/22. The last notes were from 11/23/22. The patient was having severe pain in both feet that had been getting gradually worse and had not yet been approved for this podiatric consultation. Dr. Conwisar again strongly requested this consultation.

WORK HISTORY

The patient has been a Los Angeles County Sheriff since 1990. He has had many different assignments and for the last seven years has been a lieutenant in the county jail system. There are periods of continuous was standing and walking while wearing 30 pounds of protective equipment and carrying a war bag of equipment and firearms. There is occasional running and altercations with inmates. There is occasional bending, stooping, kneeling and squatting. He wears stiff and heavy officers' boots. He retired from his occupation in September 2022

PRESENT SYMPTOMS

The patient presently has slight to moderate constant pain during ambulation in the right plantar heel and slight intermittent pain in the left plantar heel. He has moderate pain when first rising from a sitting position and the pain varies depending on his level of weight-bearing activities. The condition has gotten to this level over the last six months. He retired from his occupation in September 2022 and has not been wearing the heavy work-boots but the patient must stay off his feet to avoid pain. He has pain in his left great toe. He has had a bunion for several years and the first metatarsal prominence gets irritated with prolonged standing and walking and he wears Athletic shoes with a stretchable upper to avoid shoe compression. The patient has always been involved in physical fitness and was a regular runner along with general exercise routines. He could no longer run at his present level of disability. He has limitations in activities of daily living. He has moderate difficulty walking two blocks and severe difficulty walking one-mile. He has severe difficulty squatting. He has moderate difficulty doing household chores and engaging in hobbies and recreational activities. He has mild difficulty walking around the house and getting in and out of the bath. He has mild difficulty going shopping and carrying groceries. He has slight difficulty with balance. He has severe difficulty climbing ladders or standing for one hour. He has pain in his left great toe.

REVIEW OF SYSTEMS

The patient has had irritable bowel syndrome in the past but has no present symptoms with a change in diet. He denies all other systemic illnesses.

FAMILY HISTORY

There is no relevant Family history.

PREVIOUS INJURIES

The patient is presently undergoing physical therapy for his shoulders and lower back. He has had MRIs of his lumbar spine and bilateral knees that has shown and L5-S1 protruding lumbar disc as well as degenerative joint disease in the patellofemoral joint bilaterally. There is a meniscal injury in the left knee.

PERSONAL HISTORY

The patient is a 55-year-old Caucasian male who was born in New Hampshire and raised in California. He is married with two children. He has a high school diploma. He denies the use of tobacco and has an occasional alcoholic beverage. He denies the use of street drugs.

Objective Findings

GENERAL

The patient is alert and cooperative and in good apparent health. He is 5'11" and weighs 183 lbs. The blood pressure was 142/70 with a pulse of 72 BPM.

MUSCULOSKELETAL EXAM

There is pain on compression of the mid plantar heel on the right and along the course of the plantar fascia in the right arch. There is pain in the right plantar arch on maximum passive ankle joint dorsiflexion. There is no present pain on compression of the left heel. There is an enlarged medial eminence of the first metatarsal left characteristic of a bunion. There is slight tenderness on dorsal compression of the first metatarsal head. There is a callus below the second metatarsal on the left indicating a transfer of weight due to the bunion deformity. There is abnormal excessive subtalar joint pronation in stance bilaterally.

Range of Motion Measurements

ANKLE JOINT	LEFT	RIGHT
DORSIFLEXION	10/10	10/10
PLANTAR-FLEXION	60/60	60/60

ANKLE JOINT	LEFT	RIGHT
HIND-FOOT	**LEFT**	**RIGHT**
INVERSION	35/35	35/35
EVERSION	10/10	10/10
1ST MP JOINT	**LEFT**	**RIGHT**
DORSIFLEXION	60/60	60/60
PLANTAR-FLEXION	10/10	10/10

Vascular Exam

Dorsalis pedis and posterior tibial pulses are 2/3 bilaterally. Pulses were found to have regular rhythm. Foot/Ankle edema was found to be within normal limits. Capillary filling was instant bilaterally. No varicosities were noted bilaterally. Skin temperature was found to be normal bilaterally. Hair growth was within normal limits bilaterally.

Neurological Exam

SHARP/DULL SENSATION

Within normal limits.

PROPRIOCEPTION

Within normal limits.

VIBRATORY

Within normal limits.

Muscle Strength Testing

MUSCLE	LEFT	RIGHT
PERONEAL	4/4	4/4
ANTERIOR TIBIAL	4/4	4/4
POSTERIOR TIBIAL	4/4	4/4

MUSCLE	LEFT	RIGHT
TRICEPS SURAE	4/4	4/4
GREAT TOE EXTENSORS	4/4	4/4
GREAT TOE FLEXORS	4/4	4/4
LESSER TOE EXTENSORS	4/4	4/4
LESSER TOE FLEXORS	4/4	4/4

X-RAY FINDINGS

Three views were taken of each foot. The AP and MO views demonstrate the alignment of the metatarsals and any evidence of degenerative joint disease in the forefoot or mid-foot. The lateral weight bearing view demonstrates the contour of the plantar heel and the ankle mortise. It also demonstrates the alignment of the arch of the foot. The AP view demonstrated an increase in the intermetatarsal angle and HAV angle on the left characteristic of a bunion deformity. There were no degenerative joint changes in the first MP joint. The MO viewed demonstrated no other degenerative joint changes in the forefoot or mid-foot. The lateral weight bearing view demonstrated large well marginated plantar calcaneal spurs bilaterally. There was a dropped navicular in relation to the first metatarsal indicating abnormal pronation bilaterally.

DIAGNOSIS

M72.2 Plantar fasciitis bilaterally
M20.12 Hallux abductovalgus with bunion left
M25.571 Chronic pain right foot

DISCUSSION

The plantar fascia is a broad flat ligament that extends from the plantar heel and runs across the arch of the foot inserting into the toes. It is responsible for the structural integrity of the arch of the foot. The arch of the foot is responsible for balance and support of the limb above. The continuous and cumulative trauma of the patient's occupation causes pulling and stretching of the plantar fascia that results in micro-tears leading to inflammation and pain. Plantar calcaneal Spurs develop as a calcification takes place in the inflamed plantar fascia as it pulls away from the heel bone. It is indicative of the chronic nature of the condition but is not a direct cause of the pain. The pain is due to tissue inflammation that is exacerbated with each step unless the foot is properly supported. Measures to reduce inflammation such as icing and stretching and taking anti-inflammatory medications is a temporary help but the hallmark of treatment is to provide the patient with custom molded foot orthotics that significantly reduce the tension in the plantar fascia and allow the tissue to heal. The orthotics require a deep heel cup, a wide profile

and be well contoured to the shape of the patient's arch with a full-length shock absorbing top cover. The orthotics control abnormal pronation and relieve the stress on the plantar fascia and will likely help relieve or cure the effects of the work injury. The bunion deformity on the left would also be helped with the use of orthotics by redistributing weight-bearing forces and allowing the first ray to plantarflex into a better functional position.

CAUSATION

The condition is a result of the cumulative trauma of the patients occupation and the condition is AE/COE.

APPORTIONMENT

Although the abnormal pronation is a factor in the pathology of the condition. Absent the work trauma the patient would not have likely develop his present level of disability and I find that the work injury is 100% responsible for the patient’s disability.

DISABILITY

The subjective factors of disability includes slight to moderate constant pain on ambulation in the right plantar heel and slight intermittent pain in the left plantar heel. There are limitations in activities of daily living including difficulty with prolonged standing and walking and the patient cannot run. He has severe difficulty walking one mile or standing for one hour and moderate difficulty walking one block. He has severe difficulty climbing ladders or squatting and stooping. He has mild difficulty going shopping, getting in and out of his automobile and walking around the house. He has moderate difficulty engaging in recreational activities. The objective factors of disability includes pain on compression of the right plantar heel and arch. There is x-ray evidence of large plantar calcaneal Spurs. There is the ongoing need for custom molded foot orthotics.

WORK STATUS

The patient is presently retired from his occupation.

PERMANENT AND STATIONARY

The condition is not permanent and stationary and the patient requires additional medical treatment.

IMPAIRMENT RATING

An impairment rating can be addressed when the patient reaches maximum medical improvement.

FUTURE MEDICAL

The patient was instructed on ice massage and we discussed the ideal athletic shoes. He may require a corticosteroid injection in the right heel if there is any persistent pain after receiving the orthotics to break up the adhesions and relieve the inflammation. As previously stated, the patient requires custom molded foot orthotics. The patient will be casted in the maximum arch supinated semi-weight bearing position to obtain a full contact orthotic.The use of custom orthoses are discussed in the ACOEM Treatment Guidelines in chapter 14 pages 371-372. Custom orthoses are found effective in treatment of compensations in the joints of the foot and leg that can affect the injured part of the lower extremities. Abnormal excessive subtalar joint pronation can cause increased stress on the injured part and the orthoses can control that compensatory motion and relieve pain. A rigid flat foot or cavus foot can also cause excessive force on the injured part and the orthoses can redistribute weight-bearing forces and relieve pain. The patient may require a corticosteroid injection in the right heel if there is any persistent pain with the orthotics to break up the adhesions and relieve the inflammation. The medical literature supports the use of custom orthotics to relieve inflammatory conditions of the foot and ankle as well as the lower extremities by controlling abnormal pronation and redistributing weight-bearing forces.

Gross ML, Davlin LB, Evanski PM. Effectiveness of orthotic shoe inserts in the long distance runner. American Journal of Sports Medicine 1991; 19(4):409-412

Donoghue OA, Harrison AJ, Laxton P, et al. Orthotic control of rear foot and lower limb motion during running in participants with chronic Achilles tendon injury. Sports Biotech 2008;7(2): 194-205

Gross MT, Foxworth JL. The role of foot orthoses as an intervention for patellofemoral pain. Journal Orthopedic Sports Physical Therapy 2003;33(11); 661-670

Schepsis AA, Jones H, Haas AL. Achilles tendon disorders in athletes. American Journal Sports Medicine 2002;30(2): 287-305

Trotter, L.C. & Pierrynowski, M.R. (2008) Changes in gait, economy between full contact custom made foot orthoses and prefabricated inserts in patients with musculoskeletal pain. A randomized clinical trial. Journal of the American Podiatric Medical Association, 98(6) 429-435

Evaluating the Clinical Effectiveness and Cost-effectiveness of Foot Orthoses in the Treatment of Plantar Heel Pain. Journal of the American Podiatric Medical Association, Vol 94 No.3 May/ June 2004 229 - 238

There is additional medical evidence for the use of orthotics based on MASS theory or maximum subtalar joint stabilization. These are the orthotics that provide the maximum benefit in relieving painful syndromes of the foot and ankle.

. 1) Glaser ES, Bursch D, Currie SJ. Theory, Practice Combine for Custom Orthoses. Biomechanics 2006; 13(9):33-43.
An overview of MASS theory and application within the historical context of custom foot orthotic intervention.

. 2) Hodgson B, et al. The Effects of 2 Different Custom-Molded Corrective Orthotics on Plantar Pressure The Journal of Sports Rehabilitation, 2006;15,p. 33-44.
Conclusions state that Sole Supports orthoses “appear be more effective in achieving the goals of custom-molded orthotic intervention, which include decreased pressure on the lateral metatarsal heads and increased pressure under the first metatarsal head at toe-off”.

. 3) Cobb SC, Tis LL, Johnson JT. The Effect of 6 Weeks of Custom-molded Foot Orthosis Intervention on Postural Stability in Participants With ≥7 Degrees of Forefoot Varus, Clinical Journal of Sports Medicine, 2006;16:p.316–22.
Conclusions state that six weeks of Sole Supports foot orthosis intervention may significantly improve postural stability, both when wearing the orthosis and when not wearing the orthosis.

. 4) Trotter LC, Pierrynowski MR. Ability of foot care professionals to cast feet using the non weight-bearing plaster and the gait-referenced foam casting techniques. J Am Podiatric Med Assoc 2008; 98(1):14-18.
The results state that the MASS method of foam casting, “compared with the plaster method, had significantly better intracaster reliability”.

. 5) Trotter LC, Pierrynowski MR. The short-term effectiveness of full-contact custom-made foot orthoses and prefabricated shoe inserts on lower-extremity musculoskeletal pain: a randomized clinical trial. Journal American Podiatric Med Assoc 2008; 98(5):357-363.
The conclusions reveal that Sole Supports orthoses “provide symptomatic relief after 3 weeks of use for patients with lower-extremity musculoskeletal pain if they

are prescribed as the initial treatment".

. 6) Trotter LC, Pierrynowski MR. Changes in Gait Economy Between Full-Contact Custom-made Foot Orthoses and Prefabricated Inserts in Patients with Musculoskeletal Pain: A Randomized Clinical Trial. Journal American Podiatric Med Assoc 2008; 98(6):429-435.
For patients with lower extremity musculoskeletal pain, immediate improvements in economy of gait can be expected while wearing Sole Supports. Compared to a prefabricated orthosis, only the custom-made, full-contact Sole Supports device maintained this improvement in economy of gait for at least 1 month.

. 7) Currie S, Bursch D, Glaser ES. Orthoses: Functional Relevance of the Arch. Lower Extremity Review 2010; 2(3): 47-51.
Theory article emphasizing the relevance of foot posture to biomechanical goals and evaluation, with relation to MASS Theory.

REASON FOR OPINION

I reached my opinion after performing a history and physical exam as well as reviewing medical records. I have relied on substantial medical evidence and used reasonable medical judgment to arrive at my opinion. I also depend on 42 years of clinical experience.

DECLARATION

Pursuant to labor code for 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 the information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true".

Pursuant to labor code 5703(a)(2)

"I declare under penalty of perjury that this report is true and correct and to the best of my knowledge and that I have not violated Labor Code # 139.3 and the contents of this report are true and correct to the best knowledge of the physician."

EXECUTED AT

Northridge, CA

NAME

Arthur Fass DPM

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DATE OF BIRTH	06/27/1967
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INSURANCE CO.	Sedgwick
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CLAIM #	121-02891-A
ADJUSTOR	Linda Whitcomb
PHONE #	800-782-5888
APPLICANT ATTORNEY	Lonne Treger Helquist of Sherman & Staussner
ADDRESS	14555 Sylvan St. Vann Nuys, Ca 91411
PHONE #	818-788-1700
DEFENSE ATTORNEY	Gray & Prouty
ADDRESS	530 Camino Mercado Ste. 538 Arroyo Grande, Ca 93420
DATE OF VISIT	02/22/2023
DATE OF INJURY	CT: 11/07/1990 - 12/15/2020

Secondary Treating Physician's Progress Report

The patient returned for treatment of his work related injury. I spent 40 minutes face-to-face with the patient and 40 minutes providing this report.

HISTORY OF INJURY

The patient developed pain in the plantar heels and arches of both feet during the course of his employment as a Los Angeles County Sheriff. He is a 31 year veteran who recently retired and spent his career doing arduous and sometimes dangerous work with periods of prolonged standing and walking while wearing heavy protective equipment and heavy and stiff officers boots. He developed heel pain initially in 2001. He eventually sought medical treatment from a treating podiatrist who prescribed exercises and told the patient the condition will probably go away in six months which is not good advice for police officers. The patient continued to have moderate to severe intermittent pain with periods of remission in both plantar heels over the course of the next 15 years. He has orthopedic injuries to multiple body parts including shoulders, neck, lower back and knees and has received treatment including physical therapy and has been waiting to be referred to podiatrist for the last two years and has now been approved for a podiatric evaluation and treatment on 01/30/23. I reviewed previous medical records. I have records from the primary treating orthopedist Phillip Conwisar, MD, beginning on 03/29/21. He has been evaluated for intermittent moderate pain in the left shoulder, right-hand, neck, lower back and bilateral knees. He has pain with burning sensations in the heels and arches of both feet that can range from slight to severe depending on his level of weight-bearing activities. The patient did heavy work on his feet as a jail deputy, patrol officer, drill instructor, duty sergeant and custody/jail Lieutenant. He wore heavy protective equipment that can weight over 50 pounds with duty belt and weapons. The examination of both feet revealed pain on compression of the plantar heels bilaterally. X-rays of both feet demonstrated plantar calcaneal Spurs. The patient had MRI examinations on 10/21/21 of the cervical and lumbar spine and both knees. The cervical spine showed central cord stenosis with lumbar disc osteophyte at C-5-C6 and C6-C7. The lumbar spine demonstrated a significant disk protuberance at L5-S1. The MRI of both knees demonstrated patellofemoral degenerative joint disease with a partial lateral meniscus tear on the left. The diagnosis is lumbar strain/sprain with disc disease at L5-S1. There were shoulder labral tears bilateral as well as internal derangement of both knees. He had a diagnosis of plantar fasciitis bilaterally and a referral was recommended to a treating podiatrist with my name mentioned for the preferred referral. The patient was sent for an EMG/NCS study of the upper extremities with Kamran Hakimian, MD, on 10/28/21. There was no entrapment neuropathy found. The patient had an AME orthopedic evaluation by David Heskiaoff, MD, on 10/20/22. The patient had constant pain in both feet as well as the lower back. He had limitations in activities of daily living including moderate difficulty walking one block. He had difficulty with prolonged sitting and moderate difficulty traveling by car for one hour. He had moderate to severe pain in both feet. The pain interfered with his mood and walking around the house doing household chores. He had been doing icing and stretching of both feet. Previous x-rays demonstrated plantar calcaneal Spurs. Dr. Heskiaoff reviewed notes from a treating podiatrist Joung Lee, DPM dated 08/07/06. The patient had bilateral heel pain with the diagnosis of plantar fasciitis. The patient was to use ice and do stretching exercises. He recommended plantar fascial night splints. There was no follow-up. The patient remained on full duty. The diagnosis was lumbar strain, sprain of the shoulders and hands, internal derangement of the knees and plantar fasciitis bilaterally. A recommendation was made for a podiatric

consultation. The patient received physical therapy under the supervision of Dr. Conwisar and he continued to request a podiatric evaluation and was seeing the patient monthly from 06/24/22 through 11/23/22. The last notes were from 11/23/22. The patient was having severe pain in both feet that had been getting gradually worse and had not yet been approved for this podiatric consultation. Dr. Conwisar again strongly requested this consultation. I performed an evaluation and management service on 01/30/23. The patient presently has slight to moderate constant pain during ambulation in the right plantar heel and slight intermittent pain in the left plantar heel. He has moderate pain when first rising from a sitting position and the pain varies depending on his level of weight-bearing activities. The condition has gotten to this level over the last six months. He retired from his occupation in September 2022 and has not been wearing the heavy work-boots but the patient must stay off his feet to avoid pain. He has pain in his left great toe. He has had a bunion for several years and the first metatarsal prominence gets irritated with prolonged standing and walking and he wears Athletic shoes with a stretchable upper to avoid shoe compression. The patient has always been involved in physical fitness and was a regular runner along with general exercise routines. He could no longer run at his present level of disability. He has limitations in activities of daily living. He is presently undergoing physical therapy for his shoulders and lower back. He has had MRIs of his lumbar spine and bilateral knees that has shown and L5-S1 protruding lumbar disc as well as degenerative joint disease in the patellofemoral joint bilaterally. There is a meniscal injury in the left knee. The examination revealed pain on compression of the mid plantar heel on the right and along the course of the plantar fascia in the right arch. There is pain in the right plantar arch on maximum passive ankle joint dorsiflexion. There is no present pain on compression of the left heel. There is an enlarged medial eminence of the first metatarsal left characteristic of a bunion. There is slight tenderness on dorsal compression of the first metatarsal head. There is a callus below the second metatarsal on the left indicating a transfer of weight due to the bunion deformity. There is abnormal excessive subtalar joint pronation in stance bilaterally. The x-rays revealed an increase in the intermetatarsal angle and HAV angle on the left characteristic of a bunion deformity. There was a large well marginated plantar calcaneal spurs bilaterally. There was a dropped navicular in relation to the first metatarsal indicating abnormal pronation bilaterally. The diagnosis was 1) plantar fasciitis bilateral, 2) hallux abductovalgus with bunion left, 3) chronic pain right foot. I found the condition to be AOE/COE with no apportionment to a pre-existing condition. The condition was not permanent and stationary and the patient required additional medical treatment. He required custom molded foot orthotics and the patient presents today for an orthotic work-up.

WORK HISTORY

The patient has been a Los Angeles County Sheriff since 1990. He has had many different assignments and for the last seven years has been a lieutenant in the county jail system. There are periods of continuous was standing and walking while wearing 30 pounds of protective equipment and carrying a war bag of equipment and firearms. There is occasional running and altercations with inmates. There is occasional bending, stooping, kneeling and squatting. He wears stiff and heavy officers' boots. He retired from his occupation in September 2022

SUBJECTIVE COMPLAINTS

The patient presently has slight to moderate constant pain during ambulation in the right plantar heel and slight intermittent pain in the left plantar heel. He presents for an orthotic workup.

OBJECTIVE FINDINGS

The biomechanical examination revealed a severe fully compensated subtalar varus bilateral with a moderate fully compensated forefoot varus bilateral.

DIAGNOSIS

M72.2 Plantar fasciitis bilaterally
M20.12 Hallux abductovalgus with bunion left
M25.571 Chronic pain right foot

TREATMENT

The patient was casted for custom molded foot orthotics in the maximum arch supinated semi weight bearing position to obtain full contact orthotics. The patient to return for orthotic dispensing.

CAUSATION

The condition is a result of the cumulative trauma of the patients occupation and the condition is AE/COE.

APPORTIONMENT

Although the abnormal pronation is a factor in the pathology of the condition, absent the work trauma, the patient would not have likely develop his present level of disability. And, I find that the work injury is 100% responsible for the patient's disability.

WORK STATUS

The patient is presently retired from his occupation.

PERMANENT AND STATIONARY

The condition is not permanent and stationary and the patient requires additional medical treatment.

IMPAIRMENT RATING

An impairment rating can be addressed when the patient reaches maximum medical improvement.

DECLARATION

Pursuant to labor code for 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 the information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true”.

Pursuant to labor code 5703(a)(2)

“I declare under penalty of perjury that this report is true and correct and to the best of my knowledge and that I have not violated Labor Code # 139.3 and the contents of this report are true and correct to the best knowledge of the physician.”

EXECUTED AT

Northridge, CA

NAME

Arthur Fass DPM

CAL. LIC.#

E2475

SIGNATURE: