

FRANK GIACOBETTI, M.D., Q.M.E.

ORTHOPEDIC SURGEON

Mailing Address: 5904 Warner Ave., Ste A #2042, Huntington Beach, CA 92649
Phone: (888) 921-0161 Fax: (888) 299-9437

APPLICANT'S NAME: BILLINGSLEY, DEBORA
ADDRESS: COMPTON, CA 90221
DATE OF BIRTH: 08/23/1955
SSN: 564-92-3599
CLAIM #: SCIH-048236
WCAB #: ADJ14212174
DATE OF INJURY: 06/15/2020
EMPLOYER: STATE OF CALIFORNIA – IHSS
OCCUPATION: IHSS PROVIDER
EXAMINATION DATE/DOS: 03/04/2025
EXAMINATION LOCATION: 8617 CRENSHAW BLVD.
INGLEWOOD, CA 90305
FACE TO FACE TIME: 25 MINUTES

QUALIFIED MEDICAL REEVALUATION

Gentlepersons,

This is my Panel Qualified Medical Reevaluation of the above-named individual who was seen at my office in Inglewood, CA on March 4, 2025. At that time, a comprehensive history and interview was conducted, a physical examination was performed, and the time spent performing the evaluation was in compliance with the guidelines established by the administrative director, and the records submitted were received with the § 4062.3 declaration signed with page count attestation and reviewed in their entirety. The applicant was previously evaluated by the undersigned on July 13, 2021 and August 8, 2023.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 2 of 84

HISTORY OF PRESENT ILLNESS

Ms. Debra Billingsley is a 69-year-old female who stands 5 feet 4 inches, weighs 160 pounds, and is left-hand dominant. She reports sustaining an injury on June 15, 2020. She was working as an IHSS provider, where she had been working for the prior 7 years. On the day of the injury, she was pulling a client towards her to roll her onto her side to change her diaper when she felt a sharp, stabbing pain in her right shoulder. She reported the injury to her supervisors at IHSS. She was initially seen by her primary care physician and received treatment in the form of one cortisone injection.

She continued to have pain and was subsequently referred to an orthopedic specialist, Dr. Brian Magovern. Through Dr. Magovern's office, she received physical therapy for 6 sessions and an additional 2 cortisone injections to the right shoulder, with only temporary relief.

She was initially seen for a Panel QME in our office on July 13, 2021. At that time, I found industrial causation and recommended surgical treatment. Since last being seen in our office, she reports having no additional treatment and states she does not wish to proceed with any surgery at the current time.

INTERIM HISTORY: 03/04/2025

The applicant reported that she underwent physical therapy for 6 weeks, although it was initially planned for 12 weeks. However, she has not been contacted to resume therapy and cannot recall the exact date, but it was 2 or 3 months ago. She still experiences shoulder pain but continues to perform her therapy exercises at home while waiting to be called back to complete the full 12 sessions.

During this time, she has not received any additional medical treatment, diagnostic tests, or new prescriptions. She believes she has an appointment with Dr. Tan next month, though she cannot remember the exact date. Additionally, she has an appointment with her surgeon on the 26th of this month for her right hand (trigger finger).

OCCUPATIONAL HISTORY: 03/04/2025

Ms. Billingsley was employed at IHSS for the past 7 years, working 4-5 days per week, 5-6 hours per day. Her duties included cooking, cleaning, grooming recipients, and running errands such as grocery shopping. She was also required to lift, roll, push, and pull various clients on a repetitive basis.

Currently, the applicant reported that she has not worked since the injury.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 3 of 84

PAST MEDICAL HISTORY

Before the injury in question, she denies experiencing similar issues or injuries involving the body parts related to this claim.

PRIOR WORK-RELATED INJURIES

The applicant reports no prior work-related injuries.

PRIOR MOTOR VEHICLE ACCIDENT

The applicant reported a significant injury from an accident in 1970 that caused low back pain. She received treatment, and the symptoms improved. She denies having any serious accidents, sports injuries, or illnesses and has no prior permanent disability settlements.

MEDICATIONS: 03/04/2025

The applicant currently takes Meloxicam, as needed.

PAST SURGICAL HISTORY

The applicant reported having a left carpal tunnel release, left knee replacement, breast surgery, and two C-sections but did not provide specific dates or details.

ALLERGIES

The applicant reported no allergies.

FAMILY HISTORY

The applicant has a significant family history of heart failure, cancer, and diabetes.

INDUSTRIAL INJURIES

The applicant reported no industrial injuries.

NON-INDUSTRIAL INJURIES

The applicant reported no non-industrial injuries.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 4 of 84

HABITS

The applicant reported drinking a cup of coffee every morning. In the past, she occasionally drank alcohol. She smokes one cigarette a day but is trying to quit. She does not use illicit substances.

LEGAL STATUS

The applicant has been legally represented by Martin M. Urban, Esq.

BENEFITS

The applicant reported that she has been receiving benefits since 2023.

ACTIVITIES OF DAILY LIVING

Self-Care

The applicant reported some difficulty showering, getting on and off the toilet, and dressing herself because she needs to hold on to get in and out of the shower and to get up. She also requires help with putting on some clothes. However, she reports no difficulty brushing her teeth, combing or brushing her hair, putting on or taking off shoes or socks, opening a carton of milk or a jar, or lifting objects to her mouth.

Physical Activity

The applicant reported some difficulty getting in and out of bed, climbing a flight of 10 stairs, doing light housework, shopping, running errands, carrying groceries, lifting objects of various weights, and reaching, pushing, and pulling. She explained that her bed is medium height, requiring extra effort, and certain tasks, such as cutting food or performing activities with her right hand, cause discomfort. The objects she lifts cannot be heavy, as her shoulder hurts. However, she reported no difficulty standing, sitting, stooping, bending, twisting, or walking.

Communication

The applicant reported no difficulty writing a note, typing a message, watching television, using a mobile device, speaking clearly, or hearing clearly.

Sensory Function

The applicant reported no difficulty with her sense of touch, taste, and smell.

Non-Specialized Hand Activities

The applicant reported some difficulty applying pressure, torque, grasping, and gripping depending on the activity and object, as heavy items can cause pain. However, she reports no difficulty feeling objects by hand.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 5 of 84

Travel

The applicant reported some difficulty getting in and out of the car, driving for extended periods, and riding in the car for long durations, depending on whether the car is high or low. She tries to avoid long drives, and after a while, she needs to move to feel more comfortable.

N/A flying in a plane or riding a bike.

Sexual Function

She reports no difficulty engaging in sexual activities.

Sleep

The applicant reported some difficulty falling asleep, staying asleep, and waking up feeling rested. She needs a pillow on her right shoulder and to lie slightly to the left. She wakes up during the night due to pain but does her best to return to sleep on her back. Sleeping on her right side is more comfortable, but it causes pain, and sometimes, she has to support her hands to get up.

PREVIOUS COMPLAINTS

Ms. Billingsley is currently complaining of pain in her right shoulder. She rates this pain as 7 out of 10. It is frequent, dull, associated with any lifting, pushing, or pulling, and any over-shoulder use. It is improved with rest, ice, and medications. Prior to the injury, she was able to do heavy lifting, pushing, and pulling, and now she is limited to 5 pounds.

CURRENT COMPLAINTS

Bilateral Shoulders: The applicant experiences constant, severe, sharp pain, rated 9/10, with no radiation. The pain worsens when performing activities at home, although she feels the need to continue. The pain is relieved by stopping activities and resting. She does some stretching and exercises in the morning to help alleviate the pain, but at times, she still feels discomfort.

REVIEW OF SYSTEMS

General: The applicant reported fatigue, weight loss, and recent loss of appetite. Denied weight gain, fever, chills, or sweats.

Eyes: The applicant reported using corrective lenses and sensitivity to light. Denied blurred vision, redness, watering of the eyes, eye pain, eye discharge, or failing vision.

ENT: The applicant reported ringing in ears. Denied headaches, decreased hearing, difficulty swallowing, earaches, frequent nose bleeds, recurring sore throat, prolonged hoarseness, sinus trouble, or congestion.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 6 of 84

Cardiovascular: The applicant denied chest pain, palpitations, fainting, murmurs, shortness of breath with exertion, or swollen ankles/feet.

Respiratory: The applicant denied chronic shortness of breath, wheezing, chronic cough, coughing up blood, excessive phlegm, tightness, inspiration pain, or snoring.

Gastrointestinal: The applicant reported weight loss. Denied constipation, nausea, vomiting, heartburn, stomach irritation, diarrhea, bloody/tarry stools, chronic abdominal pain, Jaundice (yellow skin), or weight gain.

Musculoskeletal: The applicant reported joint pain, muscle pain, and stiffness. Denied instability, swelling, redness, or heat.

For Woman: The applicant denied an unusual vaginal discharge, loss of control of urine, painful urination, blood in urine, increased frequency of urine, menstrual problems, breast mass, and tenderness.

Skin: The applicant reported skin changes. Denied poor healing, rash, itching, or redness.

Neurologic: The applicant denied numbness/tingling, dizziness, unsteady gait, tremors, or seizures.

Psychiatric: The applicant denied nervousness, uncertainty, anxiety, depression, or hallucinations.

Hematologic/ Lymphatic: The applicant reported easy bruising. Denied easy bleeding.

Endocrine: The applicant reported cold intolerance. Denied excessive thirst, urination, or heat intolerance.

Sleep: The applicant reported difficulty sleeping.

Toxic/Drug exposures: The applicant denied recreational exposure to toxins or drugs.

APPLICANT:

Billingsley, Debora

Date of Birth:

08/23/1955

Page 7 of 84

PAIN DIAGRAM

PAIN RATING

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain that are not related to your present injury or condition.

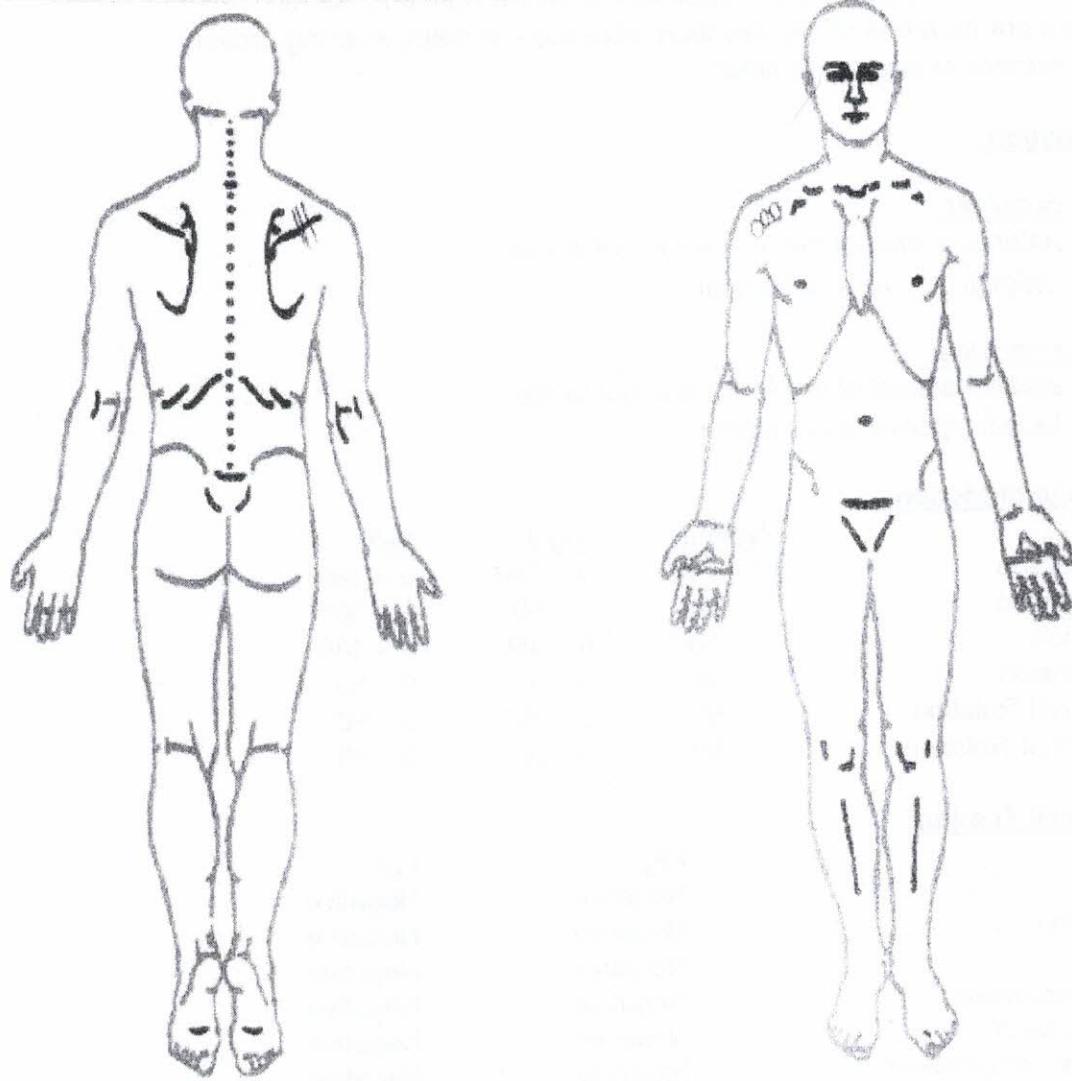
Key

/// Stabbing

xxx Burning

000 Pins and Needles

- - = Numbness



PATIENT INITIALS: AB

PHYSICAL EXAMINATION

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 8 of 84

Height: 5 feet, 4 inches
Weight: 165 pounds

SHOULDER PHYSICAL EXAM

Inspection:

Well-healed scars on the right shoulder from prior arthroscopic procedure.
Normal symmetry and movement of the shoulders with walking.
The contour and posture are symmetrical on the right and the left.
There are no areas of discoloration, abrasions or major scarring present.
No redness or swelling is noted.

Palpation:

Left Shoulder:

The anterior aspect of the AC joint is not tender.
The bicipital groove is not tender.

Right Shoulder:

The anterior aspect of the AC joint is not tender.
The bicipital groove is not tender.

Range of Motion:

	<u>Normal</u>	<u>Right</u>	<u>Left</u>
Abduction	0 – 180°	0 – 160°	0 – 180°
Adduction	0 – 50°	0 – 50°	0 – 50°
Flexion	0 – 180°	0 – 160°	0 – 180°
Extension	0 – 50°	0 – 50°	0 – 50°
Internal Rotation	0 – 90°	0 – 50°	0 – 90°
External Rotation	0 – 90°	0 – 90°	0 – 90°

Special Testing:

	<u>Right</u>	<u>Left</u>
Neer	Negative	Negative
Hawkin	Negative	Negative
Jobe	Negative	Negative
Apprehension	Negative	Negative
Relocation	Negative	Negative
Active compression	Negative	Negative
Speed	Negative	Negative
Jerk	Negative	Negative
Sulcus	Negative	Negative

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 9 of 84

O'Brien	Negative	Negative
Supraspinatus	4/5	5/5
Infraspinatus	5/5	5/5
Subscapularis	5/5	5/5
Teres minor	5/5	5/5

Grip Strength:

Jamar Grip Strength Testing (Measured in kg)

	1 st	2 nd	3 rd
Right	10	12	10
Left	20	22	20

Girth Measurements:

	Right	Left
Biceps	30 cm	30 cm
Forearm	23 cm	23 cm

REVIEW OF MEDICAL RECORDS

Medical records totaling 2005 + 96 pages were received for review. The records were reviewed by myself and summarized below. Included were miscellaneous unremarkable records, cover letter, declaration, deposition, medical reports, operative records, therapy records, imaging studies, laboratory results, communication encounters, education records, and fax cover sheets. All of these materials were thoroughly reviewed to ensure that no relevant information was overlooked.

DIAGNOSTIC TESTS

10/09/09 - Los Coyotes Imaging Center Medical Group - Bilateral Breast Mammogram, Page 578.

ORDERED BY: Anh Pham, M.D.

CLINICAL INDICATION: Routine screening.

FINDINGS: The breast parenchyma is heterogeneously dense, which may lower the sensitivity of mammography. Right Breast: There is no evidence of any dominant masses or suspicious clustered microcalcifications. No skin thickening or nipple retraction is evident. Benign-appearing calcification is noted. Left Breast: There is no evidence of any dominant masses or suspicious clustered microcalcifications. No skin thickening or nipple retraction is evident. Benign-appearing calcification is noted.

IMPRESSION: No mammographic evidence of malignancy and no significant change since 09/20/06.

10/07/13 – Medical Institute of Little Company of Mary – Pelvis X-ray, Page 524.

FINDINGS: The innominate bones and proximal femurs show no lytic or blastic process. No fracture or dislocation of the hip joints.

IMPRESSION: Radiographically normal bony pelvis. No evidence of pelvic fracture or dislocation of the hips.

12/08/15 – LabCorp – Hemoglobin A1c, Page 514.

RESULTS: High at 6.1 (4.8-5.6%).

03/29/16 – Optum – Right Knee X-ray, Page 505.

ORDERED BY: Jessica Darling, N.P.

CLINICAL INDICATION: Pain.

FINDINGS: AP view of both knees standing and additional oblique and lateral views of the right knee were obtained. There is a small right suprapatellar joint effusion. There is no acute fracture or destructive bone lesion. There is a left knee prosthesis in anatomic alignment. There is minimal to mild medial compartment joint space narrowing the right knee with prominent spurs. There is moderate joint space narrowing of the right patellofemoral compartment with moderate spurs. There is the sharpening of the tibial spines. There are no meniscal calcifications.

IMPRESSION: Mild to moderate degenerative changes in medial and patellofemoral compartments of the right knee. Small right suprapatellar joint effusion. The left knee prosthesis is in anatomic alignment on this limited exam.

03/31/16 – Affiliated Pathologists Medical Group, Inc. – Pathology Report, Page 1605.

DIAGNOSIS: Stomach, rule out h. Pylori, biopsy: antral-type gastric mucosa with no significant pathologic diagnosis. No evidence of intestinal metaplasia. No evidence of helicobacter organisms identified by H&E stain.

03/05/18 – PMI Carson – Left Finger X-ray, Page 1773.

ORDERED BY: Tu Sang Om, M.D.

CLINICAL INDICATION: Pain.

FINDINGS: Fracture, dislocation, or subluxation: None. The previously identified lucent area at the base of the third proximal phalanx is not visible on this examination, secondary to the technique. Bone density: Normal. Visualized surrounding soft tissues: Normal.

IMPRESSION: No evidence of fracture, dislocation, or subluxation. The previously identified area at the base of the third proximal phalanx was not visible on this examination, secondary to the technique. Recommend follow-up imaging as clinically indicated.

05/25/18 – PMI Carson, Page 1697.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 11 of 84
INTERPRETATION: Normal sinus rhythm. Non-specific T wave abnormality. Abnormal ECG.

06/14/18 – Beach Cities ENTS – Audiogram, Page 162-163.

INTERPRETATION: Normal, right? Mild sensorineural hearing loss on the left.

06/21/19 – LabCorp – Hemoglobin A1c, Page 1500.

RESULTS: High at 5.9 (4.8-5.6%).

07/09/19 – PMI Carson – Right Knee X-ray, Page 1419.

ORDERED BY: Joyce Chang, M.D.

CLINICAL INDICATION: Pain.

FINDINGS: Fracture, dislocation, or subluxation: None. Severe medial, mild to moderate lateral, and moderate patellofemoral degenerative joint disease, Slightly increased compared to prior examination. Suprapatellar enthesophyte. Bone density: Normal. Visualized surrounding soft tissues: Normal.

IMPRESSION: No evidence of fracture, dislocation, or subluxation. Tricompartmental degenerative Knee joint disease, slightly increased.

07/09/19 – PMI Carson – Left Knee X-ray, Page 1423-1425.

ORDERED BY: Joyce Chang, M.D.

CLINICAL INDICATION: Pain.

FINDINGS: Fracture, dislocation, or subluxation: None. There is post-left total knee arthroplasty. There is no evidence of hardware loosening or stress fracture. No dislocation or subluxation. Bone density: Normal. Visualized surrounding soft tissues: Normal.

IMPRESSION: No evidence of fracture, dislocation, or subluxation. Status post left total knee arthroplasty.

03/05/20 – Affiliated Pathologists Medical Group, Inc. – Pathology Report, Page 388.

DIAGNOSIS: Colon, transverse, polyp, polypectomy – Tubular adenoma. No evidence of high-grade dysplasia or malignancy.

06/16/20 – PMI Carson – Right Shoulder X-ray, Page 1236-1238.

ORDERED BY: Tu Sang Om, M.D.

CLINICAL INDICATION: Pain.

FINDINGS: Fracture, dislocation, or subluxation: None. Bone density: Normal.

Visualized surrounding soft tissues: Normal.

IMPRESSION: No evidence of fracture, dislocation, or subluxation.

03/15/21 – LabCorp – Hemoglobin A1c, Page 1090.

RESULTS: High at 5.7 (4.8-5.6%).

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 12 of 84

03/30/21 – Optum – Sural Nerve Conduction Study, Page 367.

INTERPRETATION: Mild DPN.

07/10/21 – OnsYte Imaging – MRI of the Lumbosacral Spine, Page 13-14B

ORDERING PHYSICIAN: Dennis Yun, MD

INDICATION: Low back pain/sore.

FINDINGS: The spinal cord is normal. The conus ends normally at the T12 level. No spondylolysis or spondylolisthesis. There is a loss of intervertebral disk height and disk desiccation changes seen at the L3 through the SI levels with preservation of normal lumbar spine lordosis.

IMPRESSION: 1) There is loss of intervertebral disk height and disk desiccation at the L5-S1 level: 3.4 mm broad-based disk protrusion is seen impressing upon the anterior portion of the thecal sac with mild bilateral lateral spinal and neural foraminal stenosis. The disk is touching the bilateral L5 nerve roots. No extrusion or sequestration of disk material. L4-L5 level: 3.1 mm broad-based disk protrusion is seen impressing upon the anterior portion of the thecal sac with mild bilateral lateral spinal and neural foraminal stenosis. The disk is touching the bilateral L4 nerve roots. No extrusion or sequestration of disk material. L3-L4 level: 2.6 mm broad-based disk protrusion is seen impressing upon the anterior portion of the thecal sac with mild bilateral neural foraminal stenosis. No extrusion or sequestration of disk material. L2-L3 level: No posterior disk protrusion is seen. No compromise of the sac, cord, or foramina. No significant compromise of the exiting neural foramina. The facet joints are unremarkable. L1-L2 level: No posterior disk protrusion is seen. No compromise of the sac, cord, or foramina. No significant compromise of the exiting neural foramina. The facet joints are unremarkable. T12-L1 level: No posterior disk protrusion is seen. No compromise of the sac, cord, or foramina. No significant compromise of the exiting neural foramina. The facet joints are unremarkable. Modic Type I endplate changes are seen at the L4-L5 and L5-S1 levels. Otherwise, no focal bone marrow abnormalities are seen. 2) L5-S1 level: 3.4 mm broad-based disk protrusion is seen impressing upon the anterior portion of the thecal sac with mild bilateral lateral spinal and neural foraminal stenosis. The disk is touching the bilateral L5 nerve roots. No extrusion or sequestration of disk material. 3) L4-L5 level: 3.1 mm broad-based disk protrusion is seen impressing upon the anterior portion of the thecal sac with mild bilateral lateral spinal and neural foraminal stenosis. The disk is touching the bilateral L4 nerve roots. No extrusion or sequestration of disk material. 4) L3-L4 level: 2.6 mm broad-based disk protrusion is seen impressing upon the anterior portion of the thecal sac with mild bilateral neural foraminal stenosis. 5) Modic Type I endplate changes are seen at the L4-L5 and L5-S1 levels. Otherwise, no focal bone marrow abnormalities are seen.

07/14/21 – LabCorp – Hemoglobin A1c, Page 977.

RESULTS: High at 5.9 (4.8-5.6%).

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 13 of 84

12/28/21 – LabCorp – Hemoglobin A1c, Page 743.

RESULTS: High at 6.1 (4.8-5.6%).

04/29/22 – Prohealth Advanced Imaging – X-Ray of the Chest, Page 91-92B

ORDERING PHYSICIAN: Kashani Houman, MD

INDICATION: Preoperative evaluation

FINDINGS: There is no abnormality of cardiac size, contour, or position. The mediastinum is midline and normal in contour. The pulmonary vasculature is within normal limits. The pleural spaces and hcmidiaphragms are clear. The trachea is in the midline position. The Inns narenchvnia is clear, with no evidence of infiltrative or congestive [Illegible Entry]. The visualized bony structures are unremarkable.

IMPRESSION: There is no evidence of acute cardiopulmonary disease.

11/08/22 – Optum – Right Knee X-ray, Page 303-304.

ORDERED BY: Steve Aziz, M.D.

CLINICAL INDICATION: Osteoarthritis.

IMPRESSION: There is a similar appearance of moderate medial dominant tricompartmental osteoarthritis of the right knee with a small joint effusion. There is no acute fracture or dislocation. No suspicious focal osseous lesions are identified. The included left knee is notable for total arthroplasty. There has been an interval increase in peri hardware lucency, particularly along the medial tibia. Recommend dedicated left knee radiographs for a full evaluation.

12/08/22 – Optum – Left Knee X-ray, Page 297-298.

ORDERED BY: Steve Aziz, M.D.

CLINICAL INDICATION: Left knee arthroplasty.

IMPRESSION: The patient is again noted to be status post total left knee arthroplasty with patellar resurfacing. The hardware is intact and well-positioned. There is prominent perihardware lucency noted along the medial tibial component and the posterior femoral component, which may reflect loosening. Recommend comparison with any previous dedicated left knee radiographs if available. Moderate suprapatellar joint effusion is noted. The included contralateral right knee is notable for moderate degenerative changes of the medial compartment/ stable.

04/26/23 – Optum – ECG, Page 282.

INTERPRETATION: Sinus rhythm. Normal ECG.

07/17/23 – DIANON Systems – Pathology Report, Page 241.

DIAGNOSIS: Small intestinal mucosa with no diagnostic abnormalities. No evidence of celiac disease. Negative for giardia, other parasites, or other pathogenic organisms. Negative for helicobacter pylori. Negative for dysplasia or malignancy.

08/01/23 – [Facility Not Specified] – Chest, Abdomen, and Pelvis CT with Contrast, Page 224-229.

CLINICAL INDICATION: Abnormal weight loss.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 14 of 84

FINDINGS: Great Vessels: No acute abnormality. Heart: The heart size is within normal limits. Mediastinum: No lymphadenopathy. Pleura and Pleural Fluid: No evidence of pleural effusion or pneumothorax. Lungs: No consolidations or acute abnormality. Chest Wall and Surrounding Tissues: No acute osseous abnormality. Abdomen and Pelvis: Liver: Hepatic steatosis. Gallbladder and Biliary Ducts: Unremarkable. Spleen: Unremarkable. Pancreas: Unremarkable. Adrenal Glands: Unremarkable. Kidneys, collecting systems, and ureters: Unremarkable as visualized. Bladder: Unremarkable as visualized. Stomach and Bowel: Unremarkable as visualized. Vascular Structures: Unremarkable as visualized. Reproductive Organs: Evidence of hysterectomy. Lymphadenopathy: None. Ascites: None Abdominal/Pelvic Wall and Surrounding Structures: Evidence of spinal stimulator. Degenerative changes of the lower lumbar spine

IMPRESSION: No evidence of acute process.

09/14/23 – Providence Women's Imaging Center Torrance – Bilateral Breast Mammogram, Page 189-190.

ORDERED BY: Minesh Mehta, M.D.

CLINICAL INDICATION: Routine screening mammogram.

FINDINGS: No suspicious mass, pathologic calcification, or abnormal parenchymal asymmetry is demonstrated. There are no findings to suggest the development of malignancy.

IMPRESSION: BI-RADS Code: #2-Benign finding.

01/24/24 – Downey Advanced Imaging – X-Ray of the Thoracic Spine, Page 94B

ORDERING PHYSICIAN: Ian Dworkin, MD

INDICATION: Pain.

FINDINGS: The vertebral body heights are maintained. There is no evidence of acute fracture. No osseous lesions are identified. There is a normal thoracic kyphosis without significant subluxation.

The discs are normal in height. The soft tissues are unremarkable. Intraspinal cord stimulation lead terminating at T8.

IMPRESSION: No evidence of acute fracture or subluxation.

05/14/24 – St. George's Medical Clinic – Chest X-ray, Page 51.

ORDERED BY: Glen John Apramian, M.D.

CLINICAL INDICATION: Pre-op.

FINDINGS: One view. The heart, mediastinum, and pulmonary vasculature are normal. No mass lesions are peripheral infiltrates, and nodules are noted. The lungs are expanded, and the bony thorax is normal.

IMPRESSION: Normal chest. There is a neurostimulator in place extending up to the level of approximately T7 through T10.

05/14/24 – St. George's Medical Clinic – ECG, Page 55.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 15 of 84

INTERPRETATION: Sinus tachycardia. Possible LVH. Marked left pre-cordial repolarization disturbance secondary to LVH, consider also ischemia. Abnormal ECG.

MEDICAL REPORTS

06/21/06 – Michael Duffin, M.D. – Optum – Rheumatology Consultation, Page 615-616.

HISTORY OF PRESENT ILLNESS: The patient had experienced pain and swelling in her left knee for a prolonged period of time, about one year. She had seen Dr. Kim, who performed an MRI, administered a steroid injection, and referred her to this facility. She did not have any fevers, skin rashes, or oral sores. There was no inflammation in any other joints, and she exhibited no muscle weakness or significant stiffness in the morning. She had not had any recent infections or dental work, nor had she been hiking in the mountains or experienced any tick bites. She had not been exposed to tuberculosis, nor did she have any history of it. In the '80s, she had fallen and traumatized her left knee. It had not been giving way or catching on her, but it was somewhat painful when walking. She had to do a lot of standing at work, which aggravated the condition.

OBJECTIVE FINDINGS: There was no nodule, and the proximal and distal muscle strength was normal in the left knee. However, there was an abundant amount of fluid present. The MRI of the left knee showed chondromalacia of the medial compartment. There was a large joint effusion, and there was partial tearing of the anterior cruciate ligament.

TREATMENT: The examiner aspirated 15 cc of Group 1 fluid from the left knee. The examiner injected the knee with 50 mg of Aristospan after preparation with Oiloraprcp. Additionally, 3 cc of lidocaine was injected. The examiner repeated the injection because Dr. Kim did not aspirate the knee, and the examiner believed that, due to dilution, it may not have had the same desired effect. The examiner also placed the patient on nabumetone 1000 mg daily. The patient was scheduled to go to physical therapy for the knee that day. Post-injection advice was given to her, and the examiner indicated that she could return for a follow-up. The examiner discontinued the Pravachol and planned to repeat the CPK.

06/22/06 – Richard Shen, P.T. – Optum – Physical Therapy Initial Evaluation, Page 606-607.

SUBJECTIVE COMPLAINTS: The patient was a 50-year-old female who arrived for physical therapy with a chief complaint of left knee pain. She described this pain as a tearing sensation and rated it as 7/10. It lasted for a few hours. Aggravating behaviors included standing for approximately seven hours, going up and down steps, lifting 40 pounds, pulling a cart, and getting in and out of the car. Easing factors included using Tiger Balm, Icy Hot, or ice. The nature of the injury indicated that approximately two months prior, the patient had started working at the post office, and her knee pain had progressively worsened. She had gone to the emergency room about a month and a

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 16 of 84

half earlier because the knee pain was so severe that she could not bend her knee. Typically, her knee was worse after increased activity at work. The patient reported having received a cortisone injection the previous week. X-rays showed arthritis and swollen cartilage.

OBJECTIVE FINDINGS: Gait: The patient walked with hyperextension of the left leg. Passive Range of Motion (PROM): Knee flexion was 120 degrees on the left, and extension was 0 degrees. Strength: Hip flexion was 4 on the left and 4 on the right. Quadriceps strength was 5 on both the left and right. Gluteus maximus strength was 3 on the left and 3 on the right. Gluteus medius strength was 3+ on the left and 4- on the right. Special Tests: The varus and valgus stress tests at 0 and 30 degrees were negative. Other Joints: The right ASIS was low and appeared to be anteriorly rotated.

ASSESSMENT: The patient exhibited decreased hip strength and poor gait mechanics, which contributed to patellofemoral dysfunction.

TREATMENT: Treatment included 1) Tib/fib mobilization. 2) Range of motion activities. 3) Lower extremity strengthening. 4) Proprioceptive training.

06/28/06 – Richard Shen, P.T. – Optum – Physical Therapy Note, Page 613.

SUBJECTIVE COMPLAINTS: She hasn't had time to time to think of knee pain secondary to taking care of her husband. Stated the knee was feeling okay.

ASSESSMENT: Very unstable with SLB and increased pain in the knee with SLB.

TREATMENT: Continue lower extremity strengthening.

[Illegible report.]

07/12/06 – Richard Shen, P.T. – Optum – Physical Therapy Note, Page 613.

SUBJECTIVE COMPLAINTS: Her knee felt pretty good.

[Illegible report.]

08/23/06 – Michael Duffin, M.D. – Optum – Progress Note, Page 605.

SUBJECTIVE COMPLAINTS: IA steroid injection had been helpful, and the patient had shown improved walking tolerance. She did not complain of muscle weakness and had been off Pravachol. There was a laboratory error in collecting the repeat CPK, and she would repeat the test.

OBJECTIVE FINDINGS: There was no proximal muscle weakness, and there were no rashes. The knees were cool with mild crepitus.

ASSESSMENT: Minimal localized primary osteoarthritis of the knee, which is improving.

TREATMENT: Lab results were reviewed.

12/14/06 – Richard Shen, P.T. – Optum – Physical Therapy Note, Page 604.

SUBJECTIVE COMPLAINTS: The patient was initially seen on 06/22/06 with a chief complaint of left knee pain. Treatment included hip strengthening exercises and balance training. Upon her last visit, the patient reported that her knee felt pretty good, and she had no more pain when going down the stairs. However, she no-showed for her last visit and did not return.

TREATMENT: Discharged from care. Attended 4 sessions.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 17 of 84

02/08/07 – Michael Duffin, M.D. – Optum – Progress Note, Page 602.

SUBJECTIVE COMPLAINTS: The patient complained of pain in her left knee with periodic swelling. There was no giving way or catching. She worked in the post office, where she had to stand for many hours daily, and that seemed to aggravate her condition.

OBJECTIVE FINDINGS: Knees: There was minimal crepitus, and there was no periarticular tenderness. The patient stated that the swelling did wax and wane.

ASSESSMENT: Left knee pain and periodic swelling, probably osteoarthritis in nature

TREATMENT: Etodolac 400 mg daily.

03/06/07 – Michael Duffin, M.D. – Optum – Progress Note, Page 600-601.

SUBJECTIVE COMPLAINTS: The patient had experienced pain that was worse with walking and swelling, without giving way, in her left knee. The pain was worse than previously and had been present for several weeks.

OBJECTIVE FINDINGS: There was swelling in the left knee, with no laxity, some crepitus, and periarticular tenderness of the left knee joint.

ASSESSMENT: Primary rheumatologic diagnosis was osteoarthritis in the left knee.

TREATMENT: Naproxen 375 mg 2 times daily. The left knee was injected with 60 mg of Aristospan Intra-Articular 20 MG/ML suspension and 3 ml of lidocaine.

03/29/07 – Michael Duffin, M.D. – Optum – Progress Note, Page 598.

SUBJECTIVE COMPLAINTS: The patient had a good response to the last steroid injection. There were no rashes or signs of synovitis.

TREATMENT: Labs were reviewed.

06/05/07 – Michael Duffin, M.D. – Optum – Progress Note, Page 596.

SUBJECTIVE COMPLAINTS: Here for injection.

ASSESSMENT: Episodic localized primary osteoarthritis of the knee, which is mildly exacerbated, left. Responsive to periodic intraarticular steroid injections.

TREATMENT: The left knee was injected with 60 mg of Aristospan Intra-Articular 20 MG/ML suspension and 3 ml of lidocaine.

06/26/07 – Michael Duffin, M.D. – Optum – Progress Note, Page 595.

SUBJECTIVE COMPLAINTS: The patient was here for a follow-up of osteoarthritis in the medial compartment of the left knee. She was injected with Aristospan in March and had a good response. Her walking tolerance was good, and there was no swelling. She used a soft brace for support.

OBJECTIVE FINDINGS: There was patellar crepitus in the left knee.

ASSESSMENT: Episodic localized primary osteoarthritis of the knee, which is mildly exacerbated, left. Responsive to periodic intraarticular steroid injections.

TREATMENT: Renewed Naproxen. Start Narcotic analgesics.

12/13/07 – Michael Duffin, M.D. – Optum – Progress Note, Page 593.

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks.

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 18 of 84

The pain was aggravated by walking and going up and down stairs. She denied experiencing redness, limitation, catching, giving way, or fever.

TREATMENT: The left knee was injected with 60 mg of Aristospan and 3 ml of lidocaine.

01/15/08 – Michael Duffin, M.D. – Optum – Progress Note, Page 592.

SUBJECTIVE COMPLAINTS: The patient was here for a follow-up of left knee osteoarthritis. During her last visit, the knee was injected with Aristospan, which provided relief for about 4 weeks. She does experience swelling, but it is not red, and she is not having any fevers.

OBJECTIVE FINDINGS: The Patella demonstrated crepitus.

ASSESSMENT: Episodic localized primary osteoarthritis of the knee, which is mildly exacerbated, left. Responsive to periodic intraarticular steroid injections.

TREATMENT: A soft offloader knee brace was requested for the patient, and she will be seen again in two months.

02/12/08 – Michael Duffin, M.D. – Optum – Progress Note, Page 589.

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks. The pain was aggravated by walking and going up and down stairs. She denied experiencing redness, limitation, catching, giving way, or fever.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness.

TREATMENT: The left knee was injected with 60 mg of Aristospan and 3 ml of lidocaine.

05/12/08 – Michael Duffin, M.D. – Optum – Progress Note, Page 587-588.

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks. The pain was aggravated by walking and going up and down stairs. She denied experiencing redness, limitation, catching, giving way, or fever.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness.

TREATMENT: 20 mL of group 1 fluid was aspirated from the left knee. Aristospan 40 mg with 3 mL of 1% lidocaine was injected without complications.

08/14/08 – Michael Duffin, M.D. – Optum – Progress Note, Page 586.

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks. The pain was aggravated by walking and going up and down stairs. She denied experiencing redness, limitation, catching, giving way, or fever.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness.

TREATMENT: 35 mL of group 1 fluid was aspirated from the left knee. Aristospan 40 mg with 3 mL of 1% lidocaine was injected without complications.

11/13/08 – Michael Duffin, M.D. – Optum – Progress Note, Page 585.

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 19 of 84

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks. The pain was aggravated by walking and going up and down stairs. She denied experiencing redness, limitation, catching, giving way, or fever.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness.

TREATMENT: 35 mL of group 1 fluid was aspirated from the left knee. Aristospan 40 mg with 3 mL of 1% lidocaine was injected without complications.

02/12/09 – Michael Duffin, M.D. – Optum – Progress Note, Page 583-584.

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks. The pain was aggravated by walking and going up and down stairs. She denied experiencing redness, limitation, catching, giving way, or fever.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness.

TREATMENT: 35 mL of group 1 fluid was aspirated from the left knee. Aristospan 40 mg with 3 mL of 1% lidocaine was injected without complications.

05/13/09 – Michael Duffin, M.D. – Optum – Progress Note, Page 581-582.

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks. The pain was aggravated by walking and going up and down stairs. She denied experiencing redness, limitation, catching, giving way, or fever.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness.

TREATMENT: 35 mL of group 1 fluid was aspirated from the left knee. Aristospan 40 mg with 3 mL of 1% lidocaine was injected without complications.

08/21/09 – Michael Duffin, M.D. – Optum – Progress Note, Page 580.

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks. The pain was aggravated by walking and going up and down stairs. She denied experiencing redness, limitation, catching, giving way, or fever. She felt that the offloader brace was helpful.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness.

TREATMENT: 35 mL of group 1 fluid was aspirated from the left knee. Aristospan 40 mg with 3 mL of 1% lidocaine was injected without complications.

11/20/09 – Michael Duffin, M.D. – Optum – Progress Note, Page 576-577.

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks. The pain was aggravated by walking and going up and down stairs. She denied

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 20 of 84

experiencing redness, limitation, catching, giving way, or fever. She felt that the offloader brace was helpful.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness.

TREATMENT: No fluid was aspirated from the left knee. Aristospan 40 mg with 3 mL of 1% lidocaine without epinephrine was injected without complications.

01/13/10 – Michael Duffin, M.D. – Optum – Progress Note, Page 574-575.

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks. The pain was aggravated by walking and going up and down stairs. She denied experiencing redness, limitation, catching, giving way, or fever. She felt that the offloader brace was helpful.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness.

TREATMENT: No fluid was aspirated from the left knee. Aristospan 40 mg with 3 mL of 1% lidocaine without epinephrine was injected without complications.

08/13/10 – Michael Duffin, M.D. – Optum – Progress Note, Page 572-573.

SUBJECTIVE COMPLAINTS: Came in for a therapeutic injection of the left knee. The following symptoms were present: pain, swelling, and pain at night for several weeks. The pain was aggravated by walking and going up and down stairs. She denied experiencing redness, limitation, catching, giving way, or fever. She felt that the offloader brace was helpful.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness.

TREATMENT: No fluid was aspirated from the left knee. Aristospan 40 mg with 3 mL of 1% lidocaine without epinephrine was injected without complications.

06/30/10 – Michael Duffin, M.D. – Optum – Progress Note, Page 571.

SUBJECTIVE COMPLAINTS: She requested a referral to an orthopedic surgeon. She had osteoarthritis of the left knee. She had grown tired of the cortisone injections, which did not seem to be helping. Anti-inflammatories were used to help. She had gone to physical therapy, and that was not helpful. The narcotic medicines did help but insufficiently.

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and periarticular tenderness. Knee brace.

ASSESSMENT: Localized primary osteoarthritis of the knee, which is mildly exacerbated, left.

TREATMENT: Referred her to orthopedic surgery and ordered an x-ray of the left knee.

08/18/10 – Michael Duffin, M.D. – Optum – Progress Note, Page 570.

SUBJECTIVE COMPLAINTS: She had surgery pending by Dr. William Kim on the left knee. She wanted to have the knee drained that day. Dr. Kim had told her not to receive any more cortisone injections.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 21 of 84

OBJECTIVE FINDINGS: The following were observed: swelling, crepitus, and peri-articular tenderness.

ASSESSMENT: Localized primary osteoarthritis of the knee, which is mildly exacerbated, left.

TREATMENT: She would have had arthroplasty on the left knee in one month. She could return as needed.

09/25/10 – William Kim, M.D. – Little Company of Mary Hospital – Operative Report, Page 558-559.

PROCEDURE PERFORMED: Left total knee replacement utilizing the Encore Foundation cemented system with a #6 femoral, #4 tibial, 11 mm ultracongruent liner, and 29 mm patella, all cemented with vancomycin-impregnated cement.

PREOPERATIVE DIAGNOSIS: Advanced osteoarthritis, left knee.

POSTOPERATIVE DIAGNOSIS: Advanced osteoarthritis, left knee.

ANESTHESIA: General with femoral block.

ESTIMATED BLOOD LOSS: 100 mL.

COMPLICATIONS: None.

09/30/10 – Lisa Young, M.D. – Little Company of Mary Hospital – Discharge Summary, Page 565-567.

DISCHARGE DIAGNOSES: Osteoarthritis, status post left total knee replacement. Debility, improved in rehabilitation. Anemia, postoperative, mild. Hypertension. Hyperlipidemia.

DISCHARGE MEDS: Triamterene/hydrochlorothiazide 37.5/25 mg p.o. Daily. Nifediac 30 mg p.o. Daily. Lovastatin 40 mg p.o. at 5 p.m. Aspirin 81 mg p.o. Daily. Ferrous sulfate 325 mg 1 p.o. b.i.d. Percocet 5/325 mg 1 p.o. q.4 hours p.r.n. Knee pain. Arixtra 2.5 mg injected subcutaneously q.24 hours through 10/09/2010.

DISCHARGE PLAN: The patient was discharged home with her family assisting with care as needed on 10/01/2010. The patient had been provided with teaching on Arixtra self-injection and was to be provided with medication through 10/09/2010. A home health RN had been ordered for staple removal on 10/09/2010. The patient had been provided with a front-wheeled walker for home use. Home health physical therapy had been ordered for continued rehab in the home and safety evaluation in the home. The patient had a follow-up appointment with Dr. Kim of Orthopedic Surgery on 10/21/2010 at 2:15 p.m. She had been requested to have an x-ray of the left knee 2-3 days prior at Del Amo Diagnostics. The patient had a follow-up appointment with her primary care physician, Dr. Joyce Chang, on 10/11/2010 at 10 a.m. Dr. Chang had been requested to monitor the patient's hemoglobin and hematocrit and discontinue ferrous sulfate when she achieved her baseline.

10/25/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Evaluation, Page 545-547/563-564.

SUBJECTIVE COMPLAINTS: The patient injured her left knee in her 20s and had progressive worsening of her symptoms. Complained of intermittent dull pain, aggravated by bending her knee, and first thing in the morning.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 22 of 84

OBJECTIVE FINDINGS: Posture: Decreased left knee extension in standing. GAIT: The patient ambulated with a single-point cane on the left side, with decreased left knee range of motion. Range Of Motion: Active: Left knee 14-90, right knee 0-120. Left ankle dorsiflexion 0 degrees, right 10 degrees. Passive: Left knee 7-95. Strength: Left quadriceps 3+/5 with slight pain, right 5/5. Accessory Motion: Good left knee patellar mobility.

ASSESSMENT: Status post left TKR on 9/25/10 with a decreased range of motion and gait imitations.

TREATMENT: Treatment included modalities, joint mobilization, soft tissue mobilization, therapeutic exercise, stretching and range of motion activities for the left knee, strengthening for bilateral lower extremities, home program instruction, Gait training/re-education - patient's cane height was adjusted today and she was directed to use it on the right side, edema management.

10/28/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 547.

SUBJECTIVE COMPLAINTS: She did not do heel slides with a strap due to increased pain. She felt sore after exercising. Mostly felt it along the front and medial part of the left knee.

TREATMENT: Provided therapeutic exercises and kinesiotaping.

[Illegible report.]

11/01/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 547.

SUBJECTIVE COMPLAINTS: Soreness today on her feet from being with grandkids yesterday. Tried heel slides with a strap but only did 3 of them and stopped secondary to discomfort.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

11/04/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 547.

SUBJECTIVE COMPLAINTS: Noted increased soreness this morning. Also complained of stiffness.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

11/08/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 548.

SUBJECTIVE COMPLAINTS: The left knee was still really stiff. She did some cooking on the weekend but took breaks to pat her leg.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

11/11/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 548.

SUBJECTIVE COMPLAINTS: Noted a lot less swelling.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 23 of 84

11/15/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 544/548.

SUBJECTIVE COMPLAINTS: She almost fell on Saturday after twisting her knee laterally secondary to a grand baby crawling. She noted increased pain and swelling.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

11/18/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 548-549.

SUBJECTIVE COMPLAINTS: The Patient reported feeling better. HEP helped last night. The knee was not as stiff.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

11/22/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 549.

SUBJECTIVE COMPLAINTS: Felt better today. She was busy over the weekend but denied soreness.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

12/01/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 549.

SUBJECTIVE COMPLAINTS: The Patient reported a little stiffness. She overdid herself over the holiday by standing too much.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

12/03/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 549.

SUBJECTIVE COMPLAINTS: Her knee was doing all right. Increased ROM today.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

12/06/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 549.

SUBJECTIVE COMPLAINTS: She bought a ball yesterday and did exercises with it.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

12/09/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 550.

SUBJECTIVE COMPLAINTS: She was doing better. She did ball exercises at home, which helped.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

12/14/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 550.

SUBJECTIVE COMPLAINTS: Complained of stiffness. Did a lot of walking yesterday, so her knee had increased stiffness.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 24 of 84

12/16/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 550.

SUBJECTIVE COMPLAINTS: She got a peddler to use at home and did 20 minutes last night.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

12/20/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 550.

SUBJECTIVE COMPLAINTS: Her knee was okay, but he needed Vicodin last night due to increased pain.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

12/22/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 550.

SUBJECTIVE COMPLAINTS: Her knee was doing better.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

12/27/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 550-551.

SUBJECTIVE COMPLAINTS: Her left knee was stiff for the last 2 days due to the cold weather. It was sore as well, so she stayed home for 2 days. Felt a little better today but stiff with hard bending.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

12/30/10 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 551.

SUBJECTIVE COMPLAINTS: She was doing much better today; she just felt a little stiff.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

01/04/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 551.

SUBJECTIVE COMPLAINTS: She felt stiff after walking to see the floats.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

01/06/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 551.

SUBJECTIVE COMPLAINTS: Her knee was doing all right.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

01/25/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 551.

SUBJECTIVE COMPLAINTS: She got back in town then got sick, and saw Dr. Kim.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

01/27/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 551.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 25 of 84

SUBJECTIVE COMPLAINTS: She was doing well but felt more tired with the new exercises last treatment.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

02/01/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 552.

SUBJECTIVE COMPLAINTS: She had not done the treadmill at home yet.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

02/03/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 552.

SUBJECTIVE COMPLAINTS: She had not tried the treadmill at home yet.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

02/07/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 552.

SUBJECTIVE COMPLAINTS: She has started the treadmill at home and has built up to 6 minutes.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

02/10/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 552.

SUBJECTIVE COMPLAINTS: She was painting yesterday and was going up and down on a ladder, which resulted in soreness in her knee.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

02/15/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 552.

SUBJECTIVE COMPLAINTS: She felt stiff today with the cold weather.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

02/17/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 552-553.

SUBJECTIVE COMPLAINTS: The soreness/stiffness from the last session has resolved. She took a pull to decrease the swelling. She continued to user her treadmill at home.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

03/01/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 553.

SUBJECTIVE COMPLAINTS: She felt stiff in rainy weather last week.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 26 of 84

03/08/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 543/553.

SUBJECTIVE COMPLAINTS: Felt intermittent soreness secondary to cold weather.

OBJECTIVE FINDINGS: Left knee PROM was 0-115 degrees. Strength of the left quadriceps was 5 minus/5, hamstrings 5/5, and calf 4+/5. The patient complained of intermittent soreness, typically with colder weather. She had maintained a good range of motion over the last several weeks and had good strength and endurance. The patient no longer had any gait deviations. She felt that she was likely ready to return to work.

ASSESSMENT:

TREATMENT: Continue PT for 2 more visits.

03/10/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 553.

SUBJECTIVE COMPLAINTS: She was feeling better.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

03/14/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 542/553.

SUBJECTIVE COMPLAINTS: She was doing well.

OBJECTIVE FINDINGS: Left knee PROM was 0-116 degrees. The progress note on 3/8/11 provided further details. The patient called and left a message that Dr. Kim had released her from therapy.

TREATMENT: Provided therapeutic exercises. She was discharged from PT.

08/16/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Initial Evaluation, Page 533-541.

SUBJECTIVE COMPLAINTS: The patient felt it might be related to trying to add jogging to her daily walk or climbing into her high bed with all the pressure on her left leg. She complained of a constant ache and intermittent catching sensation, aggravated by jogging, climbing into her bed, left side-lying, walking, and at the end of the day.

OBJECTIVE FINDINGS: Posture: Iliac crests were level, with increased lumbar lordosis. GAIT: Mild Trendelenburg and increased bilateral trunk side bend. Range Of Motion: Active: Lumbar spine flexion was within normal limits; return to extension was painful, but the extension was full and pain-free. The right side bend was within normal limits, while the left side bend was painful. Passive: Left hip flexion was 100 degrees with pain, external rotation was 40 degrees, internal rotation was 30 degrees with pain, abduction was 40 degrees, and extension was -20 degrees. The right hip flexion was 120 degrees, external rotation was 45 degrees, internal rotation was 40 degrees, abduction was 40 degrees, and extension was 0 degrees. The left knee was 0-95 degrees, and the right knee was 0-110 degrees. Strength: Left quadriceps was 4/5 and painful, hip flexor was 4/5, and gluteus medius was 3/5 and painful. Right quadriceps was 5/5, hip flexor was 4+/5, and gluteus medius was 4/5. Special Tests: Positive Faber's test, positive Thomas test for tight rectus femoris and TFL. Painful standing trunk motion to the right and painful left single leg stance. Palpation: Tender to palpation of the left ASIS and TFL.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 27 of 84

ASSESSMENT: Left TFL hip flexor strain secondary to overuse with tightness and weakness of the gluteus medius.

TREATMENT: Treatment included modalities as needed - ice, therapeutic exercise, stretching for hip flexors, ictus femoris, TFL, strengthening for gluteus medius, quadriceps, home program instruction, and patient education training.

08/30/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 535.

SUBJECTIVE COMPLAINTS: She did not exercise much.

TREATMENT: Continue PT.

[Illegible report.]

09/07/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 535.

SUBJECTIVE COMPLAINTS: She worked last night with increased left knee pain with work. She spoke with her doctor and was advised not to use a cane at work.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

09/15/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 535-536.

SUBJECTIVE COMPLAINTS: She felt tired, secondary to working on the graveyard shift. Noted decreased pain in her left knee.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

09/21/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 536.

SUBJECTIVE COMPLAINTS: She was doing better and slowly getting used to her new work.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

09/26/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 536.

SUBJECTIVE COMPLAINTS: She was off last night.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

10/03/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 536.

SUBJECTIVE COMPLAINTS: She mostly slept over the weekend. Complained of feeling sore and tight after work. She tried to sit and rest when possible.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

10/10/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 537.

SUBJECTIVE COMPLAINTS: She was feeling good today and felt getting better in general. She occasionally got sharp pain in her left hip. She did some extra walking at work on Friday, and her left leg swelled a little bit but resolved on its own when she got home and rested.

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 28 of 84

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

11/15/11 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 531.

SUBJECTIVE COMPLAINTS: The patient was last seen on 10/10/11. She stated that she was feeling good and that she was only experiencing occasional sharp pain in the right hip. The patient was able to progress well with her exercises without pain. She canceled her appointment for 10/17/11 and did not reschedule.

TREATMENT: Discharged from physical therapy.

05/18/12 – Michael Duffin, M.D. – Optum – Progress Note, Page 530.

SUBJECTIVE COMPLAINTS: The patient complained of right #1 and 2 trigger fingers for several months.

OBJECTIVE FINDINGS: The examination revealed right #1 and 2 finger triggering, with tenderness over the A1 pulley on the palmar side at the base of the finger. A palpable nodule was present, but there was no evidence of Dupuytren's contracture.

ASSESSMENT: Trigger finger (acquired).

TREATMENT: The trigger finger was injected with 10 mg of Depo-Medrol. The trigger finger was injected with 1 ml of lidocaine without epinephrine.

10/21/13 – Cynthia Lowry, P.T. – Optum – Physical Therapy Initial Evaluation, Page 526-529.

SUBJECTIVE COMPLAINTS: She complained of anterior left hip pain that started more than 1 year ago and slowly worsening. The patient did not recall any specific injury; however, she had been treated for a similar problem in 2011. She complained of intermittent dull pain, which was aggravated by pressure on the area or when in a left-lying position in bed.

OBJECTIVE FINDINGS: ROM: Active: Lumbar spine was full with end-range pain in the left anterior hip. Left hip flexion was full and painful. Passive: Left hip flexion was 110 degrees with pain, external rotation was 40 degrees with pain, internal rotation was 40 degrees with pain, and extension was 0 degrees with pain. Right hip flexion was 120 degrees, external rotation was 45 degrees, and internal rotation was 45 degrees. Strength: Lower abdominals were 1/5, left gluteus medius was 3+/5 with pain, and hip flexor was 3+/5 with pain. Special Tests: Positive Thomas test for tight left hip flexor and rectus femoris. Functional Test: The patient was able to perform a left single-leg stance without pain. Palpation: Tenderness was noted upon palpation at the anterior hip flexors. Tension Signs: Tighter left straight leg raise (SLR) compared to the right. ASSESSMENT: Recurrent left hip flexor strain.

TREATMENT: Treatment included modalities as needed - ultrasound, heat, or ice. taping p.r.n., soft tissue mobilization p.r.n., therapeutic exercise, stretching for hip flexors and rectus femoris, strengthening for abdominals and gluts home program instruction, patient education training - avoid sleeping on the left side until the pain subsides.

[Illegible report.]

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 29 of 84

10/30/13 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 526.

SUBJECTIVE COMPLAINTS: She felt improvement. Minimal fatigue with exercises.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

11/14/13 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 526.

SUBJECTIVE COMPLAINTS: She did not exercise this week secondary to cleaning out her mother's house. Felt stiff but resolved with a hot bath with Epsom salts.

TREATMENT: Provided therapeutic exercises.

[Illegible report.]

01/07/14 – Cynthia Lowry, P.T. – Optum – Physical Therapy Note, Page 521.

SUBJECTIVE COMPLAINTS: The patient was last seen on 11/4/13. She reported experiencing stiffness on one occasion, which was resolved with a hot bath. She stated that she primarily felt the stiffness while lying supine and much less so when lying on her left side. The patient noted less hip pain, improved range of motion, and increased strength. However, she experienced some left knee pain during exercises. She canceled her next appointment failed to show up for the appointment after that, and did not reschedule.

TREATMENT: Discharge from physical therapy.

03/29/16 – Jessica Darling, N.P. – Optum – Progress Note, Page 507-510.

SUBJECTIVE COMPLAINTS: The patient had right knee pain, rated 6/10, and requested an injection. She worked part-time as a caregiver to an 89-year-old family friend and lived with her husband. She was in good physical shape and walked with a cane. She looked forward to a deep-sea fishing trip in May. The patient was seen for a consultation regarding osteoarthritis. Her symptoms included joint pain, joint stiffness, decreased range of motion, joint crepitation, joint swelling, and joint tenderness. The patient was currently experiencing these symptoms, which were located in the right knee. There was no radiation of the pain. The patient described the pain as sharp and aching, with a gradual onset occurring years ago. The symptoms occurred at night.

OBJECTIVE FINDINGS: In the right knee, there was crepitus of the patella and tenderness on palpation, but no effusion was present. There was no erythema or warmth in the knee, and the patient had a full range of motion in the knees.

ASSESSMENT: Osteoarthritis, localized, knee. Obesity.

TREATMENT: Exercises. Meloxicam 7.5 mg daily. Stop Aleve 220 mg. Using a sterile technique, the aspiration/injection needle was directed from a medial aspect. A 22-gauge needle was used to inject 2 mL of 1% Lidocaine and 1 mL of 40 mg/mL Triamcinolone.

04/18/16 – Jessica Darling, N.P. – Optum – Progress Note, Page 502-504.

SUBJECTIVE COMPLAINTS: The patient presented with right knee pain rated at 9/10 and requested an injection. She had seen Deborah two weeks prior, on March 29th, when her right knee was injected. She had been feeling better until nine days ago when she went dancing. After dancing, she began experiencing severe medial knee pain.

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 30 of 84

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness upon palpation of the knee; however, there was no effusion, no erythema, no warmth, and no full range of motion in the knee.

ASSESSMENT: Osteoarthritis, localized, knee. Obesity.

TREATMENT: Tramadol 50 mg as needed. Increase Meloxicam. Using a sterile technique, the aspiration/injection needle was directed from a medial aspect. A 22-gauge needle was used to inject 2 mL of 1% Lidocaine and 1 mL of 40 mg/mL Triamcinolone.

06/06/16 – Jessica Darling, N.P. – Optum – Progress Note, Page 498-500.

SUBJECTIVE COMPLAINTS: The patient reported right knee pain, rated 8/10, and requested an injection. The patient continued to experience pain despite weight loss, two steroid injections, and as-needed meloxicam and tramadol.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee. Synvisc one injection referral.

TREATMENT: Using a sterile technique, the aspiration/injection needle was then directed from a medial aspect. A 22-gauge needle was used to inject 2 mL of 1% lidocaine and 1 mL of 40 mg/mL triamcinolone.

08/11/16 – Jessica Darling, N.P. – Optum – Progress Note, Page 476-478.

SUBJECTIVE COMPLAINTS: Here for right knee pain and for a Supartz injection#1. Pain rated at 6/10.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Using a sterile technique, the aspiration/injection needle was then directed from a medial aspect. An 18-gauge needle was used to inject 2 ml of Supartz.

08/19/16 – Jessica Darling, N.P. – Optum – Progress Note, Page 472-473.

SUBJECTIVE COMPLAINTS: Here for right knee pain and for a Supartz injection#2. Pain rated at 3/10.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Using a sterile technique, the aspiration/injection needle was then directed from a medial aspect. An 18-gauge needle was used to inject 2 ml of Supartz.

09/01/16 – Jessica Darling, N.P. – Optum – Progress Note, Page 469-470.

SUBJECTIVE COMPLAINTS: Here for right knee pain and for a Supartz injection#3. Pain rated at 3/10.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 31 of 84

TREATMENT: Using a sterile technique, the aspiration/injection needle was then directed from a medial aspect. An 18-gauge needle was used to inject 2 ml of Supartz. Tramadol and Meloxicam as needed. Continue weight loss.

03/08/17 – Jessica Darling, N.P. – Optum – Progress Note, Page 463-465.

SUBJECTIVE COMPLAINTS: Here for right knee pain and for a Supartz injection#1. She lost 16 lbs. since March 2016. Pain rated at 5/10.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Using a sterile technique, the aspiration/injection needle was then directed from a medial aspect. An 18-gauge needle was used to inject 2 ml of Supartz. Tramadol and Meloxicam as needed. Continue weight loss.

03/22/17 – Jessica Darling, N.P. – Optum – Progress Note, Page 460-462.

SUBJECTIVE COMPLAINTS: Here for right knee pain and for a Supartz injection#2. Pain rated at 3/10. No issue with the previous injection.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Using a sterile technique, the aspiration/injection needle was then directed from a medial aspect. An 18-gauge needle was used to inject 2 ml of Supartz. Tramadol and Meloxicam as needed. Continue weight loss.

03/29/17 – Jessica Darling, N.P. – Optum – Progress Note, Page 457-459.

SUBJECTIVE COMPLAINTS: Here for right knee pain and for a Supartz injection#3.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Using a sterile technique, the aspiration/injection needle was then directed from a medial aspect. An 18-gauge needle was used to inject 2 ml of Supartz.

05/31/17 – Joyce Chang, M.D. – PMI Carson Primary Care – Progress Note, Page 1962-1965.

SUBJECTIVE COMPLAINTS: The patient started smoking again and asked for a refill of Chantix, which had helped her in the past.

ASSESSMENT: Hypertension. Tobacco use. Hyperlipidemia.

TREATMENT: Continue meds. Low sodium diet. Chantix. Smoking cessation. Atorvastatin 80 mg.

06/06/17 – Jessica Darling, N.P. – Optum – Progress Note, Page 454-456.

SUBJECTIVE COMPLAINTS: Here for follow-up post-Supartz injection series.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 32 of 84

TREATMENT: Kenalog 40 mg/ml [1.5] ml and Lidocaine 2% without epinephrine injection to the right knee.

07/24/17 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 1927-1930.

SUBJECTIVE COMPLAINTS: The patient presented with left thumb and ring finger locking with pain for several days. There was no history of trauma or injuries. No swelling, rash, or fever was noted. The patient had a history of trigger fingers.

OBJECTIVE FINDINGS: Left thumb and left ring finger with triggering.

ASSESSMENT: Trigger finger of the left thumb. Trigger finger of the left ring finger.

TREATMENT: Kenalog 20mg + Lidocaine 1% 1 ML injection into the A1 pulley of the left thumb. Kenalog 20mg injection into A1 pulley, of the left ring finger.

09/20/17 – Norman Cantor – PMI Carson Primary Care – Progress Note, Page 1893-1894.

SUBJECTIVE COMPLAINTS: The patient presented for follow-up on throat symptoms and continued occasional smoking.

OBJECTIVE FINDINGS: Moderate to severe inter and post arytenoid edema consistent with active reflux.

ASSESSMENT: Laryngopharyngeal reflux. Globus pharyngeus.

TREATMENT: Urged to discontinue smoking and take meds routinely.

10/03/17 – Joyce Chang, M.D. – PMI Carson Primary Care – Progress Note, Page 1843-1848.

SUBJECTIVE COMPLAINTS: Here for hypertension follow-up. She was still trying to quit smoking.

ASSESSMENT: Hypertension. Prediabetes. Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult. Tobacco use.

TREATMENT: Advised cessation. Continue meds (aspirin 81 mg, atorvastatin 80 mg, varenicline 1 mg, cholecalciferol 1000 units, meloxicam 7.5 mg, nifedipine 30 mg, ranitidine 300 mg, triamterene-HCTZ 37.5-25 mg) and low sodium diet. Chantix.

11/01/17 – Jessica Darling, N.P. – Optum – Progress Note, Page 451-453.

SUBJECTIVE COMPLAINTS: Here for Synvisc injection series#1 for right knee pain.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Supartz injection to the right knee was performed.

11/14/17 – Jessica Darling, N.P. – Optum – Progress Note, Page 444-446.

SUBJECTIVE COMPLAINTS: Here for Synvisc injection series#2 for right knee pain. The pain level was 6/10.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 33 of 84

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Supartz injection to the right knee was performed.

11/21/17 – Jessica Darling, N.P. – Optum – Progress Note, Page 441-443.

SUBJECTIVE COMPLAINTS: Here for Synvisc injection series#3 for right knee pain.

The pain level was 6/10.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Supartz injection to the right knee was performed.

12/18/17 – Jessica Darling, N.P. – Optum – Progress Note, Page 438-440.

SUBJECTIVE COMPLAINTS: She stated that he Supartz series was not helpful. She was here for a steroid injection. The pain level was 8/10.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Kenalog 40 mg/ml [1.5] ml and Lidocaine 2% without epinephrine

02/06/18 – Joyce Chang, M.D. – PMI Carson Primary Care – Progress Note, Page 1814-1818.

SUBJECTIVE COMPLAINTS: Here for routine follow-up. Hypertension was controlled with meds.

ASSESSMENT: Hypertension. Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult.

TREATMENT: Continue medications and low sodium diet. Weight loss.

03/05/18 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 1783-1786.

SUBJECTIVE COMPLAINTS: The patient presented for persistent left ring finger pain and locking, which had lasted for several days and worsened over time.

OBJECTIVE FINDINGS: Left hand with ring trigger finger.

ASSESSMENT: Trigger finger of the left ring finger. Pain in the left finger.

TREATMENT: Left finger x-ray. Kenalog 20mg + Lidocaine 2% 1 ML injection into A1 pulley.

05/03/18 – Jessica Darling, N.P. – Optum – Progress Note, Page 433-437.

SUBJECTIVE COMPLAINTS: Here for a steroid injection. She requested a Supartz series injection for her right knee pain. The pain level was 6/10.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Kenalog 40 mg/ml (1.5) ml and Lidocaine 2% without epinephrine.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 34 of 84

05/07/18 – Joyce Chang, M.D. – PMI Carson Primary Care – Progress Note, Page 1733-1738.

SUBJECTIVE COMPLAINTS: Se had dizziness for 1 month, usually when she moved her head. Still on Chantix and had been able to avoid smoking.

ASSESSMENT: Hypertension. Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult. Bilateral cerumen impaction.

TREATMENT: Continue medications and low sodium diet. Weight loss. Ear lavage.

05/25/18 – Joyce Chang, M.D. – PMI Carson Primary Care – Progress Note, Page 1698-1703.

SUBJECTIVE COMPLAINTS: Five days ago, the patient bent over in her closet at around 8 PM after dinner, experienced a feeling of vertigo, and lost consciousness for an unknown amount of time. She thought she had been unconscious for a few seconds.

ASSESSMENT: Hypertension. History of syncope. Vertigo.

TREATMENT: Continue medications and low sodium diet. Weight loss. Meclizine. ENT referral.

06/14/18 – Maher Sesi, M.D. – Beach Cities ENTS – Progress Note, Page 134-137.

SUBJECTIVE COMPLAINTS: Debora presented today for possible vertigo. She had visited her primary care provider a few weeks ago, who had cleaned her ears and suggested that she might be experiencing vertigo. She had been given a prescription for Meclizine, but she did not like to take it. She reported having about three episodes of vertigo during which she felt like she was spinning. She noticed that these episodes occurred when she laid down on her right side and that they lasted for a few seconds. Additionally, she observed that the episodes happened when she got up in the middle of the night to use the restroom, requiring her to sit up slowly before getting up. She denied any nausea or vomiting and reported no ear pain or drainage. However, she did mention experiencing some whooshing sounds in her right ear, which she heard occasionally.

OBJECTIVE FINDINGS: Dix-hallpike was positive to the right.

ASSESSMENT: Benign paroxysmal vertigo, right ear. Acute eustachian salpingitis, right ear. Sensorineural hearing loss, left ear.

TREATMENT: Audiogram. Epley maneuver was done. Trial home BPPV exercises.

08/07/18 – Joyce Chang, M.D. – PMI Carson Primary Care – Progress Note, Page 1656-1660.

SUBJECTIVE COMPLAINTS: Here to discuss abnormal lab results. Continued to smoke.

ASSESSMENT: Renovascular hypertension. CKD (chronic kidney disease) stage 3, GFR 30-59 ml/min.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 35 of 84
TREATMENT: Continue medications and low sodium diet. Renal diet. Smoking cessation.

09/21/18 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 1625-1629.

SUBJECTIVE COMPLAINTS: She was here today requesting a cortisone injection in her ring finger on her left hand. She had received a cortisone injection previously in March of this year, which had improved her pain. She noted that she had been experiencing triggering and pain again for the last few days. She reported that the symptoms were worse in the morning, and her finger was getting stuck, requiring her to run it under warm water for relief. The patient did not want a flu shot.

OBJECTIVE FINDINGS: Left hand: Ring the finger of the left hand with triggering.

ASSESSMENT: Trigger finger of the left ring finger.

TREATMENT: Kenalog 20mg + Lidocaine 2% 1 ML injection into A1 pulley.

09/25/18 – Vinh Cam, M.D. – Internal Medicine and Nephrology Medical Group, Inc. – Progress Note, Page 1622-1625.

SUBJECTIVE COMPLAINTS: The patient presented with an eGFR of 54. She had used cocaine earlier in the year, and now her eGFR was dropping. She was also on Mobic for right knee arthritis and taking Maxzide as well. She had a history of hypertension for 20 years, which was moderately well controlled, and there was no proteinuria noted. There was no renal imaging performed. Additionally, she smoked.

ASSESSMENT: CKD stage 3 likely from hypertension. Hypertension. GERD. Arthritis.

TREATMENT: Renal ultrasound. Monitor. Discontinue NSAID. Continue Zantac and statin. May need to hold Meloxicam.

09/26/18 – Jessica Darling, N.P. – Optum – Progress Note, Page 430-432.

SUBJECTIVE COMPLAINTS: Here for Supartz series injection. She stopped Meloxicam due to CKD. Pain level at 6/10.

OBJECTIVE FINDINGS: There was crepitus of the patella and tenderness on palpation of the knee.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Supartz injection#1 to the right knee was performed.

10/10/18 – Steve Aziz, M.D. – Optum – Progress Note, Page 426-429.

SUBJECTIVE COMPLAINTS: Here for Supartz series injection for right knee pain. Pain level at 4/10.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: 1 vial of the viscosupplement was injected without complication.

10/25/18 – Steve Aziz, M.D. – Optum – Progress Note, Page 423-425.

SUBJECTIVE COMPLAINTS: Since her last visit, the patient reported that she was doing well. She stated that the injections were still helping. She had been using turmeric and noticed that she was more active. Although the pain was still present, it was now described as aching and rated at 4/10, which was an improvement. She noted

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 36 of 84

that the pain worsened with activity. The patient continued taking turmeric and expressed interest in trying CBD. She had no other complaints.

OBJECTIVE FINDINGS: Right knee with crepitus.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: 1 vial of the viscosupplement was injected without complication.

11/08/18 – Joyce Chang, M.D. – PMI Carson Primary Care – Progress Note, Page 1543-1548.

SUBJECTIVE COMPLAINTS: Here for routine follow-up of hypertension. She had stopped using cocaine in January 2018. Still smoking tobacco and has throat irritation

ASSESSMENT: CKD (chronic kidney disease) stage 3, GFR 30-59 ml/min. Renovascular hypertension. Hyperlipidemia. Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult. Cocaine dependence in remission. Throat discomfort.

TREATMENT: Renal diet. Continue medications and low sodium diet. Renal diet. Continue cocaine cessation. ENT referral. Smoking cessation. Nephrology follow-up on 11/16/18.

11/26/18 – Vinh Cam, M.D. – Internal Medicine and Nephrology Medical Group, Inc. – Progress Note, Page 1590-1593.

SUBJECTIVE COMPLAINTS: The patient's eGFR was stable in the 50s. An ultrasound showed small kidneys. The glomerulonephritis (GN) panel was negative, and there was no proteinuria noted.

ASSESSMENT: Mixed hyperlipidemia. Arthritis. Hypertension in chronic kidney disease stages 1 to 4. CKD stage 3. GERD.

TREATMENT: Discontinue Mobic for now. Continue Maxzide, Zantac, and statin.

02/14/19 – Joyce Chang, M.D. – PMI Carson Primary Care – Progress Note, Page 1490-1495.

SUBJECTIVE COMPLAINTS: The patient had chronic kidney disease stage 3, which was improving. She continued to smoke tobacco and still experienced throat discomfort. She had not yet seen an ENT specialist, as she was afraid to find out what they might say. Additionally, she reported experiencing foot pain when wearing high-heeled shoes.

ASSESSMENT: Renovascular hypertension. Tobacco use. Hyperlipidemia. Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult. Throat discomfort.

TREATMENT: Avoid NSAID. Chantix. Smoking cessation. Continue statin. Weight loss. ENT follow-up on 02/14/19. Renal diet.

03/07/19 – Alexander Perez, D.P.M. – West Torrance Podiatrists Group, Inc. – Progress Note, Page 123-124.

SUBJECTIVE COMPLAINTS: The patient stated that she had hit her right great toe approximately two months ago against a metal rod on the floor of her home and had experienced pain ever since. She noted that the pain was often exacerbated when she

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 37 of 84

wore high-heeled shoes to church. The patient denied any past treatments for this complaint and had no other complaints at this time.

OBJECTIVE FINDINGS: There was mild tenderness to palpation of the right great toe joint. There was mild hallux limitus deformity noted with weight-bearing, as well as mild plantar metatarsal fat pad atrophy bilaterally.

ASSESSMENT: Metatarsalgia. Contusion of the right foot. Pain in the right foot.

TREATMENT: RICE therapy. Recommended Clark's shoe gear and soft inserts.

03/14/19 – Steve Aziz, M.D. – Optum – Progress Note, Page 417-418.

SUBJECTIVE COMPLAINTS: Her last Supartz injection was long ago and was wearing off. The pain was described as aching and rated at 5/10. It worsened with walking and weight-bearing, with no radiation noted. The pain improved with rest, and there was no swelling. The patient was taking Tramadol once a week, which helped, and reported that CBD topical therapy helped greatly.

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Kenalog 40 mg with 3 ml of Lidocaine 1% without epinephrine was injected without complication.

06/03/19 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 1456-1459.

SUBJECTIVE COMPLAINTS: She was here today for a follow-up on her left ring trigger finger. She noted triggering and locking of the left ring finger again for the last several days. The patient had her last cortisone injection on 09/21/18, which had improved her pain at that time. She stated that it was currently causing her pain and discomfort, and the symptoms were getting worse. She reported that the symptoms were exacerbated in the morning. The patient was requesting a cortisone injection today in the office and reported that she did not have any other health concerns or complaints.

OBJECTIVE FINDINGS: Ring the finger of the left hand with triggering.

ASSESSMENT: Trigger finger of the left ring finger.

TREATMENT: Kenalog 20mg + Lidocaine 2% 1 ML injection into A1 pulley.

06/18/19 – Steve Aziz, M.D. – Optum – Progress Note, Page 414-416.

SUBJECTIVE COMPLAINTS: The right knee pain started again a few weeks ago. It was described as aching and moderate at times, worsening with walking and weight-bearing, with no radiation noted. The pain improved with rest, and there was no swelling. The patient reported taking Tramadol less frequently now that she was using CBD oil.

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Kenalog 40 mg and 3 ml Lidocaine 1% was then injected and the needle was withdrawn. Tramadol HCl 50 mg daily as needed.

07/10/19 – Vinh Cam, M.D. – Internal Medicine and Nephrology Medical Group, Inc. – Progress Note, Page 1597-1601.

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 38 of 84

SUBJECTIVE COMPLAINTS: The patient had a urinalysis (UA) that showed some bacteria and was given antibiotics, but she had no overt symptoms. Her eGFR is about 60 and stable. Her blood pressure index (BPI) is a bit high, but a recheck showed it was not too concerning. She reported occasional cocaine use, with the last use being two months ago. The patient missed her last appointment due to taking care of an IHSS (In-Home Supportive Services) patient who was ill.

ASSESSMENT: Mixed hyperlipidemia. Arthritis. Hypertension in chronic kidney disease stages 1 to 4. CKD stage 3. GERD.

TREATMENT: Discontinue Mobic for now. Continue Maxzide, Zantac, and statin. Tylenol was okay. Losartan 25 mg daily.

07/17/19 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 1377-1381.

SUBJECTIVE COMPLAINTS: The patient reported that her last episode of knee pain and swelling started two weeks ago. She has a history of knee replacement surgery and has tried using cool compresses for relief. There was no recent accident that could have caused the pain. She continues to experience pain in her right knee and is receiving injections periodically for it. Additionally, she mentioned that she still has throat discomfort but has not yet seen an ENT specialist due to her fear of going.

ASSESSMENT: Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult. Essential hypertension. Bilateral primary osteoarthritis of the knee. Throat discomfort.

TREATMENT: Continue medications and low sodium diet. Weight loss. ENT follow-up for 07/17/19. Labs ordered. Mammogram. Colonoscopy referral.

08/21/19 – William Kim, M.D. – Orthopedic Specialities Associates – Progress Note, Page 1320.

SUBJECTIVE COMPLAINTS: She was status post in 2010, left knee replacement. She was doing well until two months ago. She may attribute it to straightening and taking care of patients.

OBJECTIVE FINDINGS: The patient has a clicking sensation in her knee, which is attributed to patellofemoral issues. X-rays show that the knee looks good, with no evidence of infection. She has a full range of motion and stability in the knee, although she walks with a minimal limp. The imaging indicates moderately severe osteoarthritis of the right knee.

ASSESSMENT: Left total knee replacement, doing well with left knee strain in her work. Osteoarthritis of the right knee, possible in the future total knee replacement.

TREATMENT: Physical therapy and self-restrictions at work, avoid stretching, twisting, and bending.

09/10/19 – Michael Karas, P.T. – Optum – Physical Therapy Initial Evaluation, Page 406-407.

SUBJECTIVE COMPLAINTS: The patient presented with a sudden onset of left knee pain. There was a possible left MCL strain versus infra patellar fat pad inflammation. The patient had a history of left total knee replacement in 2010. The patient had a TKR

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 39 of 84

on her left side 9 years ago and experienced pain on the outside of her left knee after swelling started 2 months ago. The patient saw Dr. Kim, who indicated that she strained it. She worked caring for an elderly lady, and the pain had been bothering her since the swelling occurred. She felt pain in the lateral knee on the left side and felt like something was sticking to her. She reported numbness on the left lateral knee.

OBJECTIVE FINDINGS: Posture: A mild pocket of swelling was seen in the left lateral knee joint line. Gait: Gait was within functional limits, with a mild Trendelenburg gait observed bilaterally. Palpation: Tenderness was noted at the left lateral joint line. AROM Knee: R: Not tested; L: 0-97? with pain at the end range.

ASSESSMENT: Left knee pain.

TREATMENT: Provided home exercise program and Kinesio taping.

09/17/19 – Steve Aziz, M.D. – Optum – Progress Note, Page 399-401.

SUBJECTIVE COMPLAINTS: Since the last visit, the patient has still been experiencing knee pain. The pain was described as aching, mostly in the right knee, rated at 5/10, and worsened with walking and weight bearing. There was no radiation of the pain, and it improved with rest, with no swelling noted. The patient also had left knee pain and had seen an orthopedic specialist, given a history of knee replacement, and was sent to physical therapy. The patient had been taking Tramadol frequently, which helped. Additionally, they had been using CBD topical therapy and participating in physical therapy.

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Triamcinolone 40 mg and 2.5 ml Lidocaine 1% were then injected and the needle was withdrawn.

09/24/19 – Michael Karas, P.T. – Optum – Physical Therapy Note, Page 398.

SUBJECTIVE COMPLAINTS: She had been using her pedal bike, which had been helping her knee. It had bothered her when she walked on it for a long time.

OBJECTIVE FINDINGS: L knee ROM: 0-103.

ASSESSMENT: Left knee pain.

TREATMENT: Provided therapeutic exercises, cold packs, and a home exercise program.

10/09/19 – Michael Karas, P.T. – Optum – Physical Therapy Note, Page 397.

SUBJECTIVE COMPLAINTS: Her knee had been better in the morning after the exercises, but then it had bothered her in the evening when she was on her feet all day.

ASSESSMENT: Left knee pain.

TREATMENT: Provided therapeutic exercises, cold packs, and a home exercise program.

10/10/19 – Vinh Cam, M.D. – Internal Medicine and Nephrology Medical Group, Inc. – Progress Note, Page 1371-1375.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 40 of 84

SUBJECTIVE COMPLAINTS: She had still used some cocaine one month ago, along with some cannabis. There had been no swelling, her blood pressure had been better, and her eGFR had been 59, which had been good.

ASSESSMENT: Mixed hyperlipidemia. Arthritis. Hypertension in chronic kidney disease stages 1 to 4. CKD stage 3. GERD.

TREATMENT: Continue Maxzide, Zantac, and statin. Tylenol was okay. Famotidine 40 mg daily.

10/22/19 – Brett Levine, M.D. – Beach Cities ENTS – Progress Note, Page 138-141.

SUBJECTIVE COMPLAINTS: Debora had returned after one year for the feeling of a lump in her throat on the right side, which she had experienced for five years. She had felt that the generalized right-sided irritation appeared to have increased in surface area. She had reported that the globus sensation and irritation had worsened with smoking, as she had smoked cigarettes daily. When she woke up in the morning, she noticed voice changes. She had denied any trouble swallowing and had denied any trouble breathing. She had not had any tests performed.

ASSESSMENT: Pain in the throat.

TREATMENT: Flexible laryngoscopy was done which showed normal findings.

11/11/19 – Joyce Chang, M.D. – PMI Carson Primary Care – Progress Note, Page 1323-1328.

SUBJECTIVE COMPLAINTS: Here for a routine follow-up.

ASSESSMENT: Hyperlipidemia. Essential hypertension. Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult.

TREATMENT: Continue medications and low sodium diet. Continue statin. Weight loss.

11/19/19 – Benjamin Rafii, M.D. – Beach Cities ENTS – Progress Note, Page 142-145.

SUBJECTIVE COMPLAINTS: She presented today for an evaluation for the feeling of a lump in her throat on the right side, which she had experienced for about 5-6 years. She had been a current smoker and had felt the globus sensation and irritation all the time, but it had been worse while smoking, particularly on the right side of her throat. She had noted that she had attempted to stop smoking and had felt better, but she had continued to smoke. There had been no pain, dysphagia, or difficulty breathing. In the morning, her voice had been raspy but had improved throughout the day. She had acid reflux and had taken Prilosec as needed, with spicy foods being her triggers.

ASSESSMENT: Pain in the throat. Dysphonia. Chronic Laryngitis. Gastro-Esophageal Reflux Disease With Esophagitis. Other Dysphagia.

TREATMENT: Flexible Laryngoscopy with Stroboscopy and Medical Speech Evaluation. Encouraged to stop smoking.

12/02/19 – Erika Kalash, D.O. – Optum – Progress Note, Page 394-396.

SUBJECTIVE COMPLAINTS: She presented today with bilateral knee pain, greater on the right side, and had requested a cortisone injection. She had last been seen by rheumatology (Dr. Aziz) on September 17, 2019, at which time she had received a right knee steroid injection with 40 mg of triamcinolone. She had stated that she did get

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 41 of 84

good relief of pain with the cortisone injection, but it had only lasted about three months. She had tried Supartz in the past, which had provided a longer duration of pain relief (about six months), but her insurance no longer covered the cost of viscosupplementation. Repeat X-rays had been ordered at her last visit in September 2019, and she had completed them, but her orthopedic surgeon had kept copies of the disc. She had stated that there was no plan for surgery on the right knee until she was "bone on bone." The pain had been described as achy and deep, more on the medial aspect of the knee, with occasional swelling. The pain had worsened recently as she had been on her feet more for the Thanksgiving holiday, doing cooking and household chores. She had completed physical therapy, and CBD oil had helped her pain somewhat. She had not tried lidocaine gel or Voltaren gel and had used tramadol sparingly for the most intense pain. There had been no recent falls or trauma, and no recent illness. She had taken a baby aspirin but was not on any other anticoagulation. Pain level at 6/10.

OBJECTIVE FINDINGS: Her left knee had a midline surgical scar that was well-healed. The left knee had shown mild tenderness at the lateral aspect, but there had been no warmth or swelling. The right knee had had a normal range of motion but had exhibited crepitus, with no warmth or swelling. The medial infrapatellar fat pad had been noted.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Kenalog 60 mg and 1.5 ml lidocaine 1% was then injected and the needle was withdrawn.

12/17/19 – Michael Karas, P.T. – Optum – Physical Therapy Note, Page 393.

SUBJECTIVE COMPLAINTS: The patient reported that her knee was better in the morning after the exercises, but then it bothered her in the evening when she was on her feet all day.

TREATMENT: She was discharged from physical therapy at this time.

03/02/20 – Steve Aziz, M.D. – Optum – Progress Note, Page 390-392.

SUBJECTIVE COMPLAINTS: The patient described the pain as aching, rated it 5 out of 10, and noted that it was worse with walking and weight bearing. There was no radiation of the pain, and it improved with rest, with no swelling present. She was taking Tramadol intermittently, which helped a little, and CBD topical therapy provided slight relief. The patient had recently tried physical therapy for the left knee, as she was favoring it due to pain in the right knee.

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Kenalog 60 mg and 2.5 ml Lidocaine 1% was then injected and the needle was withdrawn.

03/05/20 – Shahina Hakim, M.D. – Endoscopy Center at Skypark – Procedure Note, Page 385-386.

PROCEDURE PERFORMED: Colonoscopy.

INDICATION: Screening for colonic neoplasia.

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 42 of 84

IMPRESSION: Diverticulum in the transverse colon. Mild diverticulosis of the sigmoid colon. Internal hemorrhoids. Polyp (5 mm) in the proximal transverse colon. (Polypectomy).

COMPLICATIONS: None.

05/14/20 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 1272-1279.

SUBJECTIVE COMPLAINTS: The patient complained of recurring pain in her left ring finger. She worked as a caregiver and stated that she was compliant with her current medication. She denied any side effects or changes to her medication regimen and reported that she did not have any other health concerns or complaints.

OBJECTIVE FINDINGS: Triggering of the left ring finger.

ASSESSMENT: Trigger ring finger of the left hand. Essential hypertension. Hyperlipidemia. CKD (chronic kidney disease) stage 3, GFR 30-59 ml/min.

TREATMENT: Kenalog 20mg + Lidocaine 2% 1 ML injection into A1 pulley. Continue hypertension management and atorvastatin.

06/02/20 – Steve Aziz, M.D. – Optum – Progress Note, Page 384.

SUBJECTIVE COMPLAINTS: The patient was called for a phone visit/consult regarding her knee arthritis. She described the pain as aching, rating it 8 out of 10 when it was severe. The pain was worse with walking, weight-bearing, and cold weather, with no radiation. It improved with rest, and there was no swelling present. The patient was taking Tramadol as needed for pain, which helped. She used CBD topical therapy and did not participate in physical therapy, opting for walking as her form of exercise. She had been losing weight.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: She did not want injections at this time but probably in around 2 to 3 months' time. Follow-up as needed.

06/16/20 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 1243-1247.

SUBJECTIVE COMPLAINTS: The patient was present today for shoulder pain and to manage her multiple chronic conditions, including hypertension and hyperlipidemia. She complained of persistent acute right shoulder pain for the past four days. The patient, who is a caregiver, fell on her shoulder while trying to catch her patient. She reported that she could not lift her shoulder above her head due to pain and stated that she was compliant with her current medication.

OBJECTIVE FINDINGS: Limited range of motion of right shoulder due to pain.

ASSESSMENT: Acute pain in the right shoulder. Essential hypertension. Mixed hyperlipidemia. BMI 29-29.9.

TREATMENT: Right shoulder x-ray. Mobic 15 mg daily. Maxide 25 mg. Nifedipine 30 mg daily. Lipitor 80 mg. Continue with lifestyle modifications to keep a healthy weight.

06/29/20 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 1200-1204.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 43 of 84

SUBJECTIVE COMPLAINTS: The patient complained of right shoulder pain. She reported that Mobic had not been helping her, and she continued to struggle to sleep at night.

OBJECTIVE FINDINGS: Right shoulder with limited ROM due to pain.

ASSESSMENT: Acute pain in the right shoulder. Bursitis of the right shoulder.

TREATMENT: Kenalog 40 mg + Lidocaine 1% 8 ML injection into right shoulder subacromial space, through posterolateral approach.

07/21/20 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 1142-1147.

SUBJECTIVE COMPLAINTS: Here for an annual examination. The patient reported that she was unable to take meloxicam due to its effects on her kidneys. She requested an alternative pain medication to meloxicam. The patient continued to smoke on occasion but denied any further use of cocaine. She occasionally used Chantix to help her cut down on smoking and stated that she was compliant with her current medication.

ASSESSMENT: Annual physical examination. Essential hypertension. Mixed hyperlipidemia.

TREATMENT: Labs ordered. Maxide 25 mg. Lipitor 80 mg. Vitamin D 1000 IU daily. Labs ordered. TDAP vaccine. Bilateral breast mammogram. Norco 5-325 mg every 6 hours. Continue abstaining from cocaine use.

08/20/20 – Erika Kalash, D.O. – Optum – Progress Note, Page 380-382.

SUBJECTIVE COMPLAINTS: The patient described the pain as aching, rating it 9 out of 10, and noted that it was worse with walking and weight bearing. There was no radiation of the pain, and it improved with rest, with no swelling present. She reported that injections still helped and mentioned that she was seeing orthopedics the following week.

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Primary osteoarthritis of the right knee. History of knee replacement procedure of left knee.

TREATMENT: Left knee x-ray. Kenalog 60 mg and 1.5 ml Lidocaine 1% was then injected and the needle was withdrawn.

09/08/20 – Steve Aziz, M.D. – Optum – Progress Note, Page 378-379.

SUBJECTIVE COMPLAINTS: Presented for follow-up- of knee pain. The patient stated that she was doing well since the injections two weeks ago. She experienced mild pain at times and moderate pain when very active.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Tramadol as needed. Continue to monitor, exercise, and stretch.

12/15/20 – Steve Aziz, M.D. – Optum – Progress Note, Page 375-377.

SUBJECTIVE COMPLAINTS: Here for knee pain. The patient described the pain as aching, rating it 7 out of 10. It was worse with walking, weight-bearing, and cold weather.

OBJECTIVE FINDINGS: Right knee crepitus noted.

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 44 of 84

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Kenalog 60 mg and 2.5 ml Lidocaine 1% was then injected and the needle was withdrawn.

02/23/21 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 1073-1077.

SUBJECTIVE COMPLAINTS: The patient was present today for a follow-up. She requested a Kenalog injection for her trigger finger on the left ring finger and asked for a refill of atorvastatin. She stated that she was compliant with her current medication.

OBJECTIVE FINDINGS: BP: 145/77. Left ring finger with triggering.

ASSESSMENT: Trigger ring finger of the left hand. Essential hypertension. Negative depression screening. Vitamin D deficiency. BMI 31.0-31.9, adult. Stage 3a chronic kidney disease. Mixed hyperlipidemia.

TREATMENT: Kenalog 20mg + Lidocaine 2% 1 ML injection into A1 pulley. Maxide 25 mg. Lipitor 80 mg. Vitamin D 1000 IU daily. Labs ordered.

03/17/21 – Michele Kolostian, N.P. – Optum – Progress Note, Page 368-372.

SUBJECTIVE COMPLAINTS: Presented for an annual wellness visit.

ASSESSMENT: History of crack cocaine use. History of Breast Surgery. Marijuana user. Shoulder pain, right. Osteoarthritis of knees, bilateral. Smokers' cough. Hyperlipidemia. Hypertension. Nicotine dependence. Class 1 obesity with body mass index (BMI) of 31.0 to 31.9 in adult. Stress incontinence, female. Throat discomfort.

TREATMENT: Continue with the support/accountability group. Annual mammogram. Continue Tramadol, Aleve, and IcyHot as needed. Continue Atorvastatin and aspirin. QuantaFlo. TDAP vaccine. iFOBT kit.

03/30/21 – Blanca Lansang, N.P. – Optum – Progress Note, Page 365-366.

SUBJECTIVE COMPLAINTS: Here for a QuantaFlo PAD screening exam and Neurometrix Nerve Conduction Study.

ASSESSMENT: Neuropathy due to medical condition. Prediabetes. PAD (peripheral artery disease). Screening for neurological condition.

TREATMENT: Continue monitoring. Discussed healthy eating and exercise. Neurometrix with Mild DPN.

04/26/21 – Tu Sang Om – PMI Carson Primary Care – Progress Note, Page 961-966.

SUBJECTIVE COMPLAINTS: The patient was present today for a follow-up visit to manage her multiple chronic conditions, including hypertension, prediabetes, and hyperlipidemia. She reported that she could not afford her hypertension and hyperlipidemia medications (Maxide and atorvastatin) and had stopped taking them. She used to receive a 90-day supply of her medications. The patient received Pfizer vaccines on 01/24/21 and 02/14/21. She reported experiencing heart flutter since she stopped taking her medication and requested a referral to cardiology. She planned to work on her diet by reducing her intake of potatoes, sugar, carbohydrates, and soda. She stated that she was compliant with her current medication.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 45 of 84
ASSESSMENT: Essential hypertension. Stage 3a chronic kidney disease. Prediabetes. Vitamin D deficiency. Mixed hyperlipidemia.
TREATMENT: Maxzide 37.5-25 mg daily. Nifedipine 30 mg daily. Labs ordered. Lipitor 80 mg. Vitamin D 1000 IU daily. Cardiology referral.

05/28/21 – Steve Aziz, M.D. – Optum – Progress Note, Page 360-363.

SUBJECTIVE COMPLAINTS: The patient was present for knee pain. She described the pain as aching, rating it 7 out of 10. The pain was worse with walking and weight bearing, with no radiation. It improved with rest, and there was no swelling present. She used a cane frequently.

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Osteoarthritis, localized, knee.

TREATMENT: Kenalog 80 mg and 2.5 ml Lidocaine 1% was then injected and the needle was withdrawn.

06/11/21 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 886-891.

SUBJECTIVE COMPLAINTS: The patient complained of dysuria that began this morning. She described a painful burning sensation during urination.

ASSESSMENT: Essential hypertension. Stage 3a chronic kidney disease. Mixed hyperlipidemia. Vitamin D deficiency. Urinary tract infection without hematuria.

TREATMENT: Continue with muscle exercises + Vitamin D as directed. Maxzide 25 mg. Nifedipine 30 mg. Vitamin D 1000 IU daily. Cefnidir 300 mg 2 times daily. Labs ordered.

07/26/21 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 818-825.

SUBJECTIVE COMPLAINTS: The patient was present today for a follow-up visit to discuss lab results and manage her multiple chronic conditions, including hypertension and prediabetes. She reported that she is still smoking but is trying to cut it down. The patient noted that she is stressed due to a car accident last month and complained of blurry vision in her right eye. She has a history of cataracts and a lens implant in her left eye and is requesting an ophthalmology referral.

ASSESSMENT: Stage 3a chronic kidney disease. Age-related nuclear cataract of the right eye. Essential hypertension. Mixed hyperlipidemia. Vitamin D deficiency. Osteopenia of the lumbar spine. Breast cancer screening. Prediabetes.

TREATMENT: Labs ordered. Ophthalmology referral. Vitamin D 1000 IU daily. Mammogram. Shingrix vaccine. Pneumonia vaccine.

09/14/21 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 788-792.

SUBJECTIVE COMPLAINTS: The patient complained of triggering in the ring finger of her left hand and is requesting an injection for relief.

OBJECTIVE FINDINGS: Left ring finger with triggering.

ASSESSMENT: Trigger ring finger of the left hand.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 46 of 84

TREATMENT: Kenalog 20 mg + Lidocaine 1% 8 ml injection into A1 pulley. A flu shot was offered; she declined.

09/21/21 – Dennis Yun, MD - LA Interventional – Operative Report, Page 15-16B

INDICATION: [Not indicated]

SURGEON: Dennis Yun, MD

ANESTHESIA: MAC

PRE/POST-OPERATIVE DIAGNOSIS: Ongoing lower back pain.

OPERATIONS: Bilateral L4-5 and L5-S1 facet blocks under fluoroscopic guidance.

FINDINGS: [Not indicated]

11/16/21 – Dennis Yun, MD – Pain Management Final Evaluation, Page 17-19B

DOI: 06/04/21

PRESENT COMPLAINT: The patient reports no pain in the neck and low back.

OBJECTIVE FINDINGS: WNL

DIAGNOSES: 1) Lumbar myofascial pain syndrome, resolved. 2) Ongoing/persistent lower back pain, resolved.

APPORTIONMENT/CAUSATION: 100% caused by the accident on 06/04/21.

DISCUSSION/TREATMENT PLAN: Recommend a core strengthening program in order to reduce pain and/or spasm as well as improve flexibility. The patient will follow-up an as-needed basis if pain persists.

11/29/21 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 346-352/727-732.

SUBJECTIVE COMPLAINTS: The patient was present today for a follow-up visit to manage her multiple chronic conditions, including hypertension, prediabetes, hyperlipidemia, and chronic kidney disease. She reported that she stopped smoking about one month ago. The patient is requesting a referral to ENT, noting that she was given a referral in the past in March but did not schedule an appointment and that the referral has since expired. She stated that she is compliant with her current medication.

ASSESSMENT: Essential hypertension. Mixed hyperlipidemia. Osteopenia of the lumbar spine. Prediabetes. Vitamin D deficiency. Throat discomfort. COVID-19 vaccination.

TREATMENT: Labs ordered. Continue lifestyle changes. Vitamin D 1000 IU daily./ ENT referral.

12/14/21 – Kasra Rowshan, MD – SOAP Note, Page 79-80B

DOI: 06/03/21

HPI: This is a 66 yrs individual who was involved in an accident. Date of the accident was 06/03/21. The

patient was involved in a car accident where a truck backed into her car. As the days progressed after the accident, the patient began to experience pain in the low back to the bilateral sides and legs. The patient sought medical attention through therapy, which

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 47 of 84

provided minimal help. Patient also had multiple injections in the low back, which provided help for a short term. Since the patient symptoms have not improved, an Orthopaedic consultation has been obtained.

CURRENT COMPLAINTS: The patient currently complains of pain in the low back to the bilateral sides and legs. Activities makes the pain worse. The pain level is 2/10 at its best and 4/10 at its worst. Conservative management has been tried with physical therapy, injections, NSAIDS, and physician monitored activity modification but pains and symptoms have not improved.

WORK STATUS: Retired.

VITAL SIGNS: BP 131/64. Height 162.56 cm. Weight 83.46 kg. BMI 31.58 kg/m².

OBJECTIVE FINDINGS: Lumbar Spine: Patient has pain in the lumbar spine, both midline and paraspinal areas. Minimal pain over the SI joints. Range of motion is limited secondary to pain in lower back.

DIAGNOSIS: Vertebrogenic low back pain.

PLAN: Patient will think about it. If this treatment failed, they will consider a spinal cord stimulator. L4/5 and L5/S1 RFA is recommended.

CAUSATION: Based on the mechanism of injury and denial of previous injury, with high medical probability, the accident is the cause of the injury and symptoms.

12/29/21 – Kasra Rowshan, MD – SOAP Note, Page 77-78B

CC: 2 week follow-up.

SUBJECTIVE: Patient desires further care. The patient complains of lower back pain. The pain is localized to the back, with radiation to the sides. Pain with motion of the lower back, with forward flexion and extension. Pain with twisting as well. There is pain associated with daily living and other activities. Prolonged standing or sitting causes pain. Pain is debilitating. Patient also complains of some right leg numbness. Pain level is 6-7/10 today.

ASSESSMENT: Vertebrogenic low back pain.

PLAN: Patient requires further care. Patient would prefer to move forward with spinal cord stimulator. Spinal Cord Stimulator Surgery is recommended. Patient has had symptoms for over 6 months now. Conservative management with NSAIDs and other oral medications, formal PT, activity modifications (physician guided), holistic medicine and injections have all failed. Patient continues to have pain and symptoms that interferes with daily activities and work. Risks and benefits explained. Alternatives explained. Patient asked appropriate questions and understands the surgery. Patient desires to pursue surgery. Risks include, but not limited to, bleeding, infection injury to nerves, arteries, veins, ligaments, bones and other underlying structures. Dual tear which may result in a spinal leak requiring reoperation or a lumbar drain was discussed. Failure of fusion resulting in persistent pain requiring reoperation either anteriorly or posteriorly, failure of instrumentation, possibly requiring reoperation and removal, displacement of the bone graft resulting in recurrent symptoms, wound infection or wound hematoma resulting in reoperation to debride the wound as well as prolonged intravenous antibiotics and/or removal of hardware, nerve root injury resulting in temporary or permanent loss of nerve function causing pain, numbness, and weakness, paralysis resulting in loss of all lower extremity function as well as loss of bowel and

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 48 of 84

bladder function, persistent pain or even increased pain following surgery, injury to surrounding structures including blood vessels, esophagus, and trachea, scar formation around the nerves resulting in persistent or increased pain, injury to recurrent laryngeal nerve resulting in hoarseness, difficulty swallowing and soft tissue swelling resulting in difficulty breathing with possible tracheotomy, injury to the sympathetic nerves resulting in Horner's syndrome (drooping eyelid and dryness), degeneration of an adjacent disk level requiring further surgery in the future, complications secondary to bone graft harvesting including infection, hematoma, nerve injury, persistent pain, or bone fracture, blood loss requiring transfusion, pneumonia, nerve injury and the risks, DVT, PE, stroke, and other life threatening events, or even death may occur. Patient understand and would like to continue. Patient is at risk for DVT. There are contraindication for pharma medications and there is a high bleeding risk. This type of surgery and associated risk factors places this patient at high risk.

01/07/22 – Steve Aziz, M.D. – Optum – Progress Note, Page 343-345.

SUBJECTIVE COMPLAINTS: The patient reported that the pain started 4 weeks ago. She described the pain as aching, rating it 8 out of 10, which worsens with walking and weight bearing. There is no radiation of the pain, and it improves with rest, with no swelling present. She also experiences intermittent numbness in the shin at times. The patient is taking Tramadol infrequently and noted that an injection helped during her last visit.

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Primary osteoarthritis of the right knee.

TREATMENT: Kenalog 80 mg and 2.5 ml Lidocaine 1% was then injected and the needle was withdrawn.

01/07/22 – Kasra Maasumi, MD – SOAP Note, Page 74B

SUBJECTIVE: The patient complains of lower back pain. the pain is localized to the back, with radiation to the sides. Pain with motion of the lower back, with forward flexion and extension. Pain with twisting as well. There is pain associated with daily living and other activities. Prolonged standing or sitting causes pain. Pain is debilitating.

VITAL SIGNS: Height 162.56 cm. Weight 81.19 kg. BMI 30.72. BP 142/70

OBJECTIVE FINDINGS: Pain is localized to the lower back, with limited motion. TTP over lumbar spine.

ASSESSMENT: All management options were discussed. All medical records (new and old), diagnostic tests, imaging and results were evaluated and analyzed. These were shared and discussed with the patient. Copies were given to the patient of all results. The risks and benefits of all treatment options explained. Alternatives reviewed.

TREATMENT PLAN: Recommended to perform a bilateral facet joint injection at L4/L5 level today.

01/07/22 – Kasra Maasumi, MD – Procedure Note, Page 75B/76B

CC: Low back pain.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 49 of 84

PROCEDURE: Bilateral facet joint injection at L4/L5. Dexamethasone 10 mg 1 cc with 1% lidocaine without epi was administered.

POST-OP PLAN: Patient will be weight bearing as tolerated. Dr. Maasume recommend the patient to rest today and begin normal activity tomorrow.

01/27/22 – Benjamin Rafii, M.D. – Beach Cities ENTS – Progress Note, Page 146-149.

SUBJECTIVE COMPLAINTS: She returned after 2 years for persistent right-sided globus sensation, which she reported had worsened since her last visit in November 2019. She mentioned that she had stopped smoking, but various stressors during the pandemic led her to resume smoking. However, she had cut down again and had only smoked two cigarettes in the last month. She denied any pain or tenderness in the area. She was counseled to stop smoking and successfully quit in November 2021 for 2 months, but she resumed smoking due to high-stress levels related to her granddaughter having COVID.

ASSESSMENT: Pain in Throat. Dysphonia. Chronic Laryngitis. Other Dysphagia. Chronic Sialoadenitis. Globus Sensations And Perceptions.

TREATMENT: Flexible Laryngoscopy with Stroboscopy and Medical Speech Evaluation. Smoking cessation was encouraged. Educated on optimal salivary gland care including adequate hydration, sialogogues, warm compresses, and massage.

01/28/22 – Kasraa Maasumi, MD – SOAP Note, Page 72-73B

CC: Low back pain.

SUBJECTIVE: Last visit on 01/07/22. She had bilateral L4L5 facet joint under XR. Today she reports that her back pain improved by 100% for 7 days and then slowly returned. She is currently on Tramadol 50 mg for pain control. P/S 5/10.

VITAL SIGNS: 157/89

OBJECTIVE FINDINGS: Pain is localized to the lower back, with limited motion. TTP over lumbar spine. Pain with forward flexion and extension. Extension of the back is more painful than flexion.

ASSESSMENT: Last visit on 1/7/22, she had bilateral L4L5 facet joint injection under XR. Today she reports that her back pain improved by 100% for days and then slowly returned. She is currently on Tramadol 50 mg for pain control. The diagnostic facet joint injection is a testimony to the fact that she has lumbar facet arthropathy which could be treated with radiofrequency ablation. This examiner explained to her how RFA works and how it could be beneficial to her. She stated she is tired of being injected and prefers to do the scs implantation. This examiner again explained to her that scs implantation is even more involved and that the RFA may be less invasive than scs implantation. However the latter is still an option. If she wishes to be least invasive, RFA would be the nextstep.

PLAN: Patient prefers to think about her choices of doing RFA vs scs implantation. This examiner provided information about RFA, gave the name of RFA to her to look it up and discuss it with her family and friends, giving her some time to think about it. This examiner offered to be available to her in case she has more questions by making another consultation appointment.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 50 of 84

02/01/22 – Tu Sang Om, M.D. – PMI Carson Primary Care – Progress Note, Page 335-342/674-681.

SUBJECTIVE COMPLAINTS: The patient was present today for a follow-up visit to manage her multiple chronic conditions, including hypertension, hyperlipidemia, and prediabetes. She received the COVID-19 Pfizer vaccine on 01/24/21 and 02/14/21, as well as a booster on 10/18/21. The patient stated that she is compliant with her current medication.

ASSESSMENT: Essential hypertension. Vitamin D deficiency. Prediabetes. Mixed hyperlipidemia. BMI 30.0-30.9, adult. Negative depression screening. Aortic atherosclerosis. COVID-19 vaccination.

TREATMENT: Vitamin D 1000 IU daily. Continue lifestyle changes. Continue current medications.

02/09/22 – Philip Simmons, D.O. – Optum – Progress Note, Page 332-334.

SUBJECTIVE COMPLAINTS: Her prediabetes slightly worsened. She has been eating more chocolate lately over the last couple of months. She felt okay overall.

ASSESSMENT: Prediabetes. Hypertension. Neuropathy due to a medical condition. PAD (peripheral artery disease). Smokers' cough.

TREATMENT: Continue meds. Monitor salt intake. Chantix.

02/11/22 – Ian Dworkin, MD – SOAP Note, Page 69-71B

CC: Back pain.

MOI: Date of Accident: 06/03/21. Patient was in a MVA head on collision from a ruck backing into her. Police were on scene but went the following day to start therapy. This did not result in significant relief. She then received injections from a pain provider without relief, and then saw Dr. Rowshan who recommended RFA. She then saw Dr. Maasumi who repeated facet blocks without relief.

SUBJECTIVE: The patient presents for low back pain. Pain Description: Location of Pain – Midline low back L5-S1 interspinous ligament. Pain is described as sharp and aching. P/S 7/10. Exacerbated by laying down and prolonged standing. Alleviated by rest. Pain prevents patient from ADLs, sleeping, standing and exercise. Treatments Tried: Home exercises – Has tried 6 weeks of home exercise within the past 3 months. Physical/Occupational – As above. Chiropractor – As above. Medications – Tylenol and tramadol as needed. Injections/Procedures: As above [As stated in the report].

WORK STATUS: Retired.

PAST MEDICAL HISTORY: Hypertension. Hyperlipidemia.

PAST SURGICAL HISTORY: Left TKA. Left wrist surgery. Breast surgery. Hysterectomy.

MEDICATIONS: Atorvastatin. Aspirin. Chandix. Nifedipine.

ROS: Extremities: Joint pain.

VITAL SIGNS: BP 135/66.

OBJECTIVE FINDINGS: Low Back: Tenderness diffusely throughout bilateral lumbar paraspinals and bilateral SI ligaments. ROM: 90 degrees Flexion, <10 degrees Extension, <45 degrees Lateral rotation limited by pain. +Pain with forward flexion >

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 51 of 84

than pain with extension. Facet Load: Positive bilaterally. FABER: Positive bilaterally. Gaenslens: Positive bilaterally. Thigh Thrust: Positive bilaterally.

DIAGNOSES: Other intervertebral disc displacement, lumbar region.

PLAN: Therapy: Recommend PT, patient defers as she feels she has maximized therapy. Imaging: MRI L spine reviewed with patient. Consultations: Consider surgical referral in future pending the results of conservative care. Medications: Defers RX at this time. Interventions: Patient has not benefitted from two series of facet injections and therefore, RFA is uncertain to provide relief. After review of MRI demonstrating multiple disk herniations and nerve impingement, Dr. Dworkin recommend bilateral L5-S1 TFESI for discogenic pain. Patient defers at this time. They also reviewed lumbar spine SCS. This examiner recommend ESI targeting neuropathic pain prior to consideration of SCS for axial low back pain as the lesser invasive option since patient is ambivalent about additional procedures. Patient prefers to consider these options and discuss at follow up. Education: The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. Follow up: 1 month to review the above procedures.

CAUSATION: Based on the mechanism of injury and denial of previous injury, with high medical probability, the accident is the cause of the injury and symptoms.

03/04/22 – Ian Dworkin, MD – SOAP Note, Page 65-68B

CC: 1 month follow-up.

SUBJECTIVE: The patient presents for re-evaluation of low back pain. Last visit lumbar ESI vs. SCS was

discussed but patient preferred to think about these options. Today, the patient reports ongoing low back pain. She is was considering additional options but prefers to move forward with SCS for axial back pain with hopes of achieving long term relief without the need for spine surgery. She is not interested in ESI at this time as she feels she has tried multiple interventions that have helped but not provided ongoing relief. Location of Pain – Midline low back L5-S1 interspinous ligament. Pain is described as sharp and aching. P/S 7/10. Exacerbated by laying down and prolonged standing. Alleviated by rest. Pain prevents patient from ADLs, sleeping, standing and exercise.

ROS: Extremities – Joint pain.

VITAL SIGNS: BP127/62.

OBJECTIVE FINDINGS: Low Back: Tenderness diffusely throughout bilateral lumbar paraspinals and bilateral SI ligaments. ROM: 90 degrees flexion; < 10 degrees extension; < 45 degrees lateral rotation limited by pain. Pain with forward flexion > than pain with extension. Facet Load: Positive bilaterally. FABER: Positive bilaterally. Gaenslens: Positive bilaterally. Thigh Thrust: Positive bilaterally.

ASSESSMENT: [Not indicated]

TREATMENT PLAN: Therapy: Continue therapy and home exercise program as previously prescribed. Imaging: MRI images reviewed including findings, diagnosis, and recommendations. Consultations: Consider surgical evaluation if pain persists despite conservative care. Medications: Continue current regimen. Interventions: Proceed with SCS trial. Patient prefers Nalu system due to small IPG. Spinal Cord Stimulator Trial/

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 52 of 84

Implant: The goal of this therapy is to treat the patient's low back pain that has been unresponsive to multiple trials of therapy, medications including NSAIDs, muscle relaxers, neuropathic medications, antidepressants and opioids, interventional procedures including ESIs. SCS has proven to be more effective at treating neuropathic pain than repeat spine surgery (North et. al 2005) and when compared to medical management (Kumar et al 2008). Procedure discussed in detail with patient who expressed understanding of the conversation. Dr. Dworkin have discussed risks, benefits and alternatives to the procedure. Risks include but are not limited to use of fluoroscopy/x-ray and associated radiation, discomfort, infection, bleeding, stroke, coma, death, damage to surrounding structures, including damage to nerve or spinal cord which may result in paralysis or nerve injury, and vessels that carry blood to and from the brain, adverse reaction to injected numbing medication, and/or X-ray dye. Additional risks include possibility of infection, lead migration, lead fracture, lead malformation, CSF leak, possible need for future procedures including lead or battery (IPG) repositioning, battery replacement, injections or surgery. This examiner also discussed the risks and benefits of sedation vs. local anesthesia and their associated risks, namely that anesthesia may cause restlessness, slurred speech, breathing problems, or low blood pressure, and advised patient against eating or drinking 6 hours before procedure if receiving sedation, to have a driver to take them home if receiving sedation, and to hold all anticoagulant medication including NSAIDs per ASRA guidelines. Patient expressed understanding of this discussion and due elected to proceed because of their debilitating pain. SCS has also demonstrated relief in axial low back pain in non surgical back patients (Al-Kaisy, 2017) and therefore, Dr. Dworkin recommend a trial to evaluate for improvement in pain control and increase in daily functioning. Education: The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. Follow up: for SCS trial.

04/07/22 – Ian Dworkin, MD – Sun Surgery Center – Operative Report, Page 9-10B/11-12B

INDICATION: History of low back pain radiating down her spine refractory to conservative options.

SURGERY: Ian Dworkin, MD

ANESTHESIA: Monitored anesthetic care with fentanyl and Versed.

PRE/POST-OPERATIVE DIAGNOSES: 1) Lumbar disc herniation. 2) Low back pain, vertebrogenic.

OPERATIONS: 1) Percutaneous placement of dorsal column spinal cord stimulator lead with Nalu. 2) Percutaneous placement of second dorsal columb spinal cord stimulator lead with Nalu. 3) Fluoroscopic guidance. 4) Conscious sedation performed by surgeon.

FINDINGS: Adequate post-operative stimulation with patient feedback of painful areas covered.

04/08/22 – Steve Aziz, M.D. – Optum – Progress Note, Page 317-319.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 53 of 84

SUBJECTIVE COMPLAINTS: The patient described the pain as aching, rating it 6 out of 10. The pain worsens with walking and weight bearing, with no radiation noted, and it improves with rest. There is no swelling present. She is taking Tramadol, which helps alleviate the pain, and she reports that injections continue to provide relief. Additionally, she recently had a pain stimulator placed in her spine.

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Primary osteoarthritis of the right knee.

TREATMENT: Kenalog 60 mg and 2.5 ml Lidocaine 1% was then injected and the needle was withdrawn.

04/15/22 – Ian Dworkin, MD – SOAP Note, Page 63-64B

CC: 1 week follow-up.

SUBJECTIVE: The patient presents for re-evaluation of low back pain. Last visit SCS trial was completed. Today, the patient reports that she had complete pain relief (100%) in her chronic low back pain. She required one tab of pain medication for post operative pain and then had no pain the remainder of the trial. She reports improvement in functional mobility and walking tolerance and endurance, and would like to proceed to implantation as soon as possible. **Pain Description:** Location of Pain – Midline low back L5-S1 interspinous ligament. Pain is described as sharp and aching. P/S 0-1/10. Exacerbated by laying down and prolonged standing. Alleviated by rest. Pain prevents patient from ADLs, sleeping, standing and exercise.

ROS: Extremities – Joint pain.

VITAL SIGNS: BP 146/80.

OBJECTIVE FINDINGS: Needle sites C/D/I. Leads removed without issue.

ASSESSMENT: [Not indicated]

PLAN: They will benefit from the following treatment plan: **Therapy:** Continue home exercise program as previously prescribed. **Consultations:** Recommend medical clearance with Dr. Setareh. **Medications:** Continue current regimen. **Interventions:** Recommend proceeding with Implantation of bilateral Nalu percutaneous dorsal column spinal cord stimulator leads and implantation of internal pulse generator with MAC sedation given complete relief to SCS trial with coverage of all painful areas in the low back. **Education:** The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. **Follow up:** for SCS implantation following medical clearance.

06/28/22 – Ian Dworkin, MD – SOAP Note, Page 61-62B

CC: 1st post op.

SUBJECTIVE: The patient presents for re-evaluation of low back pain. Last visit SCS implantation was completed. Today, the patient reports that her procedure pain is minimal and she notes improvement in her baseline back pain. She has minimal incisional discomfort and minimal pain at IPG site.

ROS:

VITAL SIGNS: BP 128/59.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 54 of 84

OBJECTIVE FINDINGS: Midline incision C/D/I. ROM deferred to minimize lead migration.

ASSESSMENT: [Not indicated]

PLAN: Therapy: Continue home exercise program as previously prescribed.

Medications: Continue current regimen. Interventions: SCS programming completed today. Education: The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. Follow up: 1 month to evaluate programming efficacy.

07/29/22 – Ian Dworkin, MD – SOAP Note, Page 59-60B

CC: 1 month follow-up.

SUBJECTIVE: The patient presents for re-evaluation of low back pain. Last visit SCS programming was

started. Today, the patient reports she has been doing well but not getting as much relief in her low back as expected with additional programming. The initial relief she received after the implantation has not been steadily proving. Pain worse while sleeping on back at night.

ROS: Extremities: Joint pain.

OBJECTIVE FINDINGS: Midline incision C/D/I. ROM deferred to minimize lead migration.

ASSESSMENT: [Not indicated]

PLAN: Therapy: Continue home exercise program as previously prescribed. Imaging: XR T spine to eval lead placement. Appear to be in adequate position for axial back. Will discuss additional programming with reps. Consultations: Consider surgical evaluation if pain persists despite conservative care. Medications: Continue current regimen, baclofen RX for night time back spasm. Interventions: SCS programming with reps. Education: The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. Follow up: 3 weeks to eval programming. If patient continues to receive no relief despite re-programming, she will require lead revision surgery.

08/08/22 – Steve Aziz, M.D. – Optum – Progress Note, Page 313-314.

SUBJECTIVE COMPLAINTS: Here for knee pain. The patient complained of moderate pain that worsened with walking and weight bearing. She reported no swelling and noted that injections helped alleviate the pain.

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Primary osteoarthritis of the right knee.

TREATMENT: Kenalog 60 mg and 1.5 ml Lidocaine 1% was then injected and the needle was withdrawn.

08/10/22 – Philip Simmons, D.O. – Optum – Progress Note, Page 310-311.

SUBJECTIVE COMPLAINTS: The patient complained of finger pain in her left ring finger, which had a duration of two days. She reported that the finger was getting stuck

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 55 of 84

in a flexed position but noted that it was doing better today. Additionally, she mentioned that she had received a corticosteroid injection in her right shoulder from a worker's compensation doctor on 08/08/2022.

ASSESSMENT: Finger pain.

TREATMENT: Diclofenac sodium 1% external gel.

08/19/22 – Ian Dworkin, MD – SOAP Note, Page 57-58B

CC: 3 week follow-up.

SUBJECTIVE: The patient presents for re-evaluation of low back pain. Last visit SCS programming was completed. Today, the patient reports that since the latest programming, she has seen a significant improvement in her low back pain. She is now reporting 60-70% pain relief in her low back. She has not started exercising yet but her ADLs and functional mobility have greatly improved.

ROS: Extremities – Joint pain.

VITAL SIGNS: Height 162.56 cm. Weight 80.29 kg. BMI 30.38 kg/m². BP 151/70 kg/m².

OBJECTIVE FINDINGS: Incisions C/D/I. Power disc in place right flank over IPG with good adhesion. ROM deferred to ensure no lead migration.

ASSESSMENT: [Not indicated]

PLAN: Therapy: Recommend starting light aerobic exercise, avoid bending/lifting/ twisting as much as she is able to avoid lead migration. Medications: Continue current regimen. Interventions: SCS programming as needed if progress plateaus. Nalu to reach out to patient to assist with setting up programming app on her phone. Education: The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. Follow up: 1 month to evaluate stim efficacy and consider additional programming PRN.

09/13/22 – Jason Ho, M.D. – PMI Carson Urgent Care – Progress Note, Page 649-652.

SUBJECTIVE COMPLAINTS: Presented with fourth finger stiffness and pain for the past 1 month with moderate severity.

OBJECTIVE FINDINGS: BP: 150/76. Left hand with slight swelling tenderness to dorsal aspect fourth MCP joint along flexor tendon. Limited flexion.

ASSESSMENT: Trigger finger, left ring finger.

TREATMENT: The area was cleansed, and 40 mg of Kenalog and 1 cc of 1% lidocaine were injected along the tendon sheath. Ice, rest, limited activity as tolerated, NSAID as needed.

09/16/22 – Ian Dworkin, MD – SOAP Note, Page 55-56B

CC: Follow-up.

SUBJECTIVE: The patient presents for re-evaluation of low back pain. Last visit SCS programming was completed. Today, the patient reports 100% pain relief in her low back. She has been more active, gradually walking further on a treadmill and is up from 5 minutes to 15

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 56 of 84

minutes at a time without pain flares. She gets relief with the device throughout the day and has no issues sleeping at night. She has not required pain medication for her back since last visit.

ROS: Extremities: Joint pain.

VITAL SIGNS: Height 162.56 cm. Weight 80.29 kg. BMI 30.38 kg/m². BP 142/67.

OBJECTIVE FINDINGS: WNL.

ASSESSMENT: [Not indicated]

TREATMENT PLAN: - Therapy: Continue to home exercise program and progress to baseline activities as tolerated. Medications: Continue current regimen. Interventions: SCS programming PRN. Education: The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. Follow up: as needed.

09/27/22 – Philip Simmons, D.O. – Optum – Progress Note, Page 305-309.

SUBJECTIVE COMPLAINTS: Here for a routine physical examination.

ASSESSMENT: Encounter for preventive health examination. Allergic rhinitis.

TREATMENT: Fluticasone propionate 50 mcg nasal spray. Colonoscopy referral.

12/08/22 – Steve Aziz, M.D. – Optum – Progress Note, Page 300-302.

SUBJECTIVE COMPLAINTS: The patient described the pain as aching, rating it 9 out of 10. The pain worsened with walking and weight bearing, with no radiation noted, and it improved with rest. There was no swelling present. She reported that injections still helped alleviate the pain and mentioned that she was seeing an orthopedic specialist next week.

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Primary osteoarthritis of the right knee. History of knee replacement procedure of left knee.

TREATMENT: Left knee x-ray. Kenalog 80 mg and 1.5 ml Lidocaine 1% was then injected and the needle was withdrawn.

01/24/23 – Philip Simmons, D.O. – Optum – Progress Note, Page 294-296.

SUBJECTIVE COMPLAINTS: The patient was waiting for a knee replacement and reported having toe damage. She mentioned that she had been experiencing throat pain, which had persisted. She started smoking again two months ago but stopped again yesterday. The patient expressed a desire to see an ENT specialist for her throat pain.

ASSESSMENT: Toe pain. Smokers' cough. PAD (peripheral artery disease). Neuropathy due to a medical condition. Prediabetes.

TREATMENT: Varencline tartrate 1 mg daily. ENT referral. Podiatry referral.

01/31/23 – Alexander Perez, D.P.M. – West Torrance Podiatrists Group, Inc. – Progress Note, Page 121-122.

SUBJECTIVE COMPLAINTS: The patient was here for discoloration of her left great toenail. She stated that she first noticed the discoloration changes to the great toenail approximately 2 months ago and was unaware of any inciting trauma or event. The

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 57 of 84

patient mentioned that she attempted over-the-counter antifungal medication but noted continued worsening of the toe discoloration changes. She denied any itching of the feet and reported no other complaints at this time.

OBJECTIVE FINDINGS: Mild hallux limitus deformity was noted with weight-bearing, along with mild plantar metatarsal fat pad atrophy bilaterally.

ASSESSMENT: Nail dystrophy.

TREATMENT: Ciclopirox 8% nail lacquer. Fungal culture.

03/07/23 – Philip Simmons, D.O. – Optum – Telephone Visit, Page 292.

SUBJECTIVE COMPLAINTS: The patient tested positive for COVID-19 on 02/28/2023. She has been feeling rather fatigued but reports no shortness of breath. She is experiencing a cough with mucus production and is currently using Tylenol for symptom relief. The patient has noted an altered taste and has lost some weight as a result of this.

ASSESSMENT: COVID-19.

TREATMENT: Monitor for resolution.

03/13/23 – Nathan Eivaz, M.D. – Beach Cities ENTS – Progress Note, Page 150-153.

SUBJECTIVE COMPLAINTS: The patient returned after 14 months for recurrent throat pain. She reported that she had just recovered from COVID-19, which lasted from the end of February until March 7th. She denied experiencing pain today and also denied odynophagia, dysphagia, bleeding from the nose or mouth, voice changes, fever, chills, nausea, vomiting, and weight loss. The patient mentioned that she had stopped smoking but resumed during the pandemic; however, she stopped again in mid-January and started taking Chantix. She is not currently smoking. She reported experiencing postnasal drip but denied any drainage to blow from her nose. The patient has a history of acid reflux and takes Prilosec as needed. She also uses Flonase as needed.

ASSESSMENT: Pain In Throat. Dysphonia. Chronic Laryngitis. Other Dysphagia. Chronic Sialoadenitis. Globus Sensations And Perceptions. GERD.

TREATMENT: Flexible nasolaryngoscopy was performed. Omeprazole 40 mg nightly. Continue smoking cessation.

04/05/23 – Philip Simmons, D.O. – Optum – Progress Note, Page 289-290.

SUBJECTIVE COMPLAINTS: She was feeling well overall and denied complaints.

ASSESSMENT: Hypertension. Neuropathy due to a medical condition. PAD (peripheral artery disease). Smokers' cough. Prediabetes.

TREATMENT: Monitor diet.

04/10/23 – Steve Aziz, M.D. – Optum – Progress Note, Page 287-288.

SUBJECTIVE COMPLAINTS: The patient reported still experiencing some knee pain, describing it as aching and rating it 6 out of 10. The pain worsened with walking and weight bearing, with no radiation noted, and it improved with rest. There was no swelling present. The patient is planning to undergo a right total knee replacement (TKR) next month.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 58 of 84

OBJECTIVE FINDINGS: Right knee crepitus noted.

ASSESSMENT: Primary osteoarthritis of the right knee.

TREATMENT: Exercise as tolerated. Pending TKR next month. Uses CBD oil. Intermittent Tramadol. (Norco causes a jittery sensation).

04/24/23 – Nathan Eivaz, M.D. – Beach Cities ENTS – Progress Note, Page 154-157.

SUBJECTIVE COMPLAINTS: The patient presented for a follow-up on her throat pain. She had quit smoking but mentioned that last week she smoked twice. Overall, she feels well, and her throat is not hurting. She has been taking omeprazole every morning before breakfast. The patient continues to eat a lot of spicy food at night and notices reflux in the evening after she lays down. She denied any neck pain or sialadenitis and reported that she has been drinking more water.

ASSESSMENT: Pain in Throat. Dysphonia. Chronic Laryngitis. Other Dysphagia. Chronic Sialoadenitis. Globus Sensations And Perceptions. GERD.

TREATMENT: Flexible laryngoscopy was performed. Gastroenterology referral. Pepcid. Continue PPI every morning.

04/26/23 – Philip Simmons, D.O. – Optum – Progress Note, Page 283-286.

SUBJECTIVE COMPLAINTS: Presented for a pre-operative examination for a scheduled right total knee arthroplasty.

ASSESSMENT: Preop examination. Primary osteoarthritis of the right knee. PAD (peripheral artery disease). Smokers' cough. Neuropathy due to a medical condition. Prediabetes.

TREATMENT: Labs ordered. ECG. Chest x-ray. She was optimized for the procedure.

05/24/23 – Kurt Vo, P.T. – Optum – Physical Therapy Initial Evaluation, Page 278-280.

SUBJECTIVE COMPLAINTS: The patient presented with right knee pain status post knee replacement surgery on 05/22/23, performed by Dr. William Chul Kim. She had staples in the incision and was scheduled for a follow-up with Dr. Kim on 06/06/23 to have the staples removed. The patient complained of right knee pain, rating it at 8 out of 10, and 20 out of 10 with walking. The pain was aggravated by weight bearing, walking, and standing.

OBJECTIVE FINDINGS: Gait: The patient was ambulating using a front-wheeled walker (FWW). Knee Girth: Right knee measured 45.50 cm, left knee measured 40.50 cm. Accurate assessment was unable to be performed due to postoperative bandages.

Range of Motion (ROM): Knee Flexion: Right knee 55 degrees, left knee 100 degrees.

Knee Extension: Right knee -19 degrees, left knee 0 degrees. Strength: Assessment was deferred due to high irritability. There was poor volitional quadriceps setting, although it improved with repetitions.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided home exercise program and ice packs.

05/31/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 272-273.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 59 of 84

SUBJECTIVE COMPLAINTS: The patient reported that her knee was still very painful. She had been taking pain medications, but they made her feel sick.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

06/02/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 270-271.

SUBJECTIVE COMPLAINTS: The patient reported that her knee was still very painful. She had been taking pain medications, but they made her feel sick.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

06/06/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 268-269.

SUBJECTIVE COMPLAINTS: The patient reported that she experienced less pain this week.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

06/08/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 266-267.

SUBJECTIVE COMPLAINTS: The patient stated that she did her peddler exercise at home for a few minutes. She mentioned that the pain medications still make her feel sick, so she is only taking Tylenol.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

06/13/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 264-265.

SUBJECTIVE COMPLAINTS: The patient reported feeling much better now and is walking around the house with a cane.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

06/15/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 262-263.

SUBJECTIVE COMPLAINTS: The patient reported doing well with straight leg raises (SPC) and is actively stretching the knee to achieve full extension.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

06/19/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 260-261.

SUBJECTIVE COMPLAINTS: The patient reported doing well with straight leg raises (SPC) and is stretching the knee to achieve full extension.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

06/20/23 – Philip Simmons, D.O. – Optum – Progress Note, Page 258-259.

SUBJECTIVE COMPLAINTS: The patient recently underwent a total knee replacement with Dr. Kim and is currently attending physical therapy for rehabilitation. She reported

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 60 of 84

experiencing intermittent chills, which occur when sitting at home, but noted that they are improving and happening less frequently. The chills come and go within seconds, and she has not experienced any fevers. For pain control, the patient is currently using tramadol but did not do well with oxycodone and tramadol, as they caused her a lot of anxiety. She was now using extra-strength Tylenol for pain management.

OBJECTIVE FINDINGS: BP: 158/61.

ASSESSMENT: Hypertension.

TREATMENT: Nifedipine 60 mg daily.

06/21/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 256-257.

SUBJECTIVE COMPLAINTS: The patient reported that her knee is feeling better and that she has greater ease with walking. She mentioned that while her knee feels sore, it is manageable. The patient has not yet started walking one block daily but is motivated to begin. She reported using the peddler twice a day for 10-minute sessions and is open to increasing the duration from 10 minutes to 15 minutes.

OBJECTIVE FINDINGS: Knee Active Range of Motion (AROM): -6 to 100 degrees. Knee Passive Range of Motion (PROM): -5 to 112 degrees, with greater ease noted during tibial anterior-posterior (AP) glides, achieving up to 115 degrees.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

06/27/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 254-255.

SUBJECTIVE COMPLAINTS: The patient reported that her knee feels sore but not painful. She is performing her home exercise program (HEP) twice a day.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

06/29/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 252-253.

SUBJECTIVE COMPLAINTS: The patient reported that her knee feels sore but not painful. She is performing her home exercise program (HEP) twice a day.

OBJECTIVE FINDINGS: Knee AROM: 5-118.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

07/06/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 249-251.

SUBJECTIVE COMPLAINTS: The patient reported that she hurt her back over the weekend and is unsure what she did. She mentioned that it could be that her back stimulator needs to be checked.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

07/11/23 – Ian Dworkin, MD – SOAP Note, Page 53-54B

CC: Follow-up. Pain returned.

SUBJECTIVE: The patient presents for re-evaluation of back pain. Last visit patient was doing well with

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 61 of 84

Stimulator Today, the patient reports that she had been doing very well with her device until about two weeks ago after a lot of activity,

standing and walking. She noticed progressive return in her low back pain, though pain appears to be lower than previously reported. Pain remains axial but is affecting her ambulation causing her to return to using the SPC. She has not discussed this with the Nalu representatives yet or made programming changes. She has not been using the device since the flare. Pain is 8/10 today but usually in 0-2/10 with device use until recent flare.

ROS: Extremities: Joint pain.

VITAL SIGNS: BP 136/74. Height 162.56 cm. Weight 80.29 kg. BMI 30.38 kg/m².

OBJECTIVE FINDINGS: Ambulation with SPC, antalgic gait. Lead site, incision sites C/D/I. Flex 45 degrees limited by pain; ext < 10 degrees limited by pain. + FABER. + GAENSLENS. TTP bilateral PSIS.

ASSESSMENT: Joint disorder, unspecified.

PLAN: Therapy: Continue therapy and home exercise program as previously prescribed. Imaging: XR T spine today to check lead placement. Medications: Continue current regimen. Interventions: Consider bilateral SI ligament injection in office if pain continues despite programming. Patient defers to programming first. Education: The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. Emphasized importance of adjusting programming during flares to help with pain instead of turning device off. Also emphasized importance of good communication with Nalu reps to ensure programming can be completed whenever needed. Follow up: for SCS programming upon coordination with stim rep.

07/11/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 246-248.

SUBJECTIVE COMPLAINTS: The patient saw the doctor about her back and has an appointment to have her back unit adjusted this Friday. She has been doing light leg exercises.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

07/13/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 243-245.

SUBJECTIVE COMPLAINTS: The patient is scheduled to see the doctor about her back stimulator tomorrow. She reported that her knee is doing well, although she is still experiencing numbness on the side of the knee.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

07/14/23 – Ian Dworkin, MD – SOAP Note, Page 51-52B

CC: Follow-up

SUBJECTIVE: The patient presents for re-evaluation of low back pain. Last visit SCS reprogramming was discussed and scheduled with rep present. Today, the patient

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 62 of 84

reports ongoing low back pain with re-trying the device after removing it since her pain progressed several days ago. Pain is 4-6/10 and radiates to her buttocks.

VITAL SIGNS: Height 162.56 cm. Weight 80.29 kg. BMI 30.38 kg/m². BP 140/60.

ROS: Extremities: Joint pain.

OBJECTIVE FINDINGS: Ambulation with SPC, antalgic gate. Lead site, incision sites C/D/I. Flex 45 degrees limited by pain, ext < 10 degrees limited by pain. + FABER. + GAENSLENS. TTP bilateral. PSIS.

ASSESSMENT: [Not indicated]

PLAN: Therapy: Continue home exercise program progress to baseline activities and exercises as tolerated. Medications: Continue current regimen. Interventions: Pain progression likely due to outdated programming as no recent programming has been provided since last September. Additional programming provided today with software update as well. Patient getting good paresthesia based coverage and device connectivity. Education: The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. Follow up: 1 month to evaluate programming efficacy

07/17/23 – Kenneth Holt, M.D. – Endoscopy Center at Skypark – Physical Therapy Note, Page 238-240.

PROCEDURE PERFORMED: Colonoscopy.

INDICATION: Weight loss.

IMPRESSION: Normal esophagus. Normal mucosa in the second part of the duodenum. (Biopsy). Hiatal Hernia.

COMPLICATIONS: None.

07/18/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 236-237.

SUBJECTIVE COMPLAINTS: The doctor checked the back stimulator, and it was functioning properly. However, the patient is still experiencing a dull ache in her back, which worsens with movement. She reported that her knee is doing well and is doing an easy home exercise program (HEP) that is manageable with her back condition.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

07/19/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 234-235.

SUBJECTIVE COMPLAINTS:

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

07/25/23 – Nathan Eivaz, M.D. – Beach Cities ENTS – Progress Note, Page 158-161.

SUBJECTIVE COMPLAINTS: The patient has been doing well over the last few months. She has not smoked in the past three months, and her throat pain has resolved. She underwent an EGD with GI, and everything looked normal. The patient denies experiencing dysphagia, odynophagia, voice changes, fevers, chills, or bleeding from

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 63 of 84

the nose or mouth. However, she has lost 4 pounds in the past couple of weeks, and a CT scan of her stomach has been ordered due to her unexplained weight loss.

ASSESSMENT: Pain In Throat. Dysphonia. Chronic Laryngitis. Other Dysphagia. Chronic Sialoadenitis. Globus Sensations And Perceptions. GERD.

TREATMENT: Follow-up as needed. Throat pain resolved with smoking cessation.

07/27/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 230-231.

SUBJECTIVE COMPLAINTS: The patient has been experiencing back pain for about one month and has a history of back problems stemming from a motor vehicle accident (MVA) two years ago. She has an implanted spinal cord stimulator. The patient reported that she hasn't been doing her exercises as much due to her back pain, but she does not report any significant increase in back pain from her knee exercises. She noted that the posterior knee tightness remains about the same. When using stairs, she is able to go up using a reciprocal pattern but comes down one step at a time and has not yet tried the reciprocal pattern for descending.

OBJECTIVE FINDINGS: Knee AROM: 2-120. L knee posterior knee pain with knee flexion OP.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

07/28/23 – Ian Dworkin, MD – SOAP Note, Page 47-50B

SUBJECTIVE: The patient presents for re-evaluation of low back pain. Last visit SCS reprogramming was continued. Today, the patient reports that she got some relief with reprogram, but her low back pain has been progressing recently causing her to return to use of cane. She has trouble with mobility and ADLs with this pain which she rates at 8/10.

ROS: Extremities: Joint pain.

OBJECTIVE FINDINGS: Low Back: TTP bilateral SI ligament/PSIS. FABER: Positive bilaterally. Gaenslens: Positive bilaterally. Thigh Thrust: Positive bilaterally.

ASSESSMENT: Sacrococcygeal disorders, not elsewhere classified.

PROCEDURE: Sacroiliac Ligament Corticosteroid Injection. 40 mg Kenalog and Lidocaine 1% 3.0 cc were administered.

PLAN: Therapy: Continue therapy and home exercise program as previously prescribed. Medications: Continue current regimen. Interventions: Bilateral sacroiliac ligament steroid injection completed today. See note below. SCS programming also completed. Programming with PSP moved down lower on lead. Patient previously preferred more tonic therapy. Education: The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. Follow up: 2 week post injection follow up.

08/01/23 – Steve Aziz, M.D. – Optum – Progress Note, Page 221-222.

SUBJECTIVE COMPLAINTS: Since the last visit, the patient underwent a right total knee replacement (TKR) and is doing well. She experienced some side effects from

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 64 of 84

hydrocodone but is currently taking Tylenol, which has been helpful for pain management. The patient is also participating in physical therapy (PT).

OBJECTIVE FINDINGS: Full ROM. Surgical scar clean and healed.

ASSESSMENT: History of knee replacement.

TREATMENT: Continue PT. Tylenol 1000 mg thrice daily as needed.

08/03/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 218-219.

SUBJECTIVE COMPLAINTS: The patient reported that her back was 85% better after the injection. She stated that her right knee felt good, except for some tightness in the back of the knee.

OBJECTIVE FINDINGS: Knee AROM: 2-118.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises and cold packs.

08/04/23 – Philip Simmons, D.O. – Optum – Progress Note, Page 215-217.

SUBJECTIVE COMPLAINTS: The patient had been experiencing unintentional weight loss. A CT scan of the abdomen was done at Providence, ordered by another specialist. She was 176 pounds in August 2022 and has lost 15 pounds since then.

ASSESSMENT: Unintended weight loss. Hypertension.

TREATMENT: Labs ordered.

08/08/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 213-214.

SUBJECTIVE COMPLAINTS: The patient reported that her right knee has been feeling well, although she still experiences discomfort in the posterior aspect of the right knee. She mentioned that her back has been feeling better after receiving her injection last Friday, but she still has some difficulty descending stairs compared to ascending them.

OBJECTIVE FINDINGS: Knee AROM: 2-120.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided stair training and therapeutic exercises.

08/11/23 – Ian Dworkin, MD – SOAP Note, Page 46-47B

CC: 2 week follow-up.

SUBJECTIVE: The patient presents with low back pain. Last visit SI ligament steroid injection was completed. Today, she reports significant relief in her low back following the injection, with improvement in functional mobility. In regards to her SCS, she prefers paresthesia-based treatment so these new programs were added, but the patient notes she is feeling the paresthesia more on her right low back, and not midline where most of her symptoms are. She would like as close to 100% relief as possible. At this time, she is at 85% relief. Pain is 0-4/10 worse with sit to stand motions and prolonged walking.

ROS: Extremities: Joint pain.

ASSESSMENT: [Not indicated].

PLAN: Therapy: Continue home exercise program progress to baseline activities and exercises as tolerated. Medications: Continue current regimen. Interventions: Recommend SCS programming at follow up. Education: The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 65 of 84

an understanding of this discussion and all questions were answered at this time.
Follow up: next avail for SCS programming.

08/15/23 – Michelle Capulong, P.A.-C. – Optum – Progress Note, Page 205-210.

SUBJECTIVE COMPLAINTS: The patient reported having a good appetite and is currently in physical therapy (PT) for her knees following a right total knee arthroplasty (TKA). She also regularly performs her therapy exercises at home. She has a history of hypertension but does not monitor her blood pressure at home. Earlier this year, her glomerular filtration rate (GFR) decreased, indicating stage III chronic kidney disease (CKD), but it showed improvement in the blood test conducted this month. She is also on a statin for hyperlipidemia. A QuantaFlo test indicated atherosclerosis bilaterally with borderline results, and a Neurometrix test showed signs of neuropathy. The patient was a smoker but quit last year.

ASSESSMENT: Screen for colon cancer. Chronic kidney disease.

TREATMENT: Labs ordered. Regular exercises.

08/15/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 211-212

SUBJECTIVE COMPLAINTS: The patient reported that her knee has been feeling kind of tight. She mentioned that a friend's sister passed away, and she has been helping her friend, which has left her with little time for exercise. Although she has been doing pedal bike exercises and hamstring stretches, she has not practiced the step-down exercise.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises.

08/28/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 203-204.

SUBJECTIVE COMPLAINTS: The patient participated in a lower body rehabilitation (LBR) class today.

ASSESSMENT: Right TKA 05/22/23.

TREATMENT: Provided therapeutic exercises.

09/05/23 – Shahina Hakim, M.D. – Digestive Care Consultants – Progress Note, Page 200-202.

SUBJECTIVE COMPLAINTS: The patient had lost weight, totaling approximately 10 pounds, bringing her weight down to 161 pounds on August 15. Since her visit to the primary care physician, she has regained about 4.6 pounds, and her current weight is 165.6 pounds. She reported that her appetite has improved. The patient has a history of throat pain, which has resolved, and she has not experienced a recurrence of that pain. She underwent an endoscopy due to her weight loss, which revealed a hiatal hernia, while a duodenal biopsy was normal. The patient tends to avoid spicy foods. She experienced an episode of upper abdominal pain last night, but it has since resolved. Additionally, she had other workups to evaluate her symptoms, including thyroid studies, which showed normal TSH, free T3, and free T4 levels. A CT scan was performed due to her weight loss, revealing a mild fatty liver, degenerative joint disease (DJD) of the lumbar spine, and aortic atherosclerotic calcifications. The patient also has

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 66 of 84

a spinal stimulator. She was scheduled for a FibroScan but was unaware of her appointment as she was out of town.

ASSESSMENT: Fatty (change of) liver. Abnormal weight loss.

TREATMENT: Continue to monitor. Fibroscan study.

09/06/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 198-199.

SUBJECTIVE COMPLAINTS: The patient participated in a lower body rehabilitation (LBR) class today.

ASSESSMENT: Right TKA 05/22/23.

TREATMENT: Provided therapeutic exercises.

09/11/23 – Amber Houston, P.T. – Optum – Physical Therapy Note, Page 196-197.

SUBJECTIVE COMPLAINTS: The patient participated in a lower body rehabilitation (LBR) class today.

ASSESSMENT: Right TKA 05/22/23.

TREATMENT: Provided therapeutic exercises.

09/13/23 – Kurt Vo, P.T. – Optum – Physical Therapy Note, Page 194-195.

SUBJECTIVE COMPLAINTS: The patient reported experiencing bilateral knee soreness, though it has been well managed with her home exercise program (HEP). She stated that the HEP has been helpful and that she has been able to integrate it into her daily routine. The patient is looking to get Silver Sneakers in order to utilize a stationary bike and participate in workouts to continue with lower extremity strengthening. She also has a pedal exerciser for home use. Additionally, the patient expressed that she feels ready to transition to an independent HEP.

OBJECTIVE FINDINGS: Knee AROM: 0-120.

ASSESSMENT: Orthopedic aftercare. Primary osteoarthritis of the right knee.

TREATMENT: Provided therapeutic exercises.

09/19/23 – Ian Dworkin, MD – SOAP Note, Page 44-45B

SUBJECTIVE: The patient her lower back is feeling much better with little to no issues today, patient reports she is continuing aquatic therapy classes at the local pool which seem to be helping as well.

ROS: Extremities: Joint pain.

ASSESSMENT: [Not indicated]

PLAN: Therapy – Dr. Dworkin recommended 12 sessions of physical therapy for low back program, core strengthening, back stability, postural stability and gait mechanics. This examiner recommend Newport Care Long Beach with Dr. Oh. Dr. Dworkin believe post-implant physical therapy will be helpful to build strength to support her spine while the SCS device controls her pain. Medications – Continue current regimen. Interventions – Consider SCS programming if pain progresses. Given her high % relief, it is not deal at this time to consider lead revision, but if could consider if back pain progresses despite programming and therapy. Education – The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 67 of 84

an understanding of this discussion and all questions were answered at this time.

Follow-up: 6 weeks to evaluate therapy efficacy.

10/02/23 – Shahina Hakim, M.D. – Digestive Care Consultants – Progress Note,

Page 186-188.

SUBJECTIVE COMPLAINTS: The patient's weight has been stable. She mentioned that her eating habits are inconsistent; sometimes she eats, and other times she does not. She was supposed to have her FibroScan done on September 19 but had to cancel the appointment. It has been rescheduled for today.

ASSESSMENT: Fatty (change of) liver. Abnormal weight loss.

TREATMENT: Continue to monitor. Fibroscan study.

10/03/23 – Chung Oh – SOAP Note, Page 40-42B

SUBJECTIVE: The patient chief complain of lower middle back. Received SI ligament injections recently. Patient pain started for months. Patient pain does not radiates to BLE. Patient has PMH of B TKA. Patient reports spinal cordstimulator, makes it feel better. Patient states that bending forward, sitting and standing for long periods of time, makes it worse. Patient's pain is currently at a 7/10 at lower back. She is currently not working. She reports sleep has been moderate, laying on back hurts. She uses assistive devices. She has moderate difficulty with ADLs.

ASSESSMENT: Patient presents with signs and symptoms consistent with diagnosis of lower back pain. Rehab potential is good. Key impairments include: Decreased ROM and strength of the lower back and core muscle groups. Skilled PT is required to address these key impairments and to provide and progress with an appropriate home exercise program. This evaluation ois of low complexity. Patient tolerated in-clinic exercises with mild difficulty. Patient could benefit from skilled PT services to improve overall strength and mobility of lower back to complete ADLs with less pain.

PLAN: Patient could benefit from further stabilization, strengthening, manual stretching and joint mobilization to lower back to improve ROM and strength to complete ADLs and work duties with minimal to no pain. Continue with in-clinic therapeutic exercises and manual therapy. Patient was given HEP of: Calf str ext-3x30se. Bridges 2x10. HS str-3x30se sup/strap. Piriformis str – 3x30se. Dead bug holds – 8x5s. Prone donkey kicks-2x10e [As stated in the report]. Patient was educated on activity modification, HEP compliance, modality use at home.

10/10/23 – Chung Oh – SOAP Note, Page 39B

SUBJECTIVE: The patient states that her lumbar spine has been feeling good. Patient reports that she signed up for some water aerobics. She reports mild to moderate compliance with HEP.

ASSESSMENT: Patient presents with improved motor control and strength with therapeutic exercise. Patient presented with no SE, complications and comp[plaints with

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 68 of 84

manual therapy. Patient still requires skilled PT at this time to restore ROM, strength, stability to lumbar spine to complete ADLs with little to no pain.

PLAN: Continue patient with in-clinic therapeutic exercise, and manual therapy interventions tolerated. Continue to educate patient on following HEP.

10/16/23 – Chung Oh – SOAP Note, Page 38B

SUBJECTIVE: The patient states that her lumbar spine feels better. She reports that she has been doing water aerobics and it has been helping her feel better. She reports moderate to good compliance with HEP.

ASSESSMENT: Patient presents with improved motor control and strength with therapeutic exercise. Patient presented with no SE, complications and complaints with manual therapy. Patient is progressing well towards goals at this time. Patient still requires skilled PT at this time to restore ROM, strength, stability to lower back to complete ADLs with little to no pain.

PLAN: Continue with patient with in-clinic therapeutic exercise and manual therapy interventions as tolerated. Continue to educate patient on following HEP.

10/25/23 – Chung Oh – SOAP Note, Page 37B

SUBJECTIVE: The patient states that her lower back is feeling much better with little to no issues today. Patient reports she is continuing aquatic therapy classes at the local pool which seem to be helping as well. She reports moderate compliance with HEP. Patient reports pain is at a 0-1/10 today.

ASSESSMENT: Patient presents with improved motor control and strength with therapeutic exercise. Patient presented with no SE, complications with manual therapy. Patient is progressing well towards stated goals at this time. Patient still requires skilled PT at this time to restore ROM, strength, stability to lower back to complete ADLs with little to no pain.

PLAN: Continue patient with in-clinic therapeutic exercise and manual therapy interventions as tolerated. Continue to educate patient on following HEP.

10/31/23 – Ian Dworkin, MD – SOAP Note, Page 35-36B

CC: 6 week follow-up.

HPI: The patient presents for re-evaluation of low back pain. Last visit PT was recommended. Today, the patient reports significant improvement in her low back pain, functional mobility, and strength with therapy. She has been able to return to normal exercising, returning to aquatic exercise, and has not required pain medication. She is using her stim regularly with ongoing relief, even when removed for aquatic exercising. Pain today is 0-2/10.

ROS: Musculoskeletal: Joint pain.

OBJECTIVE FINDINGS: Nalu therapy disc in place. Midline incision well healed.

ASSESSMENT: [Not indicated]

PLAN: Therapy – Recommend completion therapy and progression to normal exercise, activity as she is currently doing. Medications – Continue current regimen. Interventions – SCS programming PRN, none required at this time. Education – The patient was educated regarding their pain generators and the advised treatment plan.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 69 of 84

The patient expressed an understanding of this discussion and all questions were answered at this time. Follow-Up: 2 months to evaluate need for additional treatments.

11/01/23 – Chung Oh – SOAP Note, Page 34B

SUBJECTIVE: The patient states that her lumbar spine feels better. She reports that she met with Dr. Dworkin for a follow-up yesterday and he told her that she can stop PT early since she is doing better, and is also doing aquatic therapy elsewhere 3 times a week. Patient reports good compliance with HEP.

ASSESSMENT: Patient presents with improved motor control and strength with therapeutic exercise. Patient presented with no SE, complications and complaints with manual therapy. Patient is progressing well towards stated goals and is appropriate for discharge next visit.

PLAN: Continue patient with in-clinic therapeutic exercise and manual therapy interventions as tolerated. Continue to educate patient on following HEP.

11/09/23 – Chung Oh – SOAP Note, Page 33B

SUBJECTIVE: The patient states that he lumbar spine feels better. She reports that she will do 2 more PT visits and then discharge. She reports good compliance with HEP. She reports pain is at a 0/10 today.

ASSESSMENT: Patient presented with improved motor control and strength with therapeutic exercise. She presented with no SE, complications and complaints with manual therapy. She still requires skilled PT at this time to restore ROM, strength, stability to lower back and neck to complete ADLs with little to no pain.

PLAN: Conitnue patient with in-clinic therapeutic exercise and manual therapy interventions as tolerated. Continue to educate patient on following HEP.

11/15/23 – Chung Oh – SOAP Note, Page 32B

SUBJECTIVE: The patient states that her lower back is feeling much better and is ready for discharge next visit. Patient reports mild to moderate compliance with HEP. She reports pain is at a 0/10 today.

ASSESSMENT: Patient presents with improved motor control and strength with therapeutic exercise. Patient presented with no SE, complications and complaints with manual therapy. Patient is progressing well towards stated goals and is appropriate for discharge next visit. Patient still requires skilled PT at this time to restore ROM, strength, stability to lower back to complex ADLs with little to no pain.

PLAN: Continue patient with in-clinic therapeutic exercise and manual therapy interventions as tolerated. Continue to educate patient on following HEP.

11/22/23 – Chung Oh – SOAP Note, Page 31B

SUBJECTIVE: The patient states that her lumbar spine has been hurting since she has been standing more the past couple of days preparing for Thanksgiving. Patient said she is ready to discharge. Patient reports good compliance with HEP.

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 70 of 84

ASSESSMENT: Patient presents with improved motor control and strength with therapeutic exercises. Patient presented with no SE, complications and complaints with manual therapy. Patient is appropriate for discharge to HEP at this time.

PLAN: Discharge patient to HEP.

01/03/24 – Ian Dworkin, MD – SOAP Note, Page 29-30B

CC: 2 month follow-up.

HPI: The patient presents with low back pain. Last visit patient was doing well following therapy. Today, she reports she is noticing less coverage in her low back, more coverage in her sides. With the cold weather she is having recurrence of her pain, noticing her back pain went up to 7/10 the other day limiting functional mobility.

ROS: Extremities: Joint pain.

ASSESSMENT: [Not indicated]

PLAN: Therapy – Continue therapy and home exercise program as previously prescribed. Imaging – MRI images reviewed including findings, diagnosis, and recommendations. Medications – Continue current regimen. Interventions – SCS programming next available. They discussed changing therapy to sub-perception therapy as oppose to the paresthesia based programming she has preffered up to this point. This may assist with better long term coverage. Dr. Dworkin have discussed with her stimulator company representatives. Education – The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were anwered at this time.

Follow-Up: For programming next available.

01/10/24 – George Tang, M.D. – Huntington Orthopedics – Doctor's First Report of Occupational Injury or Illness, Page 34-38.

DATE OF INJURY: [Not Specified].

SUBJECTIVE COMPLAINTS: The patient was a left-handed 68-year-old female who was seen today for her right shoulder. The problem started after an injury at work. She described her pain as moderate, with a rating of 7/10, and characterized the symptoms as sharp, throbbing, and aching. The symptoms were constant and had been getting worse since their onset. She reported that the symptoms were exacerbated by lying in bed, lifting, and reaching overhead. Additionally, the patient experienced numbness, tingling, and weakness in the affected area. The patient complained of right shoulder pain following a work-related injury. She reported experiencing shoulder pain with lifting and overhead activities. After several weeks of physical therapy, she noted that it did not provide any relief. A cortisone injection to the shoulder also did not result in any long-lasting relief. She mentioned that nonsteroidal anti-inflammatory drugs (NSAIDs) help a little.

PAST SURGICAL HISTORY: Hysterectomy. Arthroscopy of the right knee, arthroscopy of the left knee, total replacement of the right knee, and total replacement of the left knee.

OBJECTIVE FINDINGS: The right shoulder examination revealed some swelling in the shoulder. Upon palpation, tenderness was noted laterally. The range of motion showed a decrease, with forward elevation measured at 140 degrees. Strength testing indicated

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 71 of 84

a decrease in strength, with forward elevation strength rated at 4/5. The neurovascular examination demonstrated that sensation was grossly intact distally, and palpable pulses were present distally. Additionally, the specialty examination showed positive Neer's and Hawkins' impingement signs.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder.

TREATMENT: Right shoulder MRI. OTC NSAID.

WORK STATUS: Total temporary disability until 02/29/24.

01/12/24 – Ian Dworkin, MD – SOAP Note, Page 28-29B

HPI: The patient presents for re-evaluation of low back pain. Last visit patient was doing well with SCS and returning to normal activities. Today, the patient reports some pain in mornings after strenuous activities the day before. She also notes that in certain positions such as sleeping/napping she feels stimulation coverage in her ribs. Overall, she is doing well with most activities but is concerned about lead movement given the increased pain in mornings.

ROS: Extremities: Joint pain.

OBJECTIVE FINDINGS: Low Back: Mild TTP bilateral lumbar paraspinals and PSIS.

DIAGNOSES: Pain in thoracic spine.

PLAN: Therapy – Continue therapy and home exercise program as previously prescribed. Imaging – X-ray thoracic spine 2 view to check leads. Leads have not migrated. Medications – Continue current regimen. Interventions – SCS programming today. New programs provided for sub-perception therapy. Educated patient regarding overstimulation and using stim more consistently at night to help with pain in mornings. Education – The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding to this discussion and all questions were answered at this time. Follow-Up: As needed following discussion with rep.

01/22/24 – Minesh Mehta, M.D. – Optum – Progress Note, Page 179-185.

SUBJECTIVE COMPLAINTS: The patient complained of pain and triggering in her left ring finger. She expressed a desire to receive a cortisone injection today to alleviate her symptoms.

OBJECTIVE FINDINGS: Slight tenderness overlying the left ring finger pulley

ASSESSMENT: Trigger finger. Encounter for preventive health examination. Cocaine abuse, in remission. Neuropathy due to a medical condition. Chronic kidney disease, stage 3a. Atherosclerosis of the lower extremity.

TREATMENT: Famotidine 40 mg. Labs ordered. Prilosec 20 mg. Stop PPI.

01/23/24 – Alexander Perez, D.P.M. – West Torrance Podiatrists Group, Inc. – Progress Note, Page 117-118.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 72 of 84

SUBJECTIVE COMPLAINTS: The patient stated that she had begun to notice a new problem with the splitting of her left great toenail. She requested that debridement be performed at that time to address the issue.

OBJECTIVE FINDINGS: Mild hallux limitus deformity was noted with weight-bearing, along with mild plantar metatarsal fat pad atrophy bilaterally.

ASSESSMENT: Nail dystrophy.

TREATMENT: Fungal culture. Aseptic debridement of the Left hallux toenail was performed.

02/13/24 – Ian Dworkin, MD – SOAP Note, Page 25-27B

CC: Follow-up.

HPI: The patient presents for re-evaluation of low back pain. Last visit SCS programming was completed. Today, the patient reports that she is getting about 50-60% relief but still has pain flares in her midline low back with prolonged standing and sleeping at night. When device is off, her pain progresses, but there are days when her pain increases despite appropriate stim use. Pain goes up to 8/10 on occasion and she has difficulty identifying particular exacerbating factors.

VITAL SIGNS: BP 137/74. Height 162.56 cm. Weight 80.29 kg. BMI 30.38 kg/m².

ROS: Extremities – Joint pain.

OBJECTIVE FINDINGS: Low Back: Nalu disc in place over IPG. Incisions C/D/I. Tenderness diffusely throughout bilateral lumbar paraspinals with trigger points appreciated and associated spasm and twitch response and referral of pain. TTP bilateral SI ligaments as well. ROM: <90 degrees flexion; <10 degrees extension; <45 degrees lateral rotation limited by pain. Pain with forward flexion > than pain with extension. Facet load: + bilateral.

ASSESSMENT: 1) Vertebrogenic low back pain. 2) Other intervertebral disc displacement, lumbar region.

PLAN: Therapy – Continue therapy and home exercise program as previously prescribed. Imaging – MRI images reviewed including findings, diagnosis, and recommendations. Medications – Continue current regimen. Interventions – Patient's pain at this time is most consistent with facetogenic pain. Given ongoing debility despite appropriate stim coverage, Dr. Dworkin recommend bilateral lumbar 3-L5 medial branch block with IV sedation and RFA if beneficial. Patient had facet injection at L4-5 previously but this was 2 years ago. Education – The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed an understanding of this discussion and all questions were answered at this time. Follow-up: For procedure.

04/01/24 – Alice Yoon, P.A.-C. – Huntington Orthopedics – Primary Treating Physician's Progress Report, Page 40-43.

DATE OF INJURY: [Not Specified]

SUBJECTIVE COMPLAINTS: The patient was seen today for her right shoulder, which has been problematic since a work-related injury. She complained of right shoulder pain, particularly with lifting and overhead activities. Despite several weeks of physical therapy, she reported that it did not provide any relief. A cortisone injection to the

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 73 of 84

shoulder also did not result in any long-lasting relief, although nonsteroidal anti-inflammatory drugs (NSAIDs) helped a little. This visit was a follow-up appointment, and the MRI of the right shoulder has not yet been authorized or denied. Additionally, a phone call with the attorney was scheduled today due to the patient's lack of payment from workers' compensation/disability.

OBJECTIVE FINDINGS: The right shoulder examination revealed some swelling in the shoulder. Upon palpation, tenderness was noted laterally. The range of motion showed a decrease, with forward elevation measured at 140 degrees. Strength testing indicated a decrease in strength, with forward elevation strength rated at 4/5. The neurovascular examination demonstrated that sensation was grossly intact distally, and palpable pulses were present distally. Additionally, the specialty examination showed positive Neer's and Hawkins' impingement signs.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder.

TREATMENT: Right shoulder MRI. Continue exercises for the right shoulder. OTC NSAID.

WORK STATUS: Total temporary disability until 05/321/24.

04/04/24 – Alexander Perez, D.P.M. – West Torrance Podiatrists Group, Inc. – Progress Note, Page 119-120.

SUBJECTIVE COMPLAINTS: The patient stated that she first noticed discoloration changes to her great toenail several months ago. She is unaware of any inciting trauma or event that may have caused this issue. The patient mentioned that she attempted over-the-counter antifungal medication, but she noted that the discoloration of the toe continued to worsen. She denied experiencing any itching in her feet and reported no other complaints at this time.

OBJECTIVE FINDINGS: Mild hallux limitus deformity was noted with weight-bearing, along with mild plantar metatarsal fat pad atrophy bilaterally.

ASSESSMENT: Nail dystrophy.

TREATMENT: Fungal culture result was discussed.

04/23/24 – Alice Yoon, P.A.-C. – Huntington Orthopedics – Primary Treating Physician's Progress Report, Page 45-49.

DATE OF INJURY: 06/15/20.

SUBJECTIVE COMPLAINTS: The patient complained of right shoulder pain following a work-related injury. She reported experiencing shoulder pain with lifting and overhead activities. Despite several weeks of physical therapy, she noted that it did not provide any relief. A cortisone injection to the shoulder also did not result in any long-lasting relief, although nonsteroidal anti-inflammatory drugs (NSAIDs) helped a little. The patient is here for a follow-up visit after obtaining an MRI.

OBJECTIVE FINDINGS: The right shoulder examination revealed some swelling in the shoulder. Upon palpation, tenderness was noted laterally. The range of motion showed a decrease, with forward elevation measured at 140 degrees. Strength testing indicated a decrease in strength, with forward elevation strength rated at 4/5. The neurovascular examination demonstrated that sensation was grossly intact distally, and palpable

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 74 of 84

pulses were present distally. Additionally, the specialty examination showed positive Neer's and Hawkins' impingement signs, as well as positive O'Brien's testing.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Scheduled for a right shoulder SLAP repair and subacromial decompression. OTC NSAID as needed. Continue exercises for the right shoulder. Weight-bearing as tolerated.

WORK STATUS: Total temporary disability until 06/30/24.

04/30/24 – Ian Dworkin, MD – SOAP Note, Page 22-24B

CC: Follow-up.

HPI: The patient presents for re-evaluation of back pain. Last visit injections were discussed. Today, the patient reports ongoing low back pain. She gets relief with the stimulator during the day but has to take the device off at night to charge it as she only has one functional therapy disc and she wakes up with significant pain limiting mobility and ambulation during the morning. She has questions the previous injection recommendation and will be meeting with stim rep this week for more programming.

VITAL SIGNS: BP 129/85. Height 162.56 cm. Weight 80.29 kg. BMI 30.38 kg/m².

OBJECTIVE FINDINGS: Neuro: Gait – Antalgic with SPC. Low Back: Nalu disc in place over IPG, incisions C/D/I. Tenderness diffusely throughout bilateral lumbar paraspinals with trigger points appreciated and associated spasm and twitch response and referral of pain. TTP bilateral SI ligaments as well. ROM: < 90 degrees flexion; <10 degrees extension; <45 degrees lateral rotation limited by pain. Pain with forward flexion > than pain with extension. Facet load: + bilateral.

ASSESSMENT: [Not indicated]

PLAN: Therapy – Continue therapy and home exercise program as previously prescribed. Imaging – MRI images reviewed including findings, diagnosis and recommendations. Consultations – Consider surgical evaluation if pain persists despite conservative care. Medications – Continue current regimen. Interventions – Dr. Dworkin recommend bilateral lumbar 3-L5 medial branch block with IV sedation and RFA if beneficial. SCS programming ASAP, will coordinate with rep. If pain persists, will discuss lead revision. While they appear in optimal position on XR, midline and posterior epidural space, without migration, she is getting anterior coverage at T7 vertebral body so revision with intraop paresthesia mapping may provide better coverage of low back. Education – The patient was educated regarding their pain generators and the advised treatment plan. The patient expressed understanding of this discussion and all questions were answered at this time. Follow-up: For procedure.

05/14/24 – Glen John Apramian, M.D. – St. George's Medical Clinic – Progress Note, Page 50.

SUBJECTIVE COMPLAINTS: Presented for a pre-operative evaluation for a right shoulder arthroscopy with SLAP repair and subacromial decompression.

ASSESSMENT: Pre-operative evaluation. Hypertension.

TREATMENT: Labs ordered. Chest x-ray. EMG.

[Illegible report.]

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 75 of 84

05/28/24 – Glen John Apramian, M.D. – St. George's Medical Clinic – Pre-Operative Medical Clearance, Page 54.

SUMMARY: The patient was medically cleared for surgery: right shoulder arthroscopic SLAP repair and subacromial decompression on 05/30/24.

05/30/24 – George Tang, M.D. – Huntington Specialty Surgery – Operative Report, Page 58-61.

PROCEDURE PERFORMED: Right shoulder Superior Labrum Anterior Posterior (SLAPs) lesion repair. Arthroscopic subacromial decompression. Distal clavicle undersurface resection. Complete synovectomy. Extensive debridement.

INDICATION: The patient has had shoulder pain unrelieved by conservative treatment. A magnetic resonance imaging scan showed an anterior labral deficiency.

PREOPERATIVE DIAGNOSIS: Right shoulder Superior Labrum Anterior Posterior (SLAPS) lesion. Impingement.

POSTOPERATIVE DIAGNOSIS: Right shoulder Superior Labrum Anterior Posterior (SLAP) lesion. Impingement. Acromioclavicular joint arthritis. Glenohumeral synovitis. Chondromalacia.

ANESTHESIA: General, regional.

COMPLICATIONS: None.

06/10/24 – George Tang, M.D. – Huntington Orthopedics – Primary Treating Physician's Progress Report, Page 62-66.

DATE OF INJURY: 06/15/20.

SUBJECTIVE COMPLAINTS: Here for the first post-operative follow-up. The symptoms were getting better.

OBJECTIVE FINDINGS: The right shoulder examination revealed some swelling, with the incision appearing well healed but accompanied by some erythema. Upon palpation, there was slight tenderness noted at the incision site. The range of motion showed a decrease, which was secondary to the pain. Additionally, strength testing indicated a decrease in strength, also secondary to the pain.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Continue right shoulder exercises. Continue sling use. OTC NSAID as needed. Sutures were removed from the right shoulder.

WORK STATUS: Total temporary disability until 07/31/24.

07/22/24 – George Tang, M.D. – Huntington Orthopedics – Primary Treating Physician's Progress Report, Page 69-72.

DATE OF INJURY: 06/15/20.

SUBJECTIVE COMPLAINTS: The patient's symptoms were improving, but she was still somewhat symptomatic. She had been performing home exercises, which seemed to provide some relief. Additionally, the patient was compliant with wearing the sling.

OBJECTIVE FINDINGS: The right shoulder examination revealed some swelling, with the incision appearing well healed. The palpation exam indicated slight tenderness at the incision site. The range of motion showed a decrease, which was secondary to the

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 76 of 84

pain. Additionally, the strength test demonstrated a decrease in strength, also secondary to the pain.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Start physical therapy on the right shoulder. OTC NSAID as needed. Discontinue the sling to the right shoulder.

WORK STATUS: Total temporary disability until 09/30/24.

08/26/24 – Michael Williams, D.P.T. – Huntington Orthopedics – Physical Therapy Note, Page 74-75.

SUBJECTIVE COMPLAINTS: Complained of right shoulder pain rated at 5/10.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Provided therapeutic exercises and manual therapy.

08/28/24 – Michael Williams, D.P.T. – Huntington Orthopedics – Physical Therapy Note, Page 76-77.

SUBJECTIVE COMPLAINTS: Reported moderate pain and tightness in the right shoulder. Pain rated at 5/10.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Provided therapeutic exercises and manual therapy.

09/03/24 – Preet Upadhyaya, M.D. – Huntington Orthopedics – Primary Treating Physician's Progress Report, Page 78-79.

DATE OF INJURY: [Not Specified]

SUBJECTIVE COMPLAINTS: The patient's symptoms were improving, but she was still somewhat symptomatic. She had been doing home exercises, which seemed to help. The patient was compliant with wearing the sling.

OBJECTIVE FINDINGS: Right shoulder: The palpation exam revealed slight tenderness at the incision site. The range of motion showed a decrease secondary to pain, with active forward elevation at 150 degrees and active abduction at 90 degrees. The strength test indicated a decrease in strength, also secondary to pain, with a rating of 4+/5.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Requested physical therapy 2-3 times a week for 6 to 8 weeks for the right shoulder.

09/03/24 – Jason Yonemoto, P.T. – Huntington Orthopedics – Physical Therapy Note, Page 81.

SUBJECTIVE COMPLAINTS: Denied new complaints about how her right shoulder had been feeling.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 77 of 84

TREATMENT: Provided therapeutic exercises and manual therapy.

09/09/24 – Michael Williams, D.P.T. – Huntington Orthopedics – Physical Therapy

Note, Page 82-83.

SUBJECTIVE COMPLAINTS: The patient accidentally slept on the right shoulder again, resulting in the return of their aching pain. Pain level at 6/10.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Provided therapeutic exercises and manual therapy.

09/11/24 – Michael Williams, D.P.T. – Huntington Orthopedics – Physical Therapy

Note, Page 84-85.

SUBJECTIVE COMPLAINTS: The patient returned with less pain, as they had not been sleeping on their shoulder. She was beginning to feel better. Pain level at 3/10.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Provided therapeutic exercises and manual therapy.

09/16/24 – Michael Williams, D.P.T. – Huntington Orthopedics – Physical Therapy

Note, Page 86-87.

SUBJECTIVE COMPLAINTS: The patient returned with less pain, as she had not been sleeping on her right shoulder. She was beginning to feel better. Pain level at 2/10.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Provided therapeutic exercises and manual therapy.

09/18/24 – Michael Williams, D.P.T. – Huntington Orthopedics – Physical Therapy

Note, Page 90-91.

SUBJECTIVE COMPLAINTS: The patient returned with less pain, as she had not been sleeping on her right shoulder. She was beginning to feel better. Pain level at 3/10.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Provided therapeutic exercises and manual therapy.

09/23/24 – Michael Williams, D.P.T. – Huntington Orthopedics – Physical Therapy

Note, Page 92-93.

SUBJECTIVE COMPLAINTS: The patient stated that she was feeling better but continued to have difficulty reaching and picking up heavier objects, such as taking out a full gallon of milk from the fridge. Pain level at 3/10.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder.

Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Provided therapeutic exercises and manual therapy.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 78 of 84

09/25/24 – Michael Williams, D.P.T. – Huntington Orthopedics – Physical Therapy Note, Page 94-95.

SUBJECTIVE COMPLAINTS: The patient stated that she was feeling better but continued to have difficulty reaching and picking up heavier objects. She mentioned that she was waiting for approval for increased physical therapy sessions. Pain level at 2/10.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Provided therapeutic exercises and manual therapy.

09/30/24 – Michael Williams, D.P.T. – Huntington Orthopedics – Physical Therapy Note, Page 96-97.

SUBJECTIVE COMPLAINTS: The patient stated that she was feeling better but continued to have difficulty reaching and picking up heavier objects. Pain level at 2/10.

ASSESSMENT: Pain in the right shoulder. Impingement syndrome of the right shoulder. Superior glenoid labrum lesion of the right shoulder.

TREATMENT: Provided therapeutic exercises and manual therapy.

11/08/24 – Preet Upadhyaya, M.D. – Huntington Orthopedics – Work Status Note, Page 98.

WORK STATUS: Totally disabled until 12/22/24.

NON-MEDICAL REPORTS

02/19/25 – Arsineh Arakel – Michael Sullivan & Associates, LLP – Cover Letter, Page 1-4.

Dear Dr. Giacobetti: The parties appreciate your agreement to re-evaluate the above individual in your capacity as the Orthopedic PQME. Pursuant to Labor Code § 4062.3, the parties will not issue a joint letter in this case. Rather each party will write you with its respective position. Previously you've issued your reports dated 07/13/2021, and 8/8/2023, declaring Applicant MMI. The applicant's treating orthopedic physician, Dr. Kharrazi, previously found Ms. Billingsley had reached Maximum Medical Improvement on 03/29/2023 and indicated she was not a candidate for surgery at that time. Would you agree that the Applicant was MMI as of 3/29/2023? Applicant subsequently underwent a right shoulder surgery on 5/30/2024 and post-operative care. We are serving updated medical reporting, and requesting a thorough report addressing all medical legal issues. Was her disability status back to TTD from 5/30/2024? If so, please opine if she has reached Maximum Medical Improvement status again, and on what date. Please opine on the periods of TTD with specific dates. Enclosed for your review please find copies of all pertinent Workers' Compensation claims forms, medical reports, deposition transcripts, and other exhibits as reflected in the attached exhibit list. You are hereby authorized to order or perform any diagnostic tests that you feel to be reasonable and necessary and to re-examine Applicant and/or issue any necessary supplemental reports. If you cannot conduct the diagnostics you deem necessary, it is requested to provide a script for the required diagnostics with your report. Following

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 79 of 84

your evaluation of the above individual and review of all pertinent material, please prepare a narrative report containing your findings on all issues you feel to be appropriate, including the following:

1. A detailed history of the injury and the Applicant's complaints.
2. Applicant's medical history, including prior injuries and conditions, and residuals thereof, if any.
3. A review of all information received from the parties in preparation for your report or relied upon for the formulation of your opinion.
4. Whether your findings upon examination are consistent with the injuries and symptoms being alleged by Applicant.
5. Whether Applicant suffered work-related injury as alleged, and if so, to what body parts.
6. Whether as a result of a work-related injury, there have been any periods of Temporary Total Disability or Temporary Partial Disability, and if so the relevant periods. If you find that Applicant suffered a period of Temporary Total Disability, please indicate when you feel Applicant should have been capable of returning to work, and what, if any, modifications would have been required at that time.
7. Whether Applicant's condition has reached a state of Maximum Medical Improvement, and if so, on what date Applicant's condition plateaued.
8. If you conclude that Applicant's condition is at a point of Maximum Medical Improvement, please comment on whether there is any Permanent Disability. If so, please outline all reasonable subjective factors of disability, all truly objective factors of disability, and provide a Whole Person Impairment rating in accordance with the AMA's Guides to the Evaluation of Permanent Impairment, 5th edition.
9. Whether Applicant is able to perform Applicant's usual and customary job duties or whether modified job duties are required. For injuries occurring on or after January 1, 2013, if the Applicant is Permanent and Stationary, please complete the Physician's Return-to-Work & Voucher Report (DWC AD Form 10133.36), and attach it to your report.
10. Please comment on any appropriate apportionment. In making your apportionment determination, please keep in mind the standard promulgated in Escobedo vs. Marshalls (2005), 70 Cal. Comp. Case 604 (writ denied). In this case, the WCAB en banc held that apportionment of Permanent Disability caused by, in words of Labor Code § 4663(c), "other factors both before and subsequent to the industrial injury, including prior industrial injuries" may include not only disability that could have been apportioned prior to SB 899, but also may include disability that formerly could not have been apportioned (e.g., pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions), provided there is substantial medical evidence establishing that these other factors have caused Permanent Disability. With regard to the issue of apportionment, please note the provisions of Labor Code § 4663 as follows:
(a) Apportionment of Permanent Disability shall be based on causation.
(b) Any physician who prepares a report addressing the issue of Permanent Disability due to a claimed industrial injury shall in that report address the issue of causation of the Permanent Disability.
(c) In order for a physician's report to be considered complete on the issue of Permanent Disability, it must include an apportionment determination. A

APPLICANT: Billingsley, Debora

Date of Birth: 08/23/1955

Page 80 of 84

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. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the Permanent Disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

11. Whether Applicant requires further or future medical treatment, and if so the nature and extent of the reasonable and necessary treatment. For evaluations performed on or after July 1, 2013, you may not provide an opinion on any disputed medical treatment issue but must provide an opinion about whether the injured worker will need future medical care.

DIAGNOSES

1. Right shoulder impingement syndrome with distal clavicle arthritis.
2. Status post right shoulder arthroscopy with superior labral repair, sub decompression and distal clavicle resection.

DISCUSSION

Ms. Debora Billingsley is a 69-year-old female who stand 5 feet 4 inches, weighs 165 pounds, and is left-hand dominant. She sustained a work-related injury on June 15, 2020 while working as an IHSS provider. On the day of the injury, she was pulling a client towards her to roll her on her side to change her diaper when she felt a sharp stabbing pain in her right shoulder. She reported it to her employer. She was initially referred to orthopedic specialist, Dr. Brian Magovern. Through Dr. Magovern's office, she received physical therapy, 2 cortisone injections. He recommended surgery and she did not wish to proceed as recommended.

She was last seen and made permanent and stationary in our office on August 8, 2023.

Since last being in our office, she has undergone surgery on May 30, 2024 by Dr. Tang in the form of right shoulder arthroscopy with superior labral repair, sub decompression and distal clavicle resection. After the surgery, she received only 6 visits of physical therapy. She continues to have pain 7/10 in the right shoulder area.

At this time, I'm recommending additional treatment. She's only completed 6 visits of physical therapy post-surgery. I'm recommending another 12 sessions to try and regain full range of motion and strength in the shoulder.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 81 of 84

With regard to questions about her temporary total disability status, after the surgery on May 30, 2024, I would state that her work status be temporarily totally disabled for a period of 3 months, ending on August 30, 2024. At that point, she should have been able to return to modified duty work with restrictions. I would like to see her in 2-3 months after she completed the additional physical therapy recommended to see if she has reached a point of maximum medical improvement.

The patient's account of the industrial injury is consistent with the medical records.

The applicant has not reached maximal medical improvement (MMI) and is not considered permanent and stationary (P&S) for rating purposes. The applicant will be scheduled for a follow-up re-evaluation in approximately 2-3 months.

PERMANENT AND STATIONARY STATUS

The patient has not reached permanent and stationary status at this time.

SUBJECTIVE FACTORS OF DISABILITY

- Constant, severe, sharp pain in bilateral shoulders, rated 9/10.

OBJECTIVE FACTORS OF DISABILITY

- Well-healed scars on the right shoulder from prior arthroscopic procedure.
- Decreased shoulder range of motion in abduction, flexion and internal rotation on the right.
- Weakness in supraspinatus at 4/5 on the right.
- Grip strength: Right 10/12/10 kg. Left 20/22/20 kg.

CAUSATION

Based on the history, review of medical records, clinical examination, and current reviewed medical literature, there is an industrial injury as the injury arose out of the employment and occurred during the course of employment. This injury is industrial in causation. There is substantial medical evidence indicating industrial causation.

APPORTIONMENT

Pursuant to LC Section 4663, apportionment of permanent disability shall be based on causation. On contemplation of apportionment, a review of the applicant's past employment and prior injuries was taken into consideration along with a review of the history, medical records, and clinical examination.

Apportionment will be determined when the applicant reaches maximum medical improvement. I

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 82 of 84

PERIODS OF DISABILITY

With regard to questions about her temporary total disability status, after the surgery on May 30, 2024, I would state that her work status be temporarily totally disabled for a period of 3 months, ending on August 30, 2024.

CURRENT MEDICAL TREATMENT

At this time, I'm recommending additional treatment. She's only completed 6 visits of physical therapy post-surgery. I'm recommending another 12 sessions to try and regain full range of motion and strength in the shoulder.

The subjective complaints and physical findings warrant the necessity for additional tests/consults as part of this medical-legal evaluation (Per L.C. § 9794). The results of these tests/consults will be addressed in supplemental reports.

All treatment must be approved by utilization review and in accordance to the MTUS Guidelines.

VOCATIONAL REHABILITATION

Vocational rehabilitation will be determined when the applicant reaches maximum medical improvement.

AMA IMPAIRMENT RATING ANALYSIS

The applicant has not reached maximal medical improvement (MMI) and is not considered permanent and stationary (P&S) for rating purposes.

FOUNDATION FOR OPINION

- 1) History provided by the patient, which corroborates with the medical records
- 2) Physical exam findings

This examination and recommendations pertain to my specialty only. Other specialists may be necessary to address any additional impairments and subsequent treatments.

DISCLOSURE STATEMENT

In accordance with Title 8 QME Regulations § 35.5(h) and Labor Code 4628, I declare under penalty of perjury that during the evaluation, I did not discriminate in any way against the parties to the action or the injured worker in the evaluation process or in the

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955

Page 83 of 84

content of this report. And further declare under penalty of perjury 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. Injured worker, Debora Billingsley, was evaluated on March 4, 2025 in my Inglewood, CA office. I personally performed this evaluation based upon the specific request from the parties. I was asked to physically examine and evaluate the injured worker, and to prepare a report to answer specific medical legal issues as stated in this cover letter. Please find a copy of the letter requesting this medical legal report attached to this report. Please also find attached the finalized attestation for the page count of the records reviewed for this medical legal report.

The signature on this medical report, with the exception as permitted by Labor Section 4628(a) & (c), certifies under penalty of perjury the absence of any other participants in the examination, obtaining the case history, reviewing the medical records, or in the preparation of the medical report. All the facts and opinions contained in this report are based upon my review of the submitted medical records which were initially outlined/excerpted by Jackie Gonzales, all additional inquiries and examinations as were necessary and appropriate to identify and determine the relevant medical issues were conducted. The history was obtained by historian, Laura Restrepo, from the applicant, which I reviewed with the applicant during the examination. A medical assistant, Joy Berbano, was present during the exam. The report was transcribed by Rhian Romero. The evaluation performed and the time spent performing the evaluation was in compliance with the guidelines established by the administrative director.

I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration for any referral for examination or evaluation by a physician. Any physician or facility whose specialty expertise was relied upon in the area of interpretative radiology and/or diagnostic testing was identified within the text of this document.

I declare under penalty of perjury the number of pages received for the evaluation and report are 2101, including 2101 pages from the Defense. These pages were submitted by the parties with a signed declaration under penalty of perjury that the submitter(s) have complied with §4062.3 and attest to the total page counts.

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. This report and Declaration were signed on March 10, 2025 at Inglewood, California, County of Los Angeles.

APPLICANT: Billingsley, Debora
Date of Birth: 08/23/1955
Page 84 of 84

This disclosure and declaration fulfill all requirements of Section 10606 and 9795(n), Rules of Practice and Procedure, Workers' Compensation Appeals Board, as well as all-applicable sections and subdivisions of Labor Code Sections 4628 and 5703(a)(2).

If you have any questions, please feel free to communicate with me.

Yours very truly,

Frank Giacobetti, MD

Frank Giacobetti, M.D., Q.M.E.
Orthopedic Surgeon

cc: ArsinehArakel, Esq.
Michael Sullivan & Associates LLP
P.O. Box 85059
San Diego, CA 92186-5059

Martin M. Urban, Esq.
Law Offices of John M. Urban
1712 W. Beverly Blvd., Ste. 103
Montebello, CA 90640

Michael Fletcher
Intercare
P.O. Box 1140
Rocklin, CA 95677



STATE OF CALIFORNIA
Division of Workers' Compensation
Disability Evaluation Unit

EMPLOYEE'S DISABILITY QUESTIONNAIRE

DEU Use Only

This form will aid the doctor in determining your permanent impairment or disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee

Debra A

A

First Name

MI

Last Name

Billingham

SSN (Numbers Only)

1609 E. Diane Dr

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)

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

Compton

City

Ca

90221

State

Zip Code

Date of Birth 08/23/1955

MM/DD/YYYY

Date of Injury 06/15/2020

MM/DD/YYYY

Employer

Nature of Employers Business

Claim Number 1



Claim Number 2

Claim Number 3

Claim Number 4

Claim Number 5

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:

How was your evaluating doctor selected? (check one)

From a list of doctors provided by the State of California, Division of Workers' Compensation.

Other (explain)

Martin Urban Attorney at Law

What is the name of the doctor who will be doing the evaluation? Frank Coacobett

When is your examination scheduled? 3-4-25

What were your job duties at the time of your injury?

My client was bedridden. I will go bath her, cook, clean the room, run errand, take her to Doctor Appt, comb hair, I have to push + pull her to change the Diaper, change her bed.

What is the disability resulting from your injury?

DR. George Tang MD, Did surgery on my Right shoulder Impingement syndrome of the Right Shoulder and a glenoid Labrum lesion of the shoulder

How does this injury affect you in your work?

I am still in pain and on pain medication, PT was scheduled for 12 weeks, I only received 6 weeks of PT. I continue to do PT at home on my own however I have limited mobility.

I have difficulty, stretching, sleeping, reaching, cleaning

Have you ever had a disability as a result of another injury or illness? No

If so, when?

Please describe the disability?

[Large empty rectangular box for disability description]

Date

2-27-25
MM/DD/YYYY

Signature

Selena Billingsley

DWC-AD form100 (DEU)



State of California

DIVISION OF WORKERS' COMPENSATION

Department of Industrial Relations

Panel #: 7396589

Date Request Received:	03/08/2021	Date Issued:	03/08/2021	No. of Request:	1
Claim No(s):	SCIH-048236				
Date(s) of Injury:	08/15/2020	Employer:	STATE OF CALIFORNIA/IHS3		
Requesting Party:	APPLICANT ATTORNEY	Ins./Adj. Agency:	ELSA CUEVAS YORK ANAHEIM PO BOX 619079 ROSEVILLE, CA 95681		
		Employee:	DEBORA BILLINGSLEY		
Applicant Attorney:	MARTIN URBAN JOHN URBAN ANAHEIM 160 N RIVERVIEW DR STE 175 ANAHEIM, CA 92808	Defense Attorney:			

Selected Qualified Medical Evaluator Panel:

Physician's Name:	STANLEY G KATZ, MD	Tel No.:	(951) 893-9180
Address:	5584 N PARAMOUNT BLVD STE 100 LONG BEACH, CA 90806-5149		
Specialty:	ORTHOPAEDIC SURGERY (OTHER THAN SPINE OR HAND)		
In Practice Since:	1981		
Physician's Education:	MOUNT SINAI SCHOOL OF MEDICINE, NEW YORK, NY		
Physician's Training:	SURGERY-ST. LUKE'S HOSPITAL, NEW YORK, NY, 1976-1977 ORTHOPEDIC SURGERY-MT SINAI HOSPITAL, NEW YORK, NY, 1977-1980		
Physician's Name:	NEELESH S GHODADRA, MD	Tel No.:	(818) 990-4497
Address:	16444 PARAMOUNT BLVD STE 204 PARAMOUNT, CA 90723		
Specialty:	ORTHOPAEDIC SURGERY (OTHER THAN SPINE OR HAND)		
In Practice Since:	2011		
Physician's Education:	DUKE UNIVERSITY SCHOOL OF MEDICINE, DURHAM, NC		
Physician's Training:	GENERAL SURGERY-RUSH UNIVERSITY MEDICAL CENTER, CHICAGO, IL, 2005-2006 ORTHOPEDIC SURGERY-RUSH UNIVERSITY MEDICAL CENTER, CHICAGO, IL, 2006-2010		
Physician's Name:	FRANK B GIACOBETTI, MD	Tel No.:	(800) 242-0880
Address:	1315 N BULLIS RD STE 15 COMPTON, CA 90221		
Specialty:	ORTHOPAEDIC SURGERY (OTHER THAN SPINE OR HAND)		
In Practice Since:	1998		
Physician's Education:	NEW YORK UNIVERSITY, NEW YORK, NY		
Physician's Training:	GENERAL SURGERY-PENNSYLVANIA HOSPITAL, PHILADELPHIA, PA, 1992-1993 ORTHOPEDIC SURGERY-THOMAS JEFFERSON UNIVERSITY, PHILADELPHIA, PA, 1993-1997		

Applicant's Strike
3/8/21

Declaration Pursuant to Cal. Code Regs., Tit. 8, § 9793(n)

Re: Debora Billingsley v. State of CA - IHSS
Claim # SCIH-048236
WCAB # ADJ14212174
MS&A # 4475.0701

I, Jocelyn Barragan, declare:

I am a legal assistant for the firm of Michael Sullivan & Associates, the law firm of record for Defendant **State of CA - IHSS (Rancho Dominguez)**. Pursuant to Cal. Code Regs., Tit. 8, § 9793(n), I declare that the provider of the documents has complied with the provision of Labor Code § 4062.3 before providing the documents to the physician.

I declare that the total page count of the documents provided to the physician is 2,101.

I declare under penalty of perjury under the law of the State of California that the foregoing statements are true and correct.

Executed on March 4, 2025, at El Segundo, California.

Jocelyn Barragan
Jocelyn Barragan

ARCO Medical Partners
5904 Warner Ave
Ste A #2042
Huntington Beach, CA 92649
Office (888) 921-0161

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))
PROOF OF SERVICE

Case Name: DEBORA BILLINGSLEY v STATE OF CA - IHSS (RANCHO DOMINGUEZ)

Claim No: SCIH-048236

EAMS or WCAB Case No. (if any): ADJ14212174

I declare:

1. I am over the age of 18 and not party in this action.

2. My business address is listed

3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A depositing the sealed envelope with the U.S. Postal Service with the postage fully prepaid

B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U.S. Postal Service in a sealed envelope with postage fully prepaid.

C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

D placing the sealed envelope for pickup by a professional messenger service for service. (Messenger must return to you a completed declaration of personal service.)

E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service:	Date Served:	Addressee and Address Shown on Envelope:
A	03/11/2025	ArsinehArakel, Esq. Michael Sullivan & Associates LLP P.O. Box 85059 San Diego, CA 92186-5059
A	03/11/2025	Martin M. Urban, Esq. Law Offices of John M. Urban 1712 W. Beverly Blvd., Ste. 103 Montebello, CA 90640
A	03/11/2025	Michael Fletcher Intercare P.O. Box 1140 Rocklin, CA 95677
	03/11/2025	

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

Date: 03/11/2025

/S/ Maria Valdovinos

(signature of declarant)



ARCO Medical Partners

MEDICAL BILLING AND COLLECTIONS

MEDICAL SUPERBILL

PATIENT NAME: BILLINGSLEY, DEBORA
RENDERING PHYSICIAN: FRANK GIACOBETTI, M.D.
DOS: 03/04/2025
CLAIM#: SCIH-048236
CLAIMS ADMINISTRATOR: INTERCARE

ML 201 - Medical-Legal Evaluation

REIMBURSEMENT: \$2,015.00 BILLABLE UNITS: 1 MAXIMUM

CORRESPONDENCE RECEIVED BY THE PARTIES	ML MODIFIER – Choose Applicable Modifiers
<input type="checkbox"/> Request for Appointment	<input type="checkbox"/> 94 Agreed Medical Evaluator: Evaluation Performed by an AME
<input checked="" type="checkbox"/> Appointment Letter	<input type="checkbox"/> 95 Qualified Medical Evaluator: Evaluation Performed by a QME
<input type="checkbox"/> AA Appointment Letter	<input type="checkbox"/> 93 Interpreter needed at the time of examination
<input type="checkbox"/> DA Appointment Letter	<input type="checkbox"/> 96 Evaluation performed by a Psychiatrist or Psychologist
<input type="checkbox"/> AA Cover/Advocacy Letter	<input type="checkbox"/> 97 Evaluation performed by a physician who is board certified in Toxicology, a physician who is certified as a Qualified Medical Evaluator in the specialty of Internal Medicine or a physician who is board certified in Internal Medicine
<input checked="" type="checkbox"/> DA Cover/Advocacy Letter	<input type="checkbox"/> 98 Evaluation performed by a physician who is board certified in Medical Oncology, a physician who is certified as a Qualified Medical Evaluator in the specialty of Internal Medicine or a physician who is board certified in Internal Medicine, when an Oncology evaluation is the primary focus of the medical-legal evaluation
<input type="checkbox"/> Any Misc. correspondence	<input type="checkbox"/> 92 Primary Treating Physician: Evaluation Performed by the PTP

MLPRR (\$3.00 per page) – BILLABLE UNITS: TOTAL PAGE COUNT IN EXCESS OF 200

DA § 4062.3 Declaration signed with page count attestation received. Attestation page count 2,101

AA § 4062.3 Declaration signed with page count attestation received. Attestation page count

Total pages reviewed by the physician evaluator 2,101 minus 200 = 1,901 BILLABLE PAGES

Total pages received by the physician evaluator 2,101

NO DECLARATION & ATTESTATION RECEIVED RECORDS DUE NOT HAVING THE DECLARATION & ATTESTATION AS THE PARTIES FAILED TO SERVE THESE DOCUMENTS

*Charges for review of records in excess of 200 pages. Excess pages are billed at three dollars per page.

ML 205 – Sub Rosa Recording Review REIMBURSEMENT: \$325/ hour in 15-minute increments
BILLABLE UNITS: \$81.25 per unit

W-9

Form
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to www.irs.gov/FormW9 for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. <i>See Specific Instructions on page 3.</i>	1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.) ARCO MEDICAL PARTNERS	
	2 Business name/disregarded entity name, if different from above. 	
	3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input checked="" type="checkbox"/> LLC. Enter the tax classification (C = C corporation; S = S corporation; P = Partnership). C Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions)	
	3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions. <input type="checkbox"/>	
	5 Address (number, street, and apt. or suite no.). See instructions. 5904 Warner Ave. Ste A #2042	Requester's name and address (optional)
	6 City, state, and ZIP code Huntington Beach, CA 92649-4689	
	7 List account number(s) here (optional).	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification Instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person	/s/ Maria Valdovinos
------------------	---------------------------------	----------------------

Date

03/11/2025

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

Martin M. Urban, Esq.
Law Offices of John M. Urban
1712 W. Beverly Blvd., Ste. 103
Montebello, CA 90640

