

Applicant/Employee: ALEJANDRO VARGAS

WCAB No(s): ADJ13469671

AWARD

AWARD IS MADE in favor of ALEJANDRO VARGAS against
CITY OF LOS ANGELES – TRISTAR RISK MANAGEMENT of:
(entity legally obligated to pay the award)

(A) Additional temporary disability indemnity in accordance with paragraph 2(a) above,

(B) Permanent disability indemnity in accordance with paragraph 3 above,

Less the sum of \$ NA , payable to applicant's attorney as the reasonable value
of services rendered. ☐ Fees are to be commuted pursuant to Paragraph 6.

(C) Liens in accordance with Paragraph 7 above,

(D) Further medical treatment in accordance with Paragraph 4 above

(E) Reimbursement for medical-legal expenses in accordance with Paragraph 5 above,

(F) Stipulations in Paragraph 8 and 9 are approved.

(G) The matter is ordered off calendar / set for status/lien conference.

(H)

August 6, 2020

(Dated)

/s/ Robert Sommer

Robert W. Sommer

WORKERS' COMPENSATION JUDGE

On _____, this document

☐ was personally served on all persons appearing at the
hearing on said date, as set forth in the minutes of that hearing
☐ was personally served on

☐ was served by mail on all persons listed on the Official
Address Record ☐ was served by mail on following party or
parties: _____

By _____

☒ NOTICE TO: DEF.

Pursuant to Rule 10500, you are designated to serve this
document on all parties shown on the Official Address Record,
together with a proof of service. You shall maintain this proof of
service, which shall not be filed with the WCAB unless a dispute
arises regarding service. A copy of the current Official Address
Record accompanies this notice.

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

PROOF OF SERVICE-AWARD

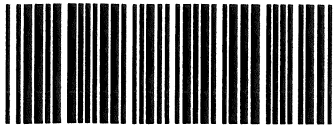
Case Number: ADJ13469671

ALEJANDRO VARGAS Injured Worker, 1025 S LOS ROBLES AVE PASADENA CA 91106

CITY OF LOS ANGELES Employer, 700 E TEMPLE STREET LOS ANGELES CA 90012

TRISTAR 29106 Claims Administrator, PO BOX 29106 GLENDALE CA 91209
GLENDALE

Served on parties on the
Official Address Record
08/10/2020 *Vannora Campos*



STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD



Date of Injury 03/22/2018

MM/DD/YYYY

Case No.

464556745

SSN (Numbers Only)



Venue Choice is based upon: (Completion of this section is required)

- ☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- ☒ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- ☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

VNO

Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

ALEJANDRO

First Name

MI

VARGAS

Last Name

1025 S. LOS ROBLES AVE

Address/PO Box (Please leave blank spaces between numbers, names or words)

PASADENA

City

CA

State

91106

Zip Code

Employer #1 Information (Completion of this section is required)

- ☐ Insured ☒ Self-Insured ☐ Legally Uninsured ☐ Uninsured

CITY OF LOS ANGELES

Employer Name (Please leave blank spaces between numbers, names or words)

700 E TEMPLE

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES

City

CA

State

90012

Zip Code



Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

CITY OF LOS ANGELES

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

700 E TEMPLE

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES

City

CA
State

90012
Zip Code

Claims Administrator Information (if known and if applicable)

TRISTAR RISK MANAGEMENT

Name (Please leave blank spaces between numbers, names or words)

PO BOX 29106

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

GLENDALE

City

CA
State

91209-9106
Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured

☐ Self-Insured

☐ Legally Uninsured

☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Insurance Carrier Information

(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #4 Information (Completion of this section is required)

☐ Insured

☐ Self-Insured

☐ Legally Uninsured

☐ Uninsured



Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City _____ State _____ Zip Code _____

Insurance Carrier Information

(if known and if applicable - include even if carrier is adjusted by claims administrator)

TRISTAR RISK MANAGEMENT

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

P.O. BOX 29106

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

GLENDALE

City _____ CA _____ 91209
State _____ Zip Code _____

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City _____ State _____ Zip Code _____

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:



1. ALEJANDRO

Employees First Name

VARGAS

Employees Last Name

birth date 02/05/1966
MM/DD/YYYY

while employed at CITY OF LOS ANGELES

CA
State

as a (n) POLICE LIEUTENANT

Occupation

490 in
Group



☐ More than 4 Companion Cases

☒ Specific Injury

Case Number 1

☐ Cumulative Injury

03/22/2018

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 450 SHOULDER Body Part 2: 313 ELBOW Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

☐ Specific Injury

Case Number 3

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

☐ Specific Injury

Case Number 4

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

RIGHT ELBOW, RIGHT SHOULDER

(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period ADEQUATELY through
MM/DD/YYYY

for which indemnity has been paid at \$ 1,215.27 per week.
MM/DD/YYYY Indemnity Paid

2(a). The injury(ies) caused additional temporary disability for the period

N/A

MM/DD/YYYY

through N/A at the rate of \$ Rate in the amount of \$ Indemnity Paid
MM/DD/YYYY

3. The injury(ies) caused permanent disability of 24.00 % for which indemnity is payable at \$ 290.00
per week beginning 09/05/2019 in the sum of \$ 27,695.00, less credit for such payments
MM/DD/YYYY Indemnity Paid

previously made. ☐ And a life pension of \$ N/A per week thereafter.
Life Pension

An informal rating ☒ has / ☐ has not (Select one) been previously issued in case no(s) DEU12765708

4. There ☒ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

DEFENDANT TO PAY, ADJUST, AND OR LITIGATE ALL LIENS OF RECORD WITH WCAB TO
RETAIN JURISDICTION.

6. Applicant's attorney requests a fee of \$ N/A

☐ Fees to be commuted as follows:

IN PRO PER

7. Liens Against compensation are payable as follows:

8. Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9. Other stipulations:

- A. PENALTIES & INTEREST REGARDING THIS AWARD IS WAIVED IF PAID WITHIN 30 DAYS OF SERVICE.
- B. THIS SETTLEMENT RESOLVES ANY AND ALL EXISTING CLAIMS FOR PENALTIES & INTEREST ACCRUED UP THROUGH DATE OF THIS AWARD.
- C. PERMANENT DISABILITY IS BASED UPON THE OPINIONS OF THE TREATING PHYSICIAN, DR. HATCH DATED 09/05/19 THE IMPAIRMENT FROM WHICH RATES AS FOLLOWS:
- RIGHT SHOULDER ROM
16.02.01.00-6[1.4]8 490I – 12-15PD(A)
RIGHT ELBOW STRENGTH
16.01.04.00 – 4[1.4]6 – 490I – 9 – 11PD (A)
(A) 15 C 11 = CVC 24%

+

Dated

07/23/2020
MM/DD/YYYY


Applicant

Applicant's Attorney or Authorized Representative:

- ☐ Law Firm/Attorney ☐ Non Attorney Representative

+

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Dated

MM/DD/YYYY

Applicant Attorney Signature

+

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney

☒ Non Attorney Representative

MARSHA

First Name

MATHEWS

Last Name

487195

Firm Number

TRISTAR 29106 GLENDALE

Law Firm Name

P O BOX 29106

Address/PO Box (Please leave blank spaces between numbers, names or words)

GLENDALE

City

CA

State

91209

Zip Code

Dated

7-30-2020

MM/DD/YYYY

Mark Mathew

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney

☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Dated

MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney

☐ Non Attorney Representative



First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Dated

MM/DD/YYYY

Defense Attorney Signature

Interpreter License Number:

Interpreter Name

Interpreter License Number

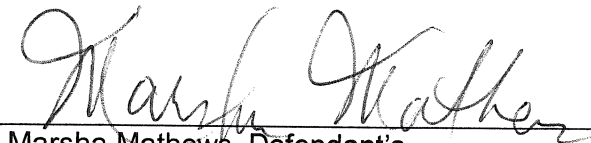


ADDENDUM A

WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

Alejandro Vargas) WCAB CASE NO.:
Applicant,)
vs.) DECLARATION IN COMPLIANCE
CITY OF LOS ANGELES,) WITH LABOR CODE 4906(h)
PERMISSIBLY SELF- INSURED;
ADMINISTRATOR)
Defendant.)

It is declared under penalty of perjury by the undersigned that I/we have not violated Labor Code Section 139.3 (prohibited physician referrals) and that I/we have not offered, delivered, received, or accepted any unlawful rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.



Marsha Mathews, Defendant's
Representative

Date

7-30-2020



Alejandro Vargas, Applicant

Date

7/23/20

Signature of Applicant's Attorney

Date

Before signing this form, you should be aware that: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."



PO BOX 29106
GLENDALE, CA 91209-9106
www.tristarrisk.com

(626) 407-0400

City of Los Angeles
California



ERIC M. GARCETTI
MAYOR

AN EQUAL EMPLOYMENT
OPPORTUNITY EMPLOYER

WWW.LACITY.ORG/PER

WAIVER OF SELECTION OF A QUALIFIED MEDICAL EVALUATOR

Employee: Alejandro Vargas
Employer: City of Los Angeles
Date of Injury: 03/22/2018
Claim Number: 4027838

I am in receipt of Dr. Hatch's report dated 09/05/19 and I am in agreement with his findings. A request form for a Qualified Medical Evaluator has been provided to me. I have been advised that I might be entitled to additional benefits should I decide to choose a Qualified Medical Evaluator from a panel of three physicians. I understand this panel is provided by the State of California, and the evaluation is provided free of charge.

I do not wish to be evaluated by a Qualified Medical Evaluator.

Signed: _____

Dated: _____

7/23/20

Document Type: Orthopedic Surgery Clinic Note
*Date - Date of Service: September 05, 2019 15:09 PDT
Document Status: Auth (Verified)
Document Title: Office Visit Note
Author: Kamath, Jason on September 05, 2019 15:16 PDT
Authenticated By: HATCH MD, GEORGE F on September 09, 2019 06:37 PDT
Encounter info: 707684676, KH-USC, Outpatient, 09/05/19 - 09/05/19

* Final Report *

Attending: George F Hatch, MD

Referring: George F Hatch, MD

DATE OF SURGERY: 12/10/2018

OPERATIVE PROCEDURE: Revision open biceps tenodesis - 22 modifier, right shoulder subpectoral major technique, and removal of failed deep retained hardware, right shoulder.

DATE OF SURGERY: 11/19/2018

OPERATIVE PROCEDURES: Right shoulder arthroscopic rotator cuff repair, supraspinatus, transosseous equivalent, double-row technique - small tear with mini open biceps tenodesis, debridement of the superior subscapularis tear and superior labral tear, and subacromial decompression.

Chief Complaint

DATE OF SERVICE: 09/05/2019

Patient Name: VARGAS, ALEJANDRO

Medical Record #: 545482

Date of Birth: 02/05/1966

Shavonte Williams
CID Management

Fax: 877-628-6724

Ph: (866) 301-6568

CLAIM #: 4027838

PATIENT ACCOUNT #: 157478643

EMPLOYER NAME: LAPD

INTERIM ORTHOPEDIC EVALUATION AND REPORT

History of Present Illness

Mr. Vargas is a 53-year-old male, status post revision open biceps tenodesis with a 22-modifier, right shoulder subpectoral major technique, and removal of failed deep retained hardware of the right shoulder December 10, 2018. Also, status post right shoulder arthroscopic rotator cuff repair, supraspinatus transosseous equivalent double-

Problem List/Past Medical History

Allergic rhinitis due to allergen
Asthma
Benign lipomatous neoplasm of skin and subcutaneous tissue
Chronic rhinitis
Deviated nasal septum
ED (erectile dysfunction)
Enlarged pulmonary artery on CT Chest
Exercise induced bronchospasm
GERD (gastroesophageal reflux disease)
HLD (hyperlipidemia)
Left hand pain
S/P excision of varicocele

Procedure/Surgical History

- Rotator cuff repair (12/10/2018)
- Tonsillectomy (01/18/2018)
- Colonoscopic polypectomy (08/23/2016)

Medications

albuterol CFC free 90 mcg/inh inhalation aerosol, 1 inhalation(s), Inhalation Oral, Q4hr, PRN, 3 refills
Crestor 10 mg oral tablet, 10 mg= 1 tab(s), Oral, Daily, 3 refills
Dymista 137 mcg-50 mcg/inh nasal spray, 1 spray(s), Nasal, BID, 12 refills
famotidine 40 mg oral tablet, 40 mg= 1 tab(s), Oral, Daily, Take 30 minutes before a meal, 3 refills
Flovent HFA 44 mcg/inh inhalation aerosol, 2 puff(s), Inhalation Oral, BID, 3 refills
omeprazole 20 mg oral delayed release capsule, 20 mg= 1 cap (s), Oral, Daily, 30 minutes before a meal
rosuvastatin 10 mg oral tablet
tadalafil 10 mg oral tablet, 10 mg= 1 tab(s), Oral, Daily, PRN
tretinoin 0.025% topical cream, 1 application(s), Topical, Q Evening, Apply thin layer to acne prone areas of face every evening, 6 refills

Allergies

No Known Allergies

Social History

Alcohol - Low Risk, 01/05/2018

Current, 1-2 times per month, 01/15/2015

Exercise - Regular exercise, 01/05/2018

row technique, small tear with open-biceps tenodesis, debridement of the superior subscapularis tear, and superior labral tear and subacromial decompression November 19, 2018. The patient is presenting to clinic for followup.

He states that his right shoulder was sore after his vacation recently, but his has since resolved. He takes Ibuprofen prn. He still does his band stretches at home. He would like a cortisone injection today to help him loosen up. He has returned to work without restrictions and is doing well with this. He is here to be deemed permanent and stationary.

Review of Systems

A 14-point review of systems is otherwise negative except for as noted in HPI.

Physical Exam

Vitals & Measurements

HT: 186 cm

GENERAL: No acute distress. Alert and oriented. Appropriate mood and affect.

RIGHT UPPER EXTREMITY:

He has well-healed incisions on the anterior aspect of his right shoulder.

Range of Motion:

Internal rotation to 5 degrees.

External rotation with arm at side to 80 degrees.

Forward flexion to 150 degrees.

Abduction to 150 degrees.

Adduction to 30 degrees.

No apprehension on exam.

Distally neuromotor and sensory intact C5-T1 including biceps, triceps, wrist flexors and extensors and hand intrinsic.

Assessment/Plan

Assessment:

1. Status post history of revision open-biceps tenodesis, subpectoral technique, removal of failed deep retained hardware on December 10, 2018.
2. Status post history of right shoulder arthroscopic rotator cuff repair, mini-open biceps tenodesis on November 19, 2018.
3. Minimal residual stiffness.
4. Please see Dr. Hatch's addendum dictation for this patient on the same date of service.

Plan:

1. Diagnosis: right shoulder pain. Risks and benefits discussed. Procedure done after verbal consent obtained. Sterile technique used to prepare shoulder. Under Ultrasound guidance, patient received 60 mg Toradol, 8mg

Exercise duration: 60. Exercise frequency: 3-4 times/week.

Exercise type: Running, Weight lifting., 01/05/2018

Home/Environment

Lives with Children, Spouse. Living situation:

Home/Independent., 01/15/2015

Substance Abuse - Denies Substance Abuse, 01/15/2015

Tobacco - Denies Tobacco Use, 01/15/2015

Never smoker, 04/21/2014

Family History

Family history is negative

Immunizations

Vaccine	Date	Status	Comments
diphtheria/pertussis, acel/tetanus adult	06/27/2019	Given	
influenza virus vaccine, inactivated	10/23/2018	Recorded	[11/19/2018] Received notification via FAX from CVS pharmacy
pneumococcal 23-valent vaccine	12/21/2017	Given	Tolerated well.
influenza virus vaccine, inactivated	10/18/2017	Recorded	
influenza virus vaccine, inactivated	09/28/2016	Recorded	
tetanus/diphth/pertuss (Tdap) adult/adol	01/07/2009	Recorded	

Lab Results

CBC

WBC: 6.14 10e3cells/mcL (06/20/19)

Hgb: 14.4 g/dL (06/20/19)

Hct: 41.6 % (06/20/19)

Platelet Count: 206 10e3cells/mcL (06/20/19)

Neutrophil Rel: 58.3 % (06/20/19)

BMP/Magnesium/Phosphorus

Sodium Lvl: 141 mmol/L (06/20/19)

Potassium Lvl: 4 mmol/L (06/20/19)

Chloride Lvl: 104 mmol/L (06/20/19)

CO2: 25 mmol/L (06/20/19)

BUN: 17 mg/dL (06/20/19)

Creatinine Lvl: 1.26 mg/dL High (06/20/19)

Calcium Lvl: 8.7 mg/dL Low (06/20/19)

Glucose Level: 112 mg/dL High (06/20/19)

Liver

Alk Phos: 85 units/L (06/20/19)

Total Protein: 7 g/dL (06/20/19)

Albumin Lvl: 4.1 g/dL (06/20/19)

AST: 21 units/L (06/20/19)

ALT: 27 units/L (06/20/19)

Bili Total: 0.4 mg/dL (06/20/19)

Decadron, and 8cc of 0.25% Marcaine using a 22 gauge needle into the glenohumeral joint. No complications of procedure. Post injection protocol instructions given to patient.

2. Permanent and stationary report was completed by Dr. Hatch.

3. We will see him back in December at the one year mark of his surgery.

I, Jason Kamath, am acting as scribe for Dr. George Hatch, MD.

The above history was obtained by this examiner. The review of records and physical examination were performed by this examiner.

The dictation of this report was performed solely by this examiner.

This examination was performed in compliance with the guidelines established by the Industrial Medical Council. It was signed in Los Angeles County. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

cc: Shavonte WilliamsCID Management, Fax: 877-628-6724
Ph: (866)
301-6568

Signature Line

Electronically Signed On 09/05/19 03:16 PM PDT

Jason Kamath

Orthopedic Surgery Clinic Note
* Final Report *

VARGAS Jr, ALEJANDRO - 000545482

Electronically Signed On 09/05/19 03:36 PM PDT

Jason Kamath

Electronically Signed On 09/05/19 03:47 PM PDT

Jason Kamath

Electronically Signed On 09/09/19 06:37 AM PDT

GEORGE HATCH, MD

Modified by Jason Kamath On 09/05/19 03:36 PM PDT

Modified by Jason Kamath On 09/05/2019 03:46 PM PDT

Workers Comp
* Final Report *

VARGAS Jr, ALEJANDRO - 000545482

Document Type: Workers Comp
*Date - Date of Service: September 05, 2019 08:30 PDT
Document Status: Auth (Verified)
Document Title: Workers Compensation
Author: HATCH MD, GEORGE F on September 05, 2019 15:42 PDT
Authenticated By: HATCH MD, GEORGE F on September 09, 2019 07:00 PDT
Encounter info: 707684676, KH-USC, Outpatient, 09/05/19 - 09/05/19
Contributor system: USC_EMDATF

*** Final Report ***

Workers Compensation

DATE OF SERVICE: 09/05/2019

Patient Name: VARGAS, ALEJANDRO
Medical Record #: 545482
Date of Birth: 02/05/1966

Shavonte Williams
CID Management

Fax: 877-628-6724
Ph: (866) 301-6568

CLAIM #: 4027838
PATIENT ACCOUNT #: 157478643
EMPLOYER NAME: LAPD

PERMANENT AND STATIONARY REPORT

He can now be consider permanent and stationary at this point.

DIAGNOSES:

1. Status post history of right shoulder arthroscopic rotator cuff repair, mini open biceps tenodesis, November 19, 2018, right shoulder.
2. Status post history of biceps tenodesis rupture.
3. Status post history of revision open biceps tenodesis with removal of retained hardware, December 10, 2018.

Printed by: James, Roseena
Printed on: 9/13/2019 12:39 PDT

At this point, Alejandro can be deemed permanent and stationary. He will receive a permanent and stationary rating with regard to his right shoulder.

He has occasional minimal right shoulder pain, which increases to slight to moderate with prolonged at or above shoulder level activities.

OBJECTIVE FACTORS OF IMPAIRMENT:

1. He has arthroscopic incisions consistent with his previous arthroscopic surgery, as well as his revision biceps tenodesis.
2. He has forward flexion on his right shoulder to 150, abduction to 150, internal rotation to 5 degrees, external rotation to 90 degrees, adduction to 30 degrees, and extension to 30 degrees.
3. He does demonstrate some slight weakness with resisted elbow flexion strength testing.

IMPAIRMENT RATING: The following is impairment rating pursuant to the AMA Guide 5th Edition. He has reached maximal medical improvement with the aforementioned treatments with regards to his right shoulder. According to page 476, figure 16-40, he has 150 degrees of forward flexion. This is equivalent to a 2% upper extremity impairment. He has 30 degrees of extension. This is equivalent to a 1% upper extremity impairment. According to page 547, figure 16-43, he has 150 degrees of abduction. This is equivalent to a 1% upper extremity impairment. He has 30 degrees of adduction. This is equivalent to a 1% upper extremity impairment.

According to page 479, table 16-46, he has 5 degrees of internal rotation. This is equivalent to a 5% upper extremity impairment. He has 80 degrees of external rotation, 0% upper extremity impairment. Using these impairment for a single joint are to be added together for an overall upper extremity impairment of 11% for the right shoulder.

When I turn to page 439, table 16-3, an 11% upper extremity impairment is equal to a 7% whole person impairment. He receives a 7% whole person impairment for the right shoulder.

In addition, he has undergone a revision biceps tenodesis and does demonstrate some very slight weakness with regards to elbow flexion and supination. He demonstrates full range of motion of the right elbow. According to page 510, table 16-35, he receives a 4% upper extremity impairment due to loss of flexion strength and a 2% upper extremity impairment due to loss of supination strength, for an overall upper extremity impairment of 6%. When I turn to page 439, table 16-3, 6% upper extremity impairment is

equivalent to a 4% whole person impairment.

When I then turn to page 604, the 7% upper extremity impairment due to loss of shoulder motion is to be combined with the 4% upper extremity impairment due to the loss of elbow flexion strength from biceps tenodesis, for an overall whole person impairment of 11%.

He receives 11% for the right upper extremity.

WORK RESTRICTIONS: With regard to the right shoulder, he can return back to his usual and customary duties.

There are no restrictions.

With regard to his right elbow and right upper extremity, he can return back to his usual and customary duties. There are no work restrictions.

FUTURE TREATMENT: With regard to the right shoulder, analgesic medication should remain available to him. A short course of physical therapy consisting of 2-3 visits per week for no more than 4-6 weeks should be available to him for exacerbation of his pain. Prolonged therapy is not indicated. The option for intraarticular as well as subacromial space corticosteroid injection should remain available to him, as well as the option for hyaluronic acid injection series and/or PRP injections.

The option for a PRP injection and/or hyaluronic acid should remain available to him. The option for future surgery for his right shoulder remain available to him as he does demonstrate some residual stiffness. This should remain available to him.

With regards to his right biceps, short court of physical therapy consisting of 2-3 visits per week for no more than 4-6 weeks should be available to him for exacerbation of his pain. The option for corticosteroid injection should remain available to him

The option for future surgery should remain available to him, although we do not anticipate the need for future surgery with regard to his biceps tenodesis.

APPORTIONMENT: He denies previous and subsequent injury. There is no underlying pathology. It is therefore 100% medically reasonably probable that the above enumerated factors of permanent disability can be attributed to the injury that occurred at work on March 22, 2018. We will see him in December 2019 at the 1-year mark after surgery.

The above history was obtained by this examiner. The review of records and physical examination were performed by this examiner. The dictation of this report was performed solely by this examiner.

This examination was performed in compliance with the guidelines established by the Industrial Medical Council. It was signed in Los Angeles County. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

cc: Shavonte WilliamsCID Management, Fax: 877-628-6724 Ph: (866) 301-6568

GH/lb

D: 09/05/2019 3:42:09 PM PST

T: 09/06/2019 5:48:26 AM PST

J#: 199326921

Signature Line

Electronically Signed On 09/09/19 07:00 AM PDT

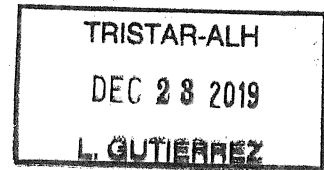
GEORGE HATCH, MD

Disability Evaluation Unit
Division of Workers' Compensation
320 W. 4TH ST. #970
LOS ANGELES, CA 90013
(213)5767426

State of California
Gavin Newsom, Governor

SUMMARY RATING DETERMINATION

Page 1



DEU CASE NO: DEU12765708
EMPLOYEE:

DATE: 12-18-2019
CARRIER/CLAIMS ADMINISTRATOR:

ALEJANDRO VARGAS

TRISTAR 29106 GLENDALE

**1025 S LOS ROBLES AVE
PASADENA CA 91106**

**PO BOX 29106
GLENDALE CA 91209**

CLAIM NO.: 4027838

THIS PERMANENT DISABILITY RATING DETERMINATION IS BASED ON THE
FOLLOWING FACTORS:

Date of Injury (DOI): 03-22-2019 Age on DOI: 53
Occupation: POLICE
LIEUTENANT

Factors from Medical
Report:

R Shoulder ROM: 10 UE = 6 WP
R Elbow Strength Loss: 6 UE = 4 WP
Rating assumes finding of pathomechanical cause for strength deficit.

Document ID: -6831948222265556992

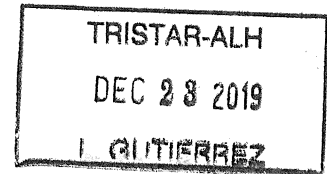
12/24/2019

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SUMMARY RATING DETERMINATION

Page 2



DEU FILE NO: DEU12765708

Formal Medical Evaluation of:	Doctor Type	Doctor Name	Report Date
	Treating Physician	George Hatch, MD	09-05-2019

Rating Formulas:

R Shoulder ROM

16.02.01.00 - 6 - [1.4]8 - 490I - 12 - 15 PD (A)


R Elbow Strength

16.01.04.00 - 4 - [1.4]6 - 490I - 9 - 11 PD (A)

(A) 15 C 11 = 24 Final PD

Future medical treatment required

The permanent disability rating is 24.00 %, which is equivalent to 95.50 weeks of disability payments. Based on average weekly earnings of \$5,827.20 , the initial weekly rate is \$290.00. Payments commence within 14 days after the date of the last payment of temporary disability indemnity. However permanent disability advances not required if injured worker is employed pursuant to LC 4650 (b).

By:  12/18/19
Armine Toukhlandjian, Disability Evaluator Rating Ref #: 2814793

Document ID: -6831948222265556992

12/24/2019

Payment Listing

Vargas, Alejandro 4027838

From	Through	Check#	Proc/Check Date	Mailing Date	Method	Vendor	Amount
IOD/4850							
IOD Eligibility							
11/17/2018	03/14/2019				Voucher	Vargas, Alejandro	0.00
Totals for IOD Eligibility							0.00
IOD Payment							
02/17/2019	03/02/2019	26397	03/23/2019	03/27/2019	Paper	Alejandro Vargas	1,352.08
02/17/2019	03/02/2019	26389	03/09/2019	03/13/2019	Paper	Alejandro Vargas	2,028.12
02/03/2019	02/16/2019	26352	02/23/2019	02/27/2019	Paper	Alejandro Vargas	5,408.30
01/20/2019	02/02/2019	26434	02/09/2019	02/13/2019	Paper	Alejandro Vargas	4,867.47
01/06/2019	01/19/2019	26312	01/26/2019	01/30/2019	Paper	Alejandro Vargas	5,408.30
12/23/2018	01/05/2019	26122	01/12/2019	01/16/2019	Paper	Alejandro Vargas	4,326.64
12/09/2018	12/22/2018	26136	12/29/2018	01/02/2019	Paper	Alejandro Vargas	5,408.32
11/25/2018	12/08/2018	26131	12/15/2018	12/19/2018	Paper	Alejandro Vargas	5,408.32
11/11/2018	11/24/2018	26145	12/01/2018	12/05/2018	Paper	Alejandro Vargas	2,704.16
Totals for IOD Payment							36,911.71
Totals for IOD/4850							0.00
Recovery							0.00
Totals for Claim							36,911.71
Recovery							0.00