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Name	THOMPSON, MARK
Address	4248 Alpha St Medicity , NY 10001
Date of Birth	05/19/1970
SSN	012-34-5678
Claim#	WC987654321
Date(s) of Injury	**06/21/2024**
Employer	Cleaning Services inc
Occupation	Janitor
Body Part(s)	Cervical Spine, Lumbar Spine, Right Shoulder, Left Knee, Left Ankle
Examination Date	07/24/2024
Examination Location	3142 East Plaza Dr Unit T National City, CA 91950

Orthopaedic Surgery Qualified Medical Examination
John C. Austin, M.D.

This is my Panel Qualified Medical Evaluation of Mr. Mark Thompson who was seen at my office in Medicity, NY on 07/24/2024. At that time, a comprehensive history and interview were conducted, a physical examination was performed, and the records submitted were received with the § 4062.3 declarations signed with page count attestation and reviewed in their entirety. I spent 60 minutes face-to-face time.

Mr. Mark Thompson did not speak English, a certified interpreter was necessary to perform a thorough examination of Mr. Mark Thompson, this increased the time required for the examination. Provided by: Adriana Guajardo #101990. Estimated time increased by 15 minutes.

A declaration and attestation was received, signed by Ms. Cathy Brewer for 339 pages, dated 06/13/2024.

I verify under penalty of perjury that I have reviewed 339 pages of medical records as part of the medical-legal evaluation and preparation of the report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of an attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was advised of their rights pursuant to QME regulation 40. The applicant stated that the aforementioned was understood and agreed to proceed with the evaluation.

CODE	Description
ML 201-95-93	Comprehensive Medical-Legal Evaluation
ML PRR	Record Review 339 - 200 = 139 pages

Chief Complaints

Mr. Mark Thompson presented today for evaluation complaining of Cervical Spine, Lumbar Spine, Right Shoulder, Left Knee, and Left Ankle pain secondary to a specific injury of 06/21/2024 which occurred while employed with Cleaning Services Inc. He worked for Cleaning Services Inc for approximately 3.5 years.

History of the Injury

Mr. Thompson is a 54-year-old right-handed male janitor who stated that he was employed with Cleaning Services Inc since approximately 2018 or 2019.

He reported that on 07/21/2022, he was cleaning a light fixture while standing on 6-8-foot ladder that was leaning against the wall. He was standing on the last step on the top when the ladder started to slide down. He lost his balance and fell forwards into the ladder as it slid down the wall. His left ankle/foot was caught in between the steps of the ladder, and he subsequently hit his spine against the floor during the fall. He could not recall further details of the mechanism of injury as the event happened rapidly. However, he had severe right shoulder and left knee/ankle pain following the accident, and he could not lift his right shoulder overhead following the accident. The incident was witnessed by his manager, name unrecalled, who was also recording him cleaning the light fixture. He noted immediate pain all over his body and asked the manager to help him by calling the paramedics. The manager did not know what to do, so the 1st manager who witnessed the fall called a second manager. He was assisted to stand and was taken to a bunk in the hallway and waited for the second manager to arrive. Once the second manager arrived, he was told to get up and continue working. He reported his symptoms and asked them to call the paramedics. Christian, another manager was ultimately called and when he arrived, he took Mr. Thompson to the emergency room.

On that same day, Mr. Thompson sought medical care in the emergency room at Paradise Valley Hospital in National City. He complained of pain all over his body, although his most severe pain localized to his cervical spine, lumbar spine, left shoulder, left knee and left ankle. He completed radiographs of his left humerus, thoracic spine, lumbar spine, left foot, right ankle, left ankle, left leg, chest, and pelvis, as well as Cervical Spine and Head/Brain CT scans. He was prescribed

pain-relieving medication and he was provided with a pair of crutches. He was placed off work for approximately 1-2 weeks.

Mr. Thompson opted to retain the services of an attorney and he was then referred for medical care at Concentra. He was initially evaluated at Concentra in the middle or end of August 2024. He complained of cervical spine, lumbar spine, bilateral shoulder, bilateral knee and left ankle/foot pain. He was recommended to have left ankle radiographs and he was referred for physical therapy, as well as prescribed pain-relieving and anti-inflammatory medications. He was released to return to Modified Duty, precluding him from standing, walking, lifting and carrying.

His employer was unable to accommodate his restrictions and placed him off work. He continued to be evaluated at Concentra once every 2-3 weeks and started to receive physical therapy for his cervical spine, lumbar spine, shoulders, left knee and left ankle. He completed 6-8 sessions of treatment with minimal improvement. In approximately September 2022, acupuncture was incorporated into his treatment plan. He completed 6-8 sessions of treatment, but his symptoms remained unchanged. On 10/21/2022, at the referral of his primary care physician, Mr. Thompson was evaluated by orthopaedic surgeon Dr. David Smith, MD at Concentra. Dr. Smith requested authorization to refer him for a Right Shoulder MRI and requested authorization to refer him to an ankle surgeon. he continued to be off work.

On 08/07/2022, at the referral of his attorney, Mr. Thompson care was transferred to chiropractor Dr. Kent Karras, DC. At the referral of Dr. Karras, he started to receive chiropractic treatment to his cervical spine, lumbar spine, shoulders and knees. Physical therapy, acupuncture, and chiropractic treatment provided some relief of his symptoms.

In March 2023, he was evaluated by orthopaedic surgeon Dr. Jerome Hall. Dr. Hall evaluated his cervical spine and lumbar spine. However, no treatment was recommended other than for him to continue with physical therapy and medication.

On 04/04/2023, he was initially evaluated by neurologist Dr. Thomas Schweller, MD for his headaches and TMJ issues. Dr. Schweller recommended a dental evaluation to address his mandibular pain. However, this was not authorized.

On 07/25/2023, Mr. Thompson was evaluated by foot and ankle orthopaedic surgeon Dr. Franz Kopp, MD in San Diego. Dr. Kopp requested authorization to treat his left ankle and ordered a Left Ankle MRI, which Mr. Thompson completed on 08/23/2023 and revealed abnormal results. Dr. Kopp also administered a cortisone injection to his left ankle and foot on 09/14/2023, which provided significant but temporary relief of his symptoms.

On 10/24/2023, Mr. Thompson was initially evaluated by orthopaedic spine surgeon Dr. Maneesh Bawa, MD in San Diego. Dr. Bawa considered that he was not a candidate for cervical spine or lumbar spine surgery. He recommended treatment in the form of physical therapy and medication,

as well as evaluation with a shoulder orthopaedic surgeon for his right shoulder. He received chiropractic and physical therapy to his cervical spine and lumbar spine at the referral of Dr. Bawa.

On 12/15/2023, Mr. Thompson was evaluated by orthopaedic shoulder surgeon Dr. Christopher Behr, MD in San Diego. Dr. Behr recommended Bilateral Shoulder MRIs. He stated that these studies took a long time to be approved. In the meantime, he continued to receive chiropractic treatment and physical therapy for his cervical spine and lumbar spine under the direction of Dr. Bawa.

On 02/08/2024, Mr. Thompson completed a Right Shoulder MRI, which revealed supraspinatus and infraspinatus tears. These studies were reviewed by Dr. Behr, who recommended right shoulder arthroscopic surgery. Mr. Thompson agreed to proceed with surgery.

On 03/27/2024, Dr. Behr performed Right Shoulder Arthroscopy with Rotator Cuff Repair at Mission Valley Heights Surgery Center. Mr. Thompson received postoperative physical therapy beginning around late April/early May 2024. He received approximately 10-12 sessions of physical therapy, which improved his symptoms. However, he continues to have discomfort and restricted range of motion in his right shoulder.

Mr. Thompson is currently waiting for approval for additional acupuncture as requested by Dr. Bawa or Dr. Karras. He completed a Left Knee MRI on 07/13/2024 at the request of Dr. Kopp or Dr. Behr.

Additional Treatment

Mr. Thompson is currently not under medical treatment.

Legal Status

Mr. Thompson is represented by Manuel Rios, Esq.

Work History

Mr. Thompson not working. He is currently on Temporary Total Disability.

he stated that after the 07/21/2022 incident he was placed on temporary total disability from 07/21/2022 through approximately the beginning of 2023. He was released to return to work by Dr. Karras and his employer accommodated him with transitional work. He stated that for a couple of months, he worked as a store clerk for a thrift store in San Diego, name unrecalled. He was required to sort, hang and place labels on clothing. He would receive donations, distribute donation tickets/proof and push and pull racks of clothing. He was required to stand and walk throughout most of his shift. However, he was allowed to take breaks as needed. In approximately the middle of 2023, he was assisted to work at a senior center/convalescent facility in Mission Beach. He described this position as entailing sitting in the front desk and monitoring that patients were

singing in and out. He was required to alternate between sitting and standing. He was placed off work by his employer approximately in July or August of 2023, since they could no longer accommodate his restrictions. He has not worked in any capacity since then.

Past Employment

Prior to working for Cleaning Services Inc, Mr. Thompson reported that he was employed by a cell phone store in the capacity of a cell phone programmer for approximately 6 years. Prior to this, he worked as an independent laborer for approximately 6-8 years. He stated that he would take small jobs that required painting, floor/carpet installation, construction and demolition cleaning. He was unable to remember his prior employers.

Job Description

Mr. Thompson began employment with Cleaning Services Inc as a janitor in approximately 2018-2019.

He worked 16 hours per day, 5 days per week. He explained that he would work in the mornings as a kitchen helper and in the evenings as a janitor/maintenance worker. He is right-hand dominant.

Mr. Thompson described the kitchen helper position as entailing cleaning the kitchen, ranges, washers, refrigerators, counters and the deep fryer. He was occasionally required to take out trash, sweep and mop floors, and lift the floor mats. He was required to stand and walk throughout his shift, with intermittent bending, stooping, lifting, carrying, pushing, pulling, reaching at and above shoulder level, gripping, grasping, pushing and pulling. The heaviest lifting was of approximately 60-80 pounds as needed.

He stated that as a janitor/maintenance worker, he was required to respond to spills, assist housekeepers in cleaning using leaf blowers and pressure washers, and pick up towels from the pool or beach areas. He continued to be required to stand and walk throughout his shift, with intermittent bending, stooping, reaching, gripping, grasping, lifting, carrying, pushing and pulling. He continued to be required to lift between 60 and 80 pounds.

He denied concurrent employment.

Military

None reported

Prior/Subsequent Industrial Injuries

- Left Knee, 30 years ago, White House Moody's
  Mr. Thompson filed a workers' compensation claim for a left knee injury while employed by

White House Moody's as a maintenance worker/janitor. He was cleaning a slippery slope when he slipped on oil and twisted his leg, injuring his left knee. He received treatment in the form of physical therapy and medication. He underwent left knee arthroscopy and received a course of post-operative physical therapy, which was beneficial, and he was able to return to work. He hired an attorney and received a settlement. He reported a full recovery. He stated that he was asymptomatic of left knee pain prior to his employment at Cleaning Services, Inc.

Nonindustrial Injuries

None reported

Past Medical History

Mr. Thompson denied any history of illness. He stated that his blood pressure has been read as high whenever he was experiencing increased pain.

Past Surgical History

- Left knee arthroscopy, 30 years ago
- Rhinoplasty, 25 years ago
- Right shoulder arthroscopy with rotator cuff repair, 03/27/2024

Medications

- Ibuprofen, as needed

Allergies

No known drug allergies

Social History

Mr. Thompson is single with 4 children.

He does not smoke. He occasionally drinks alcohol. He denied illicit drug use.

Family History

He reported that his mother had a history of cancer.

Education

Mr. Thompson completed middle school in Mexico.

Hobbies/Sports

Mr. Thompson stated that he enjoyed going to the gym. He feels that his activities are limited due to pain.

Current Complaints

Cervical Spine

He reported constant cervical spine pain rated 2-3/10 located centrally. He reported occasional radiating upper extremity pain, numbness, paresthesias and weakness. Symptoms are exacerbated by bending, turning, gazing up or with activities performed at or above shoulder level. Symptoms are improved with rest, medication and physical therapy. No bowel or bladder dysfunction. His symptoms have significantly improved.

Lumbar Spine

He reported constant lumbar spine pain rated 3/10 that increases to 4-5/10 located in the lower half of his central spine. He denied radiating lower extremity pain, numbness, paresthesias and weakness. Symptoms are exacerbated by bending, stooping, lifting, carrying, sitting for more than 30 minutes, standing for more than 30-45 minutes and walking for more than 30-60 minutes. He avoids lifting. Symptoms are improved with rest and medication. No bowel or bladder dysfunction.

Right Shoulder

He reported intermittent right shoulder pain rated 3/10 located anterosuperiorly and diffusely. He reported occasional clicking and popping. He has experienced 1 episode of locking/catching followed by sharp pain. Symptoms are exacerbated by reaching, lifting, carrying, pushing, pulling and performing activities at or above shoulder level. Symptoms are improved with rest and medication. His symptoms are 75% improved as compared to before surgery.

Left Shoulder

He denied current left shoulder symptoms.

Left Knee

He reported intermittent left knee pain rated 4/10 located anteromedially with weakness and instability. He has clicking and popping with flexion and extension. Symptoms are exacerbated by kneeling, crouching, squatting, standing for more than 30-45 minutes and walking for more than 30-60 minutes. Symptoms are improved with rest and medication.

Left Ankle

He reported intermittent left ankle pain rated 1-2/10 located laterally. He reported occasional weakness and instability with walking, standing or stair climbing. He denied swelling. Symptoms are exacerbated by standing for more than 30-45 minutes and walking for more than 30-60 minutes. Symptoms are improved with rest and medication. His symptoms have significantly improved.

Effect on Activities of Daily Living

Self-Care/Personal Hygiene
He reported mild interference taking a shower, getting in/out of bath, brushing his teeth, getting on/off toilet, combing/brushing his hair, getting dressed or putting on socks/shoes.

Communication
He denied interference with mobile device use, typing, writing, seeing, and hearing.

Physical Activity
He reported mild interference with walking, sitting, standing, getting in and out of bed, taking out the trash, climbing stairs, sweeping, running, lifting, stooping, bending, twisting, carrying, reaching, pushing, pulling, crouching, and standing.

Sensory Function
He denied interference with seeing, tactile sensation, tasting smelling, hearing, and touching.

Non-Specialized Hand Activities
He reported mild to moderate interference with grasping, lifting, cutting food, opening jars, washing dishes, buttoning clothes, applying pressure, applying torque, grasping, and gripping.

Travel
Mr. Thompson does not drive.

Sexual Function
He denied interference with orgasm, ejaculation, and erection.

Sleep
He reported mild to moderate with restful sleep, waking cycles, sleep patterns, inability to fall asleep due to pain, and lack of sleep causing reduced daytime alertness.

Review of Systems

General: Positive for some gradual weigh gain. No fever, chills or fatigue.
Eyes: No eye pain, watering of the eyes, double vision, or redness.
ENT: No headaches, difficulty swallowing, nose bleeds, tinnitus, or earaches.
Cardiovascular: No chest pain, palpitations, fainting, or murmurs.

Respiratory: No shortness of breath, wheezing, cough, tightness, pain upon inspiration, or snoring.
Gastrointestinal: No heartburn and stomach irritation, nausea, vomiting, constipation, diarrhea, or bloody/tarry stools.
Genitourinary: No frequency and urgency, difficult/painful urination, flank pain, or bleeding.
Musculoskeletal: As stated in current complaints.
Skin: No poor healing, rash, itching, or redness.
Neurological: No dizziness, tremors, or seizures.
Psychiatric: Positive for difficulty sleeping due to pain, feelings of hopelessness, or excessive sadness.
Hematologic/Lymphatic: No easy bleeding or bruising.
Endocrine: No excessive thirst or urination or heat/cold intolerance.

Physical Examination

54-year-old right-handed male
Height: 5'5"
Weight: 165 pounds
BMI: 27.5 kg/m2
Alert/Oriented x3, No acute distress

Cervical Spine:
Appearance and muscle bulk: Normal
Skin: Intact
Palpation: Mild central third and right cervical paraspinal tenderness. No associated muscle spasms or guarding
Vascular: 2+ radial artery pulses bilaterally; good capillary refill of all 5 fingers bilaterally
Sensation: Sensation intact to light touch in the C5 through T1 dermatomes bilaterally
Strength: 5/5 bilaterally including shoulder abduction, shoulder forward flexion, shoulder extension, shoulder internal rotation, shoulder external rotation, supraspinatus, elbow flexion, elbow extension, wrist flexion, wrist extension, and finger abduction/adduction with the exception of 4+/5 right shoulder external rotation, 5-/5 right supraspinatus, and palpable weak right infraspinatus and teres minor
Reflexes: Trace biceps, and no triceps and brachioradialis reflexes bilaterally
Specialized testing: Negative Spurling's tests bilaterally. Negative Hoffman's tests bilaterally

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Extension	60Q/60Q/60Q	60Q
Flexion	50Q/S0Q/50Q	50Q
Left Rotation	60Q/62Q/62Q	SQQ
Right Rotation	58Q/60Q/62Q	80Q
Left Lateral Bend	45Q/45Q/45Q	45Q
Right Lateral Bend	45Q/45Q/45Q	45Q

Lumbar Spine:
Appearance and muscle bulk: Normal

Skin: Intact
Palpation: Moderate lower quartile central and right lumbar paraspinal tenderness with mild to moderate associated muscle spasms and guarding
Vascular: Palpable 1+ posterior tibial and 2+ dorsalis pedis pulses bilaterally; good capillary refill of all 5 toes bilaterally
Sensation: Sensation intact to light touch in the L1 through S1 dermatomes bilaterally
Strength: 5/5 bilaterally including hip flexion, hip extension, knee flexion, knee extension, ankle dorsiflexion, ankle plantarflexion, **EHL,** and **FHL**
Reflexes: No patellar and 1+ Achilles and symmetric reflexes bilaterally
Specialized testing: Negative seated and supine straight leg raises bilaterally
Negative clonus bilaterally. Negative Babinski's bilaterally

Lumbar Spine ROM		**Normal**
True Extension	25º/25º/25º	25º
True Flexion	60º/60º/60º	
Left Lateral Bend	15º/15º/15º	
Right Lateral Bend	15º/15º/15º	

Note: Lumbar spine flexion and extension reproduced low back pain.

Upper Extremities:
Appearance and muscle bulk: Normal bilaterally
Skin: Intact bilaterally
Neurovascular: Motor function and sensation to light touch intact in the median, radial, ulnar, and axillary nerve distributions bilaterally
Palpable 2+ radial artery pulse; good capillary refill fingers bilaterally
Reflexes: Trace biceps, and no triceps and brachioradialis reflexes bilaterally
Strength: 5/5 bilaterally including shoulder abduction, shoulder forward flexion, shoulder extension, shoulder internal rotation, shoulder external rotation, supraspinatus, elbow flexion, elbow extension, wrist flexion, wrist extension, and finger abduction/adduction with the exception of 4+/5 right shoulder external rotation, 5-/5 right supraspinatus, and palpable weak right infraspinatus and teres minor

Girth l'ltaf.1Jre111«,nts (cm)	**Right**	**Left**
Arm	30.6	31.1
Forearm	25.9	25.6

Right Shoulder:
Appearance: Well-healed arthroscopic portals
Palpation: Moderate subacromial crepitus with circumduction. Moderate pain with circumduction
No AC pain with crossarm adduction
AS rotator cuff: No tenderness AC joint: Mild tenderness Bicipital groove: Mild tenderness
Periscapular: No tenderness, including the levator scapulae, rhomboids, and trapezius muscles.
Strength: IR 5/5 ER 4+/5 Supraspinatus 5-/5
Impingement testing: Hawkins: Negative Neers: Negative Abduction arc: No discomfort
Biceps testing: Speed's: Negative Yergason's: Negative
SLAP testing: O'Brien's: Negative Overhead compression test: Negative
Lift off: Negative
ABER: Mildly positive

ShoUlder ROM	Ri,nt·:.....i. ....[ff		Norm:ar .....
Extension	50Q/50Q/50Q	50Q/50Q/50Q	50Q
Flexion	156Q/156Q/156Q	180Q/180Q/180Q	180Q
Abduction	156Q/156Q/156Q	180Q/180Q/180Q	180Q
Adduction	50Q/50Q/50Q	50Q/50Q/50Q	50Q
External Rotation	90Q/90Q/90Q	90Q/90Q/90Q	90Q
Internal Rotation	64Q/64Q/64Q	90Q/90Q/90Q	90Q

Left Shoulder:
Palpation: No subacromial crepitus with circumduction. No AC pain with crossarm adduction
AS rotator cuff: No tenderness AC joint: No tenderness Bicipital groove: No tenderness
Periscapular: No tenderness, including the levator scapulae, rhomboids, and trapezius muscles
Strength: IR 5/5 ER 5/5 Supraspinatus 5/5
Impingement testing: Hawkins: Negative Neers: Negative Abduction arc: No discomfort
Biceps testing: Speed's: Negative Yergason's: Negative
SLAP testing: O'Brien's: Negative Overhead compression test: Negative
Lift off: Negative
ABER: Negative

Lower Extremities:
Appearance and muscle bulk: Normal bilaterally
Skin: Intact
Neurovascular: Motor function and sensation to light touch intact in the tibial, superficial peroneal, and deep peroneal nerve distributions bilaterally

Palpable 1+ posterior tibial and 2+ dorsalis pedis pulses bilaterally; good capillary refill toes bilaterally
Strength: 5/5 bilaterally including hip flexion, hip extension, knee flexion, knee extension, ankle dorsiflexion, ankle plantar flexion, EHL, and FHL
Clonus: Negative bilaterally Babinski: Negative bilaterally

Girth Measurements (cm)	Right	Left
Thigh	46.3	46.2
Leg	35.7	35.7

Right Hip:
Palpation: Greater Trochanter: No tenderness Anterior Hip: No tenderness
Ischial Tuberosity: No tenderness
Strength: Quadriceps 5/5 Hamstring 5/5 Abduction 5/5
No groin pain throughout the full hip range of motion

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Extension	30Q/30Q/30Q	30Q/30Q/30Q	30Q
Flexion	100Q/100Q/100Q	100Q/100Q/100Q	100Q
External Rotation	50Q/50Q/50Q	50Q/50Q/50Q	50Q
Internal Rotation	20Q/20Q/20Q	20Q/20Q/20Q	20-40Q
Abduction	40Q/40Q/40Q	40Q/40Q/40Q	40Q
Adduction	20Q/20Q/20Q	20Q/20Q/20Q	20Q

Left Hip:
Palpation: Greater Trochanter: No tenderness Anterior Hip: No tenderness
Ischial Tuberosity: No tenderness
Strength: Quadriceps 5/5 Hamstring 5/5 Abduction 5/5
No groin pain throughout the full hip range of motion

Right Knee:
Alignment: Neutral coronal alignment
Swelling/Patellofemoral (PF): No effusion. No patellofemoral (PF) crepitus throughout the ROM
Palpation: Medial Joint Line (JL): No tenderness Lateral JL: No tenderness PF: No tenderness
Strength: Quadriceps 5/5 Hamstrings 5/5
LigamenVProvocative Testing
McMurray's: No medial and no lateral JL tenderness with no palpable meniscus displacement

Full flexion: No medial and no lateral JL tenderness
Full extension: No medial and no lateral JL tenderness
Lachman's: Negative
Pivot shift: Negative
Posterior drawer: Negative
MCL: Stable to valgus stress at O and 30°
LCL: Stable to varus stress at O and 30°

Knee ROM	Riijftt	Left	Normal
Extension	0º/0º/0º	0º/0º/0º	0º
Flexion	132º/132º/132º	135º/135º/135º	150º

Left Knee:
Alignment: Neutral coronal alignment
Swelling/Patellofemoral (PF): No effusion. No patellofemoral (PF) crepitus throughout the ROM
Palpation: Medial Joint Line (JL): Mild to moderate tenderness Lateral JL: No tenderness
PF: No tenderness
Strength: Quadriceps 5/5 Hamstrings 5/5
LigamenVProvocative Testing
McMurray's: No medial and no lateral JL tenderness with no palpable meniscus displacement
Full flexion: No medial and no lateral JL tenderness
Full extension: No medial and no lateral JL tenderness
Lachman's: Negative
Pivot shift: Negative
Posterior drawer: Negative
MCL: Stable to valgus stress at O and 30°
LCL: Stable to varus stress at O and 30°

Right Ankle/Foot:
Alignment: Hindfoot: Neutral alignment
Midfoot: No pes planus
Palpation: Anterior TaloFibular Ligament (ATFL): None CalcaneoFibular Ligament (CFL): None
Plantar fascia: None Base 5th MT: None Metatarsals: None
Strength: OF 5/5 PF 5/5 Peroneal 5/5 PTT: 5/5 EHL: 5/5 FHL: 5/5
LigamenVProvocative Testing
Tarsometatarsal Articulation: Chopart joint ROM: Normal
First TMT joint mobility: Normal
Passive external rotation: No anterior syndesmosis tenderness
Anterior drawer: Symmetric compared to the contralateral side
Talar tilt: Symmetric compared to the contralateral side
Mulder's test: No pain or click with metatarsal head compression

Too many toes sign: Negative

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Dorsiflexion w/ knee extended	10Q/10Q/10Q	10Q/10Q/10Q	10Q
Dorsiflexion w/ knee flexed	20Q/20Q/20Q	20Q/20Q/20Q	20Q
Plantarflexion	40Q/40Q/40Q	40Q/40Q/40Q	40Q
Hindfoot Inversion	30Q/30Q/30Q	30Q/30Q/30Q	30Q
Hindfoot Eversion	20Q/20Q/20Q	20Q/20Q/20Q	20Q

Left Ankle/Foot:

Alignment: Hindfoot: Neutral alignment
Midfoot: No pes planus
Palpation: Anterior TaloFibular Ligament (ATFL): Mild tenderness
CalcaneoFibular Ligament (CFL): None Plantar fascia: None Base 5th MT: None
Metatarsals: None
Deltoid ligament: Mild tenderness
Strength: OF 5/5 PF 5/5 Peroneal 5/5 PTT: 5/5 EHL: 5/5 FHL: 5/5
LigamenVProvocative Testing
Tarsometatarsal Articulation: Chopart joint ROM: Normal
First TMT joint mobility: Normal
Passive external rotation: No anterior syndesmosis tenderness
Anterior drawer: Symmetric compared to the contralateral side
Talar tilt: Symmetric compared to the contralateral side
Mulder's test: No pain or click with metatarsal head compression
Too many toes sign: Negative

Medical Record Review

Medical records totaling 339 pages were received for review. The records were reviewed by myself and summarized below. Enclosed were miscellaneous unremarkable records, cover letter, and declaration/attestation. All of these materials were thoroughly reviewed to ensure that no relevant information was overlooked.

Relevant Imaging Studies

06/12/2024 - Right Shoulder/Upper Extremity MRI, Brady Huang, M.D., California Orthopedic Institute Imaging Center, Page 302-303.

ORDERING PROVIDER: Christopher Behr, MD
HISTORY: Right shoulder pain with limited range of motion. Work-related fall on 07/21/2022.
FINDINGS: Full-thickness, full width tears of the supraspinatus and infraspinatus tendons with failure at their footprints, with retraction of tendon fibers to the level of the glenoid. There is low-to-moderate grade articular sided partial-thickness tearing of the superior fibers of the subscapularis tendon. The teres minor tendon is intact. There is severe atrophy of the supraspinatus and infraspinatus muscle, slightly progressed. There is mild atrophy of the superior fibers of the subscapularis muscle, slightly progressed. The teres minor muscle is normal in signal and bulk. The deltoid muscle is normal in size. There is attenuation of the intra-articular portion of the long head biceps tendon extending to the upper portion of the bicipital groove consistent with moderate to high-grade partial tearing. The lower portions of the long head biceps tendon are normal. There is degenerative fraying of the anterior labrum. There is chondral fissuring with underlying subchondral cyst formation in the posterior glenoid (series 3, image 12). There are prominent osteophytes along the inferior humeral head. There is a trace joint effusion. There is no evidence of acute fracture. There is moderate acromioclavicular osteoarthrosis with capsular hypertrophy. There is articulation of the humeral head with the undersurface of the acromion with resultant acromiohumeral interval narrowing secondary to full-thickness rotator cuff tear. There is a type 2 acromion on the sagittal views. The coracoacromial ligament is not thickened. A small amount of glenohumeral joint fluid communicates with the subacromial/subdeltoid bursa.
IMPRESSION: 1) Status post failed rotator cuff repair with 2 suture anchors evident in the greater tuberosity. No other significant change compared to the prior exam on 10/27/2022 with full-thickness tears of the supraspinatus and infraspinatus tendons retracted to the level of the glenoid and severe atrophy of the supraspinatus and infraspinatus muscles. Accompanying superior migration of the humeral head relative to the glenoid. 2) Low to moderate grade articular sided partial thickness tearing of the superior fibers of the subscapularis tendon. 3) Mild osteoarthrosis of the glenohumeral joint with low-grade chondral fissuring with underlying subchondral cyst formation in the posterior glenoid and prominent inferior humeral head osteophytes. Degenerative fraying of the anterior glenoid labrum. 4) Moderate to high-grade partial thickness tearing of the

intra-articular portion of the long head biceps tendon. 5) Moderate acromioclavicular osteoarthrosis.

08/23/2023 - Left Ankle MRI. Russell Fritz, M.D., SMI Imaging of San Diego. Page 300-301.

ORDERING PROVIDER: Franz Kopp, M.D.
HISTORY: Left ankle injury and pain.
FINDINGS: Lisfranc's ligament appears intact. There is a moderate sprain of the deltoid ligament. There is mild adjacent bone marrow edema in the anterior aspect of the medial malleolus. The syndesmotic ligaments appear intact. There is moderate thickening of the anterior talofibular ligament and mild thickening of the calcaneofibular ligament compatible with scarring from prior sprain injury. The plantar fascia, Achilles tendon, and extensor tendons appear normal. There is mild posterior tibial tendinosis distal to the medial malleolus. There is mild peroneus brevis and peroneus longus tendinosis along the lateral aspect of the calcaneus. There is mild thinning of the cartilage in the anteromedial aspect of the talar dome and adjacent anteromedial aspect of the tibial plafond. No loose bodies are identified.
IMPRESSION: 1) Moderate sprain of the deltoid ligament. 2) Moderate thickening of the anterior talofibular ligament and mild thickening of the calcaneofibular ligament compatible with scarring from prior sprain injury. 3) Mild posterior tibial tendinosis as well as mild peroneus brevis and longus tendinosis. 4) Mild thinning of the cartilage in the anteromedial aspect of the talar dome and adjacent anteromedial aspect of the tibial plafond.

10/27/2022 - Right Shoulder MRI. Ross Schwartzberg, M.D., Imaging Healthcare Specialists. Page 177-178.

ORDERING PROVIDER: Hai Lam, N.P.
HISTORY: Right shoulder pain.
FINDINGS: Rotator Cuff Region: Cuff Tendons: Full-thickness tear of the conjoined tendon component rotator cuff measuring approximately 4.6 x 3.9 cm in anterior posterior and mediolateral diameter respectively. Subscapularis tendon is preserved. Teres minor tendon is preserved. Cuff Muscles: Normal appearing muscles. Cuff Goutallier Stage: Stage II: Less fat than muscle within the muscle. Deltoid: Normal. No significant atrophy or tear. Long Biceps Tendon: Normal. No abnormal signal, attrition, or tear. Labrum/Biceps Anchor: Superior: Normal. No visible labral tear or biceps anchor pathology. Anterior/Inferior: Normal. No visible tear or attrition. Posterior: Normal. No posterior labrum abnormality. Capsule: Anterior/Inferior: Normal. No visible capsular laxity or thickening. Posterior: Normal. No visible capsular laxity or thickening. AC Joint Region: AC Joint: Arthrosis acromioclavicular joint. AC Ligaments: Normal acromioclavicular ligament. CC Ligaments: Normal coracoclavicular ligaments. Acromion: Normal horizontal (Type I) configuration. Subacromial Bursa: Small volume subacromial bursal effusion. Hyaline Cartilage: Normal. No visible cartilage narrowing or focal defect. Other Bones: Normal proximal humerus, glenoid, and coracoid. Other Observations: Small volume glenohumeral joint effusion with synovitis inferior axillary recess.

IMPRESSION: 1) Full-thickness tear of the conjoined tendon component rotator cuff including the footplate insertion on the greater tuberosity with myotendinous retraction and muscle atrophy. 2) Small volume subacromial bursal effusion and small volume glenohumeral joint effusion with synovitis inferior axillary recess. 3) Acromioclavicular joint arthrosis and capsular thickening.

10/12/2022 - Lumbar Spine MRI. Felix Wong, M.D., Imaging Healthcare Specialists. Page 175-176.

ORDERING PROVIDER: Hai Lam, N.P.
HISTORY: Back pain.
FINDINGS: Paraspinal Area: Normal with no visible mass. Bones: No fracture, pars defect, or osseous lesion. Cord/Cauda Equina: Normal caliber, contour, and signal intensity. Other: Hepatomegaly measuring 20 cm. Lumbar Disc Levels: L1-L2: Mild disc height loss and disc desiccation. No spinal canal or neural foraminal stenosis. L2-L3: No significant disc/facet abnormality, spinal stenosis, or foraminal stenosis. L3-L4: Mild disc height loss and disc desiccation. No spinal canal or neural foraminal stenosis. L4-L5: Mild disc height loss and disc desiccation. No spinal canal stenosis. Mild bilateral neural foraminal stenosis secondary to the mild disc bulge and mild facet arthropathy. L5-S1: Mild disc height loss and disc desiccation. No spinal canal stenosis. Mild bilateral neutral foraminal stenosis secondary to disc bulge and mild facet arthropathy. Other: None.
IMPRESSION: 1) Mild degenerative changes of the lumbar spine. 2) Mild bilateral neural foraminal stenosis at L4-L5 and L5-S1 secondary to the mild disc bulge and mild facet arthropathy.

10/12/2022 - Left Ankle MRI. Felix Wong, M.D., Imaging Healthcare Specialists. Page 173-174.

ORDERING PROVIDER: Hai Lam, N.P.
HISTORY: Left ankle pain.
FINDINGS: Lateral Ligaments and Soft Tissue Structures: Talofibular: Irregularity of the anterior talofibular ligament, likely related to low-grade partial tearing. Calcaneofibular: Normal. Tibiofibular: Normal. Peroneal Tendons: Normal. No subluxation, tendinopathy, or tear. Other: None. Medial Ligaments and Soft Tissue Structures: Deltoid Complex: Irregularity of the deep fibers of the deltoid ligament, concerning for partial ligamentous tear. Spring Ligament: The spring ligament also is not clearly identified, also concerning for partial ligamentous tear. Tarsal Tunnel: Normal. Flexors: Normal. Other: None. Other Tendons: Extensors: Normal. Achilles: Normal. No surrounding abnormality. Other: None. Plantar Fascia: Normal. No tear or surrounding soft tissue edema to suggest fasciitis. Sinus Tarsi: Normal. No edema or synovitis to suggest sinus tarsi syndrome. Bones: Mild osseous edema along the medial malleolus and distal fibula. Effusions: None. No synovitis or loose bodies. Cartilage: Normal thickness and signal. No visible chondral defect. Other: No other significant findings.
IMPRESSION: 1) Irregularity of the spring ligament and deep fibers of the deltoid complex, raising concern for partial thickness ligamentous tears. Correlation with stress view radiographs of the ankle and orthopedic consultation is suggested. 2) Low-grade partial tear of the ATFL. 3) Mild osseous edema along the medial and lateral malleolus. No discrete fracture identified.

08/26/2022 - Left Knee Radiographs. Harold Tate, M.D., Concentra, Page 72.
ORDERING PROVIDER: Hai Lam, N.P.
HISTORY: Strain.
FINDINGS: There is no evidence of acute fracture, dislocation or osseous lesion. The tibiofemoral joint space is preserved. The adjacent soft tissues appear unremarkable, with no evidence of joint effusion.
IMPRESSION: Normal knee.

08/24/2022 - Left Foot Radiographs. Ronald Petcher, M.D., Concentra, Page 58.
ORDERING PROVIDER: Cynthia Purviance, M.D.
HISTORY: Fell 1 month ago/persistent left ankle pain.
FINDINGS/IMPRESSION: There is mild swelling overlying the medial malleolus of the left foot. The osseous architecture and mortise are preserved. Mild swelling over the medial malleolus without underlying osseous pathology.

07/21/2022 - Cervical Spine CT Scans. Kok Tan, M.D., Paradise Valley Hospital, Page 6-7.
ORDERING PROVIDER: Allison Kornblatt, M.D.
HISTORY: Pain.
FINDINGS: There is loss of the normal cervical lordosis. Straightening of the cervical spine likely due to muscle spasm. Vertebral body heights are maintained. Multilevel degenerative disc disease, narrowing at C3-4, C4-5 and CS-6. Minimal facet arthropathy. No dislocated facets. There is no perched or jumped facet. The prevertebral soft tissues are not thickened. Limited sections of the lung apices demonstrate no pneumothorax. The dens is intact. The occipital condyles are intact. The atlantoaxial distance is not widened. The lateral atlanto-dental distances are not widened. The craniocervical junction is intact. The mastoid air cells are clear. The thyroid gland is heterogeneous and would benefit from nonemergent thyroid ultrasound imaging. lntraspinal contents such as epidural hematomas are suboptimally resolved on CT, and MRI is recommended, if symptoms persist.
IMPRESSION: No displaced fracture. Degenerative changes. No loss of vertebral body height. Recommend MRI if clinical symptoms persist.

07/21/2022 - Head/Brain CT Scans. Kok Tan, M.D., Paradise Valley Hospital, Page 8.
ORDERING PROVIDER: Allison Kornblatt, M.D.
HISTORY: Altered mental state.
FINDINGS: There is no acute infarct, intracranial hemorrhage, or mass effect. There is no hydrocephalus, or significant midline shift. The basal cisterns are not effaced. The visualized paranasal sinuses and mastoids are well-aerated, irregularity of the nasal bone, probably due to prior fractures.
IMPRESSION: No intracranial hemorrhage. MRI is recommended if symptoms persist.

07/21/2022 - Left Humerus Radiographs. Tuan Nguyen. M.D.. Paradise Valley Hospital. Page i-

ORDERING PROVIDER: Richard Obler, M.D.
HISTORY: Status post fall.
FINDINGS: AP and lateral views demonstrate anatomic shoulder and elbow joints. No acute displaced fracture, opaque foreign body or abnormal soft tissue calcification.
IMPRESSION: No acute bony injury seen involving the left humerus.

07/21/2022 -Thoracic Spine Radiographs. Robert Obedian. M.D.. Paradise Valley Hospital. Page 10.

ORDERING PROVIDER: Richard Obler, M.D.
HISTORY: Fall. Pain.
FINDINGS: There is normal mineralization without fracture. There is normal anatomic alignment. There is mild to moderate multilevel intervertebral disc space narrowing and small endplate osteophyte formation. The pedicles are intact. The surrounding soft tissues are unremarkable.
IMPRESSION: No fracture. Mild to moderate multilevel degenerative changes of the thoracic spine.

07/21/2022 - Lumbar Spine Radiographs. Tuan Nguyen. M.D.. Paradise Valley Hospital. Page 11.

ORDERING PROVIDER: Allison Kornblatt, M.D.
HISTORY: Status post fall, back pain.
FINDINGS: The vertebral body heights are maintained. There is no evidence of acute fracture. No suspicious focal osseous lesions are identified. There is normal lumbar lordosis without significant subluxation. The discs are normal in height. Mild multilevel endplate spurring is noted.
IMPRESSION: No acute bony injury is seen involving the lumbar spine.

07/21/2022 - Left Foot Radiographs. Tuan Nguyen. M.D.. Paradise Valley Hospital. Page 12.

ORDERING PROVIDER: Allison Kornblatt, M.D.
HISTORY: Status post fall.
FINDINGS: AP, oblique and lateral views demonstrate anatomic alignment. There is no acute displaced fracture, opaque foreign body or abnormal soft tissues calcification. The alignment is within normal limits including the Lisfranc joint.
IMPRESSION: No acute bony injury involving the left foot.

07/21/2022 - Right Ankle Radiographs. Robert Obedian. M.D.. Paradise Valley Hospital. Page 13.

ORDERING PROVIDER: Allison Kornblatt, M.D.
HISTORY: Fall.
FINDINGS: There is normal mineralization without fracture or dislocation. The joint spaces are well maintained. There is no hypertrophic or erosive change. The surrounding soft tissues are unremarkable.

IMPRESSION: No fracture or dislocation.

07/21/2022 - Left Ankle Radiographs, Tuan Nguyen, M.D., Paradise Valley Hospital, Page 14.
ORDERING PROVIDER: Allison Kornblatt, M.D.
HISTORY: Fall injury.
FINDINGS: AP, mortise and lateral views of the left ankle are provided. There is no acute displaced fracture. The alignment is within normal limits with no medial or lateral clear space widening. The distal tibiofibular syndesmotic distance is within normal limits. The talar dome is smooth. No suspicious focal osseous lesions are identified. No significant tibiotalar joint effusion is present. No heel spur is seen.
IMPRESSION: No acute bony injury involving the left ankle.

07/21/2022 - Left Leg Radiographs, Tuan Nguyen, M.D., Paradise Valley Hospital, Page 15.
ORDERING PROVIDER: Allison Kornblatt, M.D.
HISTORY: Status post injury.
FINDINGS: AP and lateral views demonstrate relative osteopenia and no acute displaced fracture, opaque foreign body or abnormal soft tissues calcification. The knee and ankle joints are anatomic.
IMPRESSION: No acute bony injury seen involving the left leg.

07/21/2022 - Chest Radiographs, Robert Obedian, M.D., Paradise Valley Hospital, Page 16.
ORDERING PROVIDER: Allison Kornblatt, M.D.
HISTORY: Fall.
FINDINGS: The cardiomediastinal silhouette is unremarkable. The lungs are clear. There is no infiltrate, pleural effusion or pneumothorax. There is a mild dextroscoliosis of the thoracic spine with moderate degenerative changes.
IMPRESSION: No evidence of acute disease.

07/21/2022 - Pelvis Radiographs, Robert Obedian, M.D., Paradise Valley Hospital, Page 17.
ORDERING PROVIDER: Allison Kornblatt, M.D.
HISTORY: Fall.
FINDINGS: There is normal mineralization without fracture or dislocation. There is mild left hip joint space narrowing with snail bony productive changes. The remainder of the joint spaces are well maintained. The surrounding soft tissues are unremarkable.
IMPRESSION: No fracture or dislocation. Mild left hip degenerative change.

Relevant Operative Reports

03/27/2024 - Operative Report, Right Shoulder Arthroscopy, Rotator Cuff Repair, Debridement, Decompression with Acromioplasty and Coracoacromial Ligament Release, Christopher Behr, M.D., Mission Valley Heights Surgery Center, Page 315-317.
SURGEON: Christopher T. Behr, M.D.
ASSISTANT: Bryan Bourland, DO.

PREOPERATIVE DIAGNOSIS: Rotator cuff tear, right shoulder.
POSTOPERATIVE DIAGNOSIS: 1) Massive rotator cuff tear, right shoulder involving entire supraspinatus and infraspinatus. 2) Partial long head biceps tendon tear. 3) Anterior labral tear/sprain. 4) SLAP tear. 5) Subacromial impingement. 6) Subacromial bursitis.
PROCEDURE: 1) Diagnostic arthroscopy, right shoulder. 2) Arthroscopic rotator cuff repair, right shoulder. 3) Arthroscopic extensive debridement of partial biceps tear, anterior labral tear, SLAP tear, bursitis, right shoulder. 4) Arthroscopic subacromial decompression with acromioplasty and coracoacromial ligament release, right shoulder.
ANESTHESIA: General with right interscalene nerve block performed by the anesthesiologist under ultrasound guidance for postoperative analgesia.
IMPLANTS: 5.5: titanium corkscrew anchor from Parcus Medical.
OPERATIVE INDICATIONS: A 53-year-old male who has disabling shoulder pain as a result of a work-related injury. He was referred and worked up and found to have a significant rotator cuff tear. Discussed further management. The tear was large with some atrophy but due to his young age and activity level, occupation, discussed proceeding with rotator cuff repair. He was advised that it is likely that only a partial repair can be performed. He does give his consent to proceed.
EXAMINATION UNDER ANESTHESIA: Full range of passive motion. No instability.
OPERATIVE FINDINGS: 1) Massive rotator cuff tear involving the entire supraspinatus and infraspinatus. The supraspinatus was not repairable. The infraspinatus was repairable. 2. Anterior labral tear/sprain. 3) SLAP tear. 4) Partial long head biceps tendon tear. 5) Type Ill acromion with subacromial impingement. 6) Subacromial bursitis.
OPERATIVE PROCEDURE: The patient was taken to the operating room and placed on the operating room table. After appropriate placement of hemodynamic monitoring device by the anesthesiologist, the patient underwent successful induction of anesthesia. The patient was then positioned supine on the operating room table. The patient had a right interscalene nerve block, followed by general anesthesia. The patient was carefully positioned in the beach chair position on the operating room table. The head and neck were placed in neutral position. The eyes were protected. Legs were padded. All bony prominences were padded. The patient had sequential compression devices to the lower extremities for DVT prophylaxis. The right shoulder and right upper extremity were carefully prepped and draped adherent to strict sterile technique. A surgical time-out was performed. All operating room staff was in agreement with the surgical plan. A posterior portal incision was then made with a scalpel and the arthroscope was placed into the glenohumeral joint of the right shoulder. Under direct visualization, using spinal needle localization, an anterior portal was established and made with a scalpel. An outflow cannula was placed through the rotator interval. A probe was placed. A diagnostic arthroscopy was then carried down in systematic fashion. The articular cartilage on the humeral head and glenoid were intact. The anterior labrum was frayed and torn. The superior labrum was frayed and torn. Subscapularis was intact. There was a complete tear of the supraspinatus and the infraspinatus. The teres minor was intact. At this point, an arthroscopic shaver was placed in the glenohumeral joint and a thorough extensive debridement was carried out. The anterior labrum was debrided. The superior labrum was debrided. The long head of the biceps tendon was debrided. There was a partial tear involving 30% of the thickness of the tendon. The arthroscope was then placed in the subacromial space.

The torn rotator cuff scarred to the acromial roof. There was noted to become atrophy of the tendon and muscle. Meticulous dissection of the tendon off of the acromion and off of the deltoid was carefully performed with an ArthroCare radiofrequency wand and an elevator. The coracoacromial ligament was significantly frayed consistent with an external impingement pattern. The coracoacromial ligament was released. This exposed a hooked acromion. A 5.5 resector was used to perform an anterior acromioplasty. Anterior acromion resected back to a stable flat acromion. At this point, the rotator cuff was mobilized. The supraspinatus was not able to be brought back over, however the infraspinatus was able to be repaired. The greater tuberosity was prepared with the motorized shaver to remove any soft tissue. A spinal needle was used to localize the insertion of an anchor. A pilot hole was created and a 5.5 Titanium Corkscrew anchor from Parcus Medical was then implanted into the greater tuberosity. This was a triple loaded anchor. The suture passed in a simple fashion through the torn edge of the infraspinatus. The infraspinatus was advanced back down to the greater tuberosity. The posterior half of the greater tuberosity was covered. A margin convergence suture was then used to repair the edge of the supraspinatus into the infraspinatus. At this point, excess suture was cut off. The arm was taken through range of motion. It was not undue tension on the repair. The instruments were removed, portals were closed with Monocryl sutures and Steri Strips. Sterile dressings were applied. The patient tolerated the procedure well and the patient was transferred to the recovery room in stable condition.

09/14/2023 - Cortisone Injection, Franz Kopp, M.D., San Diego Orthopedic Associates, Page 245.

SURGEON: Franz Kopp, M.D.
PRE/POSTOPERATIVE DIAGNOSIS: Primary osteoarthritis, left ankle and foot.
PROCEDURE PERFORMED: Cortisone injection with 2 cc lidocaine, 2 cc Marcaine, 2 cc Depa, with ultrasound guidance.

Relevant Orthopaedic Reports

04/18/2024 - Follow Up Report, Maneesh Bawa, M.D., San Diego Orthopedic Associates, Page 296-298.

SUBJECTIVE COMPLAINTS: Patient presents for follow up. He recently had right rotator cuff repair with Dr. Behr on 03/27/2024 and reports he is doing well overall. He will resume chiropractic appointments when he recovers. Additionally, he endorses acupuncture helped him with his pain in the past and would like to request for visits. He continues to practice a home exercise program for neck, core, and back strengthening. Patient has been experiencing increasing **left knee** pain.
PHYSICAL EXAM: Patient is in a **right shoulder** sling. Mild tenderness to palpation of the **back.** 4/5 strength in left deltoid, biceps, triceps, wrist extensors, intrinsics, and grip. Right upper extremity exam limited due to recent surgery and sling. Mild difficulty with toe and heel walk due to pain.
ASSESSMENT: 1) **Neck** pain. 2) Loss of normal **cervical** lordosis. 3) C5-C6 spondylolisthesis. 4) C6-C7 ODD. 5) **Low back** pain. 6) Mild multilevel lumbar ODD. 7

PLAN: Request additional 6 visits of chiropractic therapy as well as referral to acupuncture x6. His **left knee** pain has been worsening. Dr. Kopp is authorized to treat the **left knee.** He should reach out to his primary treating physician to confirm who is authorized to treat him for this.
WORK STATUS: No repetitive climbing, bending, or twisting. No lifting greater than 20 pounds. Avoid prolonged neck extension or flexion postures.

04/04/2024 - Primary Treating Physician's Postop Report, Christopher Behr, M.D., San Diego Orthopedic Associates, Page 293-294.

PRESENT COMPLAINTS: The patient comes for his first postoperative office visit. The patient is status post arthroscopic rotator cuff repair with extensive debridement and SAD, **right shoulder,** 03/27/2024.
PHYSICAL EXAM: Normal exam.
RADIOGRAPHIC EVALUATION: Right shoulder radiographs showed some glenohumeral arthritis with an inferior humeral head spur and a metallic anchor in appropriate position.
DIAGNOSIS: Status post arthroscopic rotator cuff repair with extensive debridement and SAD, **right shoulder.**
DISCUSSION: The procedure and the operative findings were discussed with the patient. The patient is 1 week status post arthroscopic rotator cuff repair with extensive debridement and SAD, **right shoulder.** He presents doing good. Incisions are well healed. Recommend the continued use of ice and medication as needed for pain management. He may begin to wash normally. Will begin physical therapy next visit. The patient was given instructions for his postoperative recovery.
WORK STATUS: Unable to perform any work activities at this time.

03/21/2024 - Primary Treating Physician's Follow Up Report, Christopher Behr, M.D., San Diego Orthopedic Associates, Page 289-292.

PRESENT COMPLAINTS: Patient was seen for follow up. He presents with ongoing pain in the **right shoulder.** The surgery was approved however he has not received medical clearance.
PHYSICAL EXAM: **Bilateral shoulder:** Range of motion with pain and showed abduction to 120 degrees bilaterally, forward elevation to 120 degrees bilaterally, external rotation (arm at side) to 60 degrees bilaterally, external rotation (90 degree abduction) to 80 degrees bilaterally, internal rotation to (90 degree abduction) to 40 degrees, internal rotation (spinous process) to T12 bilaterally. External rotation, supraspinatus strength was 4/5 on the right.
DIAGNOSIS: Rotator cuff tear with retraction, **right shoulder.**
DISCUSSION: The request for **right shoulder** arthroscopy with rotator cuff repair, subacromial decompression, debridement, and possible biceps tenodesis was authorized. He presents with ongoing pain in the **right shoulder.** The patient's surgical procedure was discussed with him in detail. The patient was given a prescription for postoperative pain medication, Percocet, and physical therapy. The patient was dispensed arm brace immobilizer sling.
WORK STATUS: Per primary treating physician.

03/04/2024 - Orthopedic Foot and Ankle Consultation, Franz Kopp, M.D., San Diego Orthopedic Associates, Page 286-288.

SUBJECTIVE COMPLAINTS: Patient was seen for follow up. Overall, his ankle has been doing much better. He does not experience any ankle pain when he wears his brace. He wears the brace most of the time, especially if he anticipates doing a lot of walking.
PHYSICAL EXAM: **Left foot/ankle:** Minimal tenderness over anterior medial aspect of ankle. Range of motion showed ADF to 10 degrees, APF to 45 degrees with significant pain. Mild laxity with anterior drawer test.
ASSESSMENT: **Left ankle** sprain/strain, ankle arthrosis.
PLAN: Continue with functional ankle brace. No further treatment may be necessary for his ankle. He plans to focus on his upcoming shoulder surgery with Dr. Behr.
WORK STATUS: Per primary treating physician.

02/23/2024 - Primary Treating Physician's Supplemental Report, Christopher Behr, M.D., San Diego Orthopedic Associates, Page 283-285.
PRESENT COMPLAINTS: Patient was seen for follow up. He has significant **shoulder** pain.
PHYSICAL EXAM: **Bilateral shoulder:** Range of motion with pain and showed abduction to 120 degrees bilaterally, forward elevation to 120 degrees bilaterally, external rotation (arm at side) to 60 degrees bilaterally, external rotation (90 degree abduction) to 80 degrees bilaterally, internal rotation to (90 degree abduction) to 40 degrees, internal rotation (spinous process) to T12 bilaterally. External rotation, supraspinatus strength was 4/5 on the right.
DIAGNOSIS: Rotator cuff tear with retraction, **right shoulder.**
DISCUSSION: Request authorization for **right shoulder** arthroscopy with rotator cuff repair, subacromial decompression, debridement, and possible biceps tenodesis.

02/20/2024 - Follow Up Report, Maneesh Bawa, M.D., San Diego Orthopedic Associates, Page 279-281.
SUBJECTIVE COMPLAINTS: Patient presents for follow up. He continues to have pain in the **neck and low back** aggravated with extended periods of walking and sitting.
PHYSICAL EXAM: He cannot toe walk secondary to **left ankle** pain. **Lumbar** extension to 10 degrees with some pain. Mild tenderness to palpation of the **back.** Tenderness to palpation over posterior **cervical** area.
ASSESSMENT: 1) **Neck** pain. 2) Loss of normal **cervical** lordosis. 3) C5-C6 spondylolisthesis. 4) C6-C7 ODD. 5) **Low back** pain. 6) Mild multilevel lumbar ODD. 7) **Right shoulder** pain. 8) Right rotator cuff tear with retraction and muscle atrophy. 9) Right AC OA. 10) Mild right glenohumeral OA.
PLAN: Request additional 8 visits of chiropractic therapy.
WORK STATUS: No repetitive climbing, bending, or twisting. No lifting greater than 20 pounds. Avoid prolonged neck extension or flexion postures.

01/22/2024 - Orthopedic Foot and Ankle Consultation, Franz Kopp, M.D., San Diego Orthopedic Associates, Page 276-278.

SUBJECTIVE COMPLAINTS: Patient was seen for follow up. Overall, his ankle has been feeling a little bit better. Although he still experiences some ankle pain with weight bearing activity the pain has improved a little bit.
PHYSICAL EXAM: **Left foot/ankle:** Ambulates with a slight limp favoring the left lower extremity. Minimal swelling of ankle. Generalized tenderness about the entire ankle. Maximum tenderness over anterior medial aspect of ankle. Range of motion showed ADF to 10 degrees, APF to 40 degrees with pain. Some laxity with anterior drawer test.
ASSESSMENT: **Left ankle** sprain/strain, ankle arthrosis.
PLAN: Advised to wear a functional ankle brace. He may wear the brace with supportive shoe for weightbearing activity.
WORK STATUS: Per primary treating physician.

01/19/2024 - Primary Treating Physician's Follow Up Report, Christopher Behr, M.D., San Diego Orthopedic Associates, Page 271-273.
PRESENT COMPLAINTS: Patient presents with ongoing pain in the **bilateral shoulders** with popping and grinding.
PHYSICAL EXAM: **Bilateral shoulder:** Range of motion showed abduction to 90 degrees on the right, 110 degrees on the left, forward elevation to 90 degrees on the right and 110 degrees on the left, external rotation (arm at side) to 50 degrees bilaterally, external rotation (90 degree abduction) to 60 degrees bilaterally, internal rotation to (90 degree abduction) to 40 degrees, internal rotation (spinous process) to T12 bilaterally, extension to 30 degrees bilaterally, adduction to 30 degrees bilaterally. Positive Neer and Hawkins bilaterally. Drop arm test positive on the right. External rotation, supraspinatus strength was 4/5.
DIAGNOSIS: 1) Industrial rotator cuff tear **left shoulder.** 2) Industrial rotator cuff tear **right shoulder.**
DISCUSSION: His MRI is too old so will request an updated MRI of the **right shoulder.** He still has not retrieved the MRI of the **left shoulder.** Advised to get this in order for it to be reviewed.
WORK STATUS: Per primary treating physician.

01/18/2024 - Follow Up Report, Maneesh Bawa, M.D., San Diego Orthopedic Associates, Page 267-269.
SUBJECTIVE COMPLAINTS: Patient presents for follow up. He continues to have pain in the **neck and low back** aggravated with extended periods of walking and sitting.
PHYSICAL EXAM: He cannot toe walk secondary to **left ankle** pain. **Lumbar** extension to 10 degrees with some pain. Mild tenderness to palpation of the **back.** Tenderness to palpation over posterior **cervical** area.
ASSESSMENT: 1) **Neck** pain. 2) Loss of normal **cervical** lordosis. 3) C5-C6 spondylolisthesis. 4) C6-C7 ODD. 5) **Low back** pain. 6) Mild multilevel lumbar ODD. 7) **Right shoulder** pain. 8) Right rotator cuff tear with retraction and muscle atrophy. 9) Right AC OA. 10) Mild right glenohumeral OA.
PLAN: Request additional 8 visits of chiropractic therapy with Dr. Michael Flint.

WORK STATUS: No repetitive climbing, bending, or twisting. No lifting greater than 20 pounds. Avoid prolonged neck extension or flexion postures.

01/03/2024 to 02/10/2024 - Chiropractic Reports, Michael Flint, D.C., Facility not Indicated, Page 304-310.

Attended 8 sessions of chiropractic treatment.
01/03/2024: Patient indicated he is feeling frequent moderately severe pain in the **neck.** This is further described as restricted movement and stiffness as well as dull and sharp pain. He related that he is feeling frequent moderately severe headache. He further describes it as dull and sharp, pain. He remarked that he has been feeling frequent moderately severe pain in the **lower back** area. This is further described as restricted movement and stiffness as well as dull and sharp pain He also stated today that he has been feeling frequent moderately severe pain in the **upper back** area. This is further described as inflexibility and stiffness as well as dull and sharp pain. Pain has been problematic off and on since a fell off a ladder in 2021.
02/10/2024: Patient stated there has been an improvement in the amount of pain felt in the **neck.** In addition, he states that he is experiencing some improvement in the degree of headache. He also reported that the pain in the **low back** area is reported as less intense today. He further stated that the **thoracic** pain is slightly more pronounced.
DIAGNOSIS: 1) Headache. 2) Segmental and somatic dysfunction of **cervical** region. 3) Cervicalgia. 4) Torticollis. 5) Muscle spasm of **back.** 6) Segmental and somatic dysfunction of **lumbar** region. 7) **Low back** pain. 8) Segmental and somatic dysfunction of **thoracic** region. 9) Pain in **thoracic spine.**
TREATMENT: Myofascial release, diathermic deep heating, adjustments.

12/15/2023 - Orthopedic Consultation, Christopher Behr, M.D., San Diego Orthopedic Associates, Page 262-266.

DATE OF INJURY: 07/21/2022
JOB DESCRIPTION: The patient is employed by Cleaning Service where he has worked as a kitchen cleaning tech, for 3.5 years. His job entails all aspect of deep cleaning kitchens. He works 8 hours per day for a total of 40 hours per week. He doesn't not work for this employer anymore.
HISTORY OF INJURY: Patient states that on 07/21/2022 he was working in his usual and customary fashion, when he was working on top of a ladder when he slipped and fell 12 feet. He reported the incident to his manager and received treatment the same day. He noted the left is worse than the right shoulder. He has attempted physical therapy and acupuncture for the shoulder. He noted the physical therapy relieved his pain temporarily. He returned to work for 6 months on modified duty however at this time he doesn't work for this employer. He rates his pain is 8/10.
PRESENT COMPLAINTS: **Bilateral shoulder** pain.
PHYSICAL EXAM: **Bilateral shoulder:** Range of motion showed abduction to 90 degrees on the right, 110 degrees on the left, forward elevation to 90 degrees on the right and 110 degrees on the left, external rotation (arm at side) to 50 degrees bilaterally, external rotation (90 degree abduction)

to 60 degrees bilaterally, internal rotation to (90 degree abduction) to 40 degrees, internal rotation (spinous process) to T12 bilaterally, extension to 30 degrees bilaterally, adduction to 30 degrees bilaterally. Positive Neer and Hawkins bilaterally. Drop arm test positive on the right. External rotation, supraspinatus strength was 4/5.
RADIOGRAPHIC EVALUATION: Plain radiographs, 3 views, of the **right shoulder** reveal superior migration of the humeral head, AC arthritis, spur on the clavicle. Plain radiographs, 3 views, of the **left shoulder** reveal mild degenerative change glenohumeral.
DIAGNOSIS: 1) Industrial rotator cuff tear **left shoulder.** 2) Industrial rotator cuff tear **right shoulder.**
DISCUSSION: The patient presents for an evaluation or his **bilateral shoulder.** He sustained a fall off a ladder 12 feet. His **left shoulder** is more painful than the right shoulder. He has attempted physical therapy and acupuncture with no relief. He had a prior MRI scan however didn't bring it in today. Recommend the patient obtain the MRI scan and bring it in next visit. The patient will follow up once MRI is obtained.
DISABILITY STATUS: The patient is not permanent and stationary.
WORK RESTRICTIONS: Per primary treating physician.
CAUSATION: It was opined, based within reasonable medical probability, that his symptoms are causally related to the industrial injury of 07/21/2022.
APPORTIONMENT: 100% of the patient's disability is a result of his industrial injury.
VOCATIONAL REHABILITATION: Not indicated.
TREATMENT RECOMMENDATIONS: Patient needs to retrieve MRI discs of both shoulders.

12/05/2023 - Follow Up Report, Maneesh Bawa, M.D., San Diego Orthopedic Associates, Page 258-260.

SUBJECTIVE COMPLAINTS: Patient presents for follow up. He was only approved for 2 sessions of physical therapy stating he has exhausted his therapy sessions. He states physical therapy heled to improve the range of motion of both his neck and back. He does however continue to have pain in the **neck and back.** He was approved to see Dr. Behr for treatment of his **bilateral shoulders.**
PHYSICAL EXAM: He cannot toe walk secondary to **left ankle** pain. **Lumbar** extension to 10 degrees with some pain. Mild tenderness to palpation of the **back.** Tenderness to palpation over posterior **cervical** area. Range of motion of the **shoulders** showed flexion to 160 degrees on the left and 140 degrees on the right, external rotation to 40 degrees on the left and 30 degrees on the right, internal rotation to L4 bilaterally. 4/5 strength of the right rotator cuff. Positive impingement signs with Hawkin's and Neer's on the right.
ASSESSMENT: 1) **Neck** pain. 2) Loss of normal **cervical** lordosis. 3) C5-C6 spondylolisthesis. 4) C6-C7 ODD. 5) **Low back** pain. 6) Mild multilevel lumbar ODD. 7) **Right shoulder** pain. 8) Right rotator cuff tear with retraction and muscle atrophy. 9) Right AC OA. 10) Mild right glenohumeral OA.
PLAN: He continues to have pain in the **neck and back.** Request 6 visits of chiropractic therapy. Continue home exercise program. Follow up with Dr. Behr regarding the bilateral shoulders and Dr. Kopp regarding the lower extremities.

WORK STATUS: No repetitive climbing, bending, or twisting. No lifting greater than 20 pounds. Avoid prolonged neck extension or flexion postures. No overhead reaching or work with the right upper extremity. Lower extremity restrictions per Dr. Kopp.

11/16/2023- Orthopedic Foot and Ankle Consultation, Franz Kopp, M.D., San Diego Orthopedic Associates, Page 255-257.

SUBJECTIVE COMPLAINTS: Patient was seen for follow up. The injection to the **left ankle** failed to provide any benefit. His symptoms remain unchanged. He continues to experience **left ankle** pain. Pain involves the entire ankle. Although the pain is exacerbated by weightbearing activity, he occasionally experiences ankle pain at rest as well.

PHYSICAL EXAM: **Left foot/ankle:** Ambulates with a slight limp favoring the left lower extremity. Minimal swelling of ankle. Generalized tenderness about the entire ankle. Maximum tenderness over anterior medial aspect of ankle. Range of motion showed ADF to 10 degrees, APF to 40 degrees with pain. Some laxity with anterior drawer test.

ASSESSMENT: **Left ankle** sprain/strain, ankle arthrosis.

PLAN: He failed to derive any benefit from the **left ankle** injection at the time of his last visit. His ankle pain persists despite numerous treatment modalities including physical therapy, ultrasound, acupuncture, medication and injection. It was opined there are no orthopedic foot and ankle surgical indications at this time. He has not tried a brace up to this point. Will request authorization for this.

WORK STATUS: Per primary treating physician.

10/24/2023 - New Patient Report, Maneesh Bawa, M.D., San Diego Orthopedic Associates, Page 249-251.

DATE OF INJURY: 07/21/2022

HISTORY OF INJURY: Patient presents for evaluation of his **neck and low back.** At the time of injury, he was employed by Cleaning Service where he worked in maintenance for 3.5 years. This required constant bending, twisting, stooping, kneeling, squatting, crawling, lifting, carrying, pushing, pulling, grasping, and pinching. He was completing his normal work duties on 07/21/2022 when he was on a ladder, it slipped and he fell 11 feet onto his face. Since then, he has had pain in his **low back.** He denies pain down the legs. He also has pain in the **neck and right shoulder.** He also complains of **right shoulder** weakness. He previously had 16-24 sessions of physical therapy for the neck, right shoulder, and back which he states improved his function but not the pain. He had 24 sessions of chiropractic therapy which he states helped with both neck and back pain. He had 16 sessions of acupuncture therapy which he states helped. He practices a home exercise program. He is light duty but not currently working.

PHYSICAL EXAM: He cannot toe walk secondary to **left ankle** pain. **Lumbar** extension to 10 degrees with some pain. Mild tenderness to palpation of the **back.** Tenderness to palpation over posterior **cervical** area. Range of motion of the **shoulders** showed flexion to 160 degrees on the left and 140 degrees on the right, external rotation to 40 degrees on the left and 30 degrees on the right, internal rotation to L4 bilaterally. 4/5 strength of the right rotator cuff. Positive impingement signs with Hawkin's and Neer's on the right.

CERVICAL SPINE RADIOGRAPHS: Loss of normal cervical lordosis. C5-C6 spondylolisthesis. There is C6-7 ODD.
LUMBAR SPINE RADIOGRAPHS: Mild multilevel ODD.
RIGHT SHOULDER RADIOGRAPHS: AC osteoarthritis. Mild glenohumeral osteoarthritis.
ASSESSMENT: 1) **Neck** pain. 2) Loss of normal **cervical** lordosis. 3) C5-C6 spondylolisthesis. 4) C6-C7 ODD. 5) **Low back** pain. 6) Mild multilevel lumbar ODD. 7) **Right shoulder** pain. 8) Right rotator cuff tear with retraction and muscle atrophy. 9) Right AC OA. 10) Mild right glenohumeral OA.
CAUSATION: It was opined within reasonable medical probability, based on the patient's history and review of the documentation, that the patient's current symptoms are a direct result of the industrial injury in question.
PLAN: Surgery is not recommended for the **neck or back** unless he develops significant arm pain or leg pain. Recommend 12 visits of physical therapy for the cervical and lumbar spine for degenerative disc disease. He may take anti-inflammatory medications and use ice as needed. For the **right shoulder,** recommend seeing Dr. Behr or Dr. Tanaka for evaluation and treatment.
WORK STATUS: No repetitive climbing, bending, or twisting. No lifting greater than 20 pounds. Avoid prolonged neck extension or flexion postures. No overhead reaching or work with the right upper extremity. Lower extremity restrictions per Dr. Kopp.

10/05/2023 - Orthopedic Foot and Ankle Consultation, Franz Kopp, M.D., San Diego Orthopedic Associates, Page 246-248.

SUBJECTIVE COMPLAINTS: Patient was seen for follow up. Overall, he denies a change in his symptoms. He experiences ankle pain. Pain involves the entire ankle. Although the pain is exacerbated by weightbearing activity, he also experiences some ankle pain even at rest.
PHYSICAL EXAM: **Left foot/ankle:** Ambulates with a slight limp favoring the left lower extremity. Minimal swelling of ankle. Generalized tenderness about the entire ankle. Maximum tenderness over anterior medial aspect of ankle. Range of motion showed ADF to 10 degrees, APF to 40 degrees with pain. Some laxity with anterior drawer test. Breakaway type weakness associated with pain with strength testing.
ASSESSMENT: **Left ankle** sprain/strain, ankle arthrosis.
PLAN: He would like to try ankle joint injection today which may be beneficial from both a diagnostic and therapeutic standpoint.
PROCEDURE: **Left ankle** joint injection with lidocaine, Depa Medrol.
WORK STATUS: Per primary treating physician.

09/14/2023 - Orthopedic Foot and Ankle Consultation, Franz Kopp, M.D., San Diego Orthopedic Associates, Page 242-244.

SUBJECTIVE COMPLAINTS: Patient was seen for follow up. He continues to experience ankle pain. Pain involves the entire ankle. Pain is exacerbated by weight bearing activity. He also experiences pain at rest and even while sleeping.
PHYSICAL EXAM: **Left foot/ankle:** Ambulates with a slight limp favoring the left lower extremity. Mild swelling of ankle. Generalized tenderness about the entire ankle. Maximum tenderness over

anterior medial aspect of ankle. Range of motion showed ADF to 10 degrees, APF to 40 degrees with pain. Some laxity with anterior drawer test. Breakaway type weakness associated with pain with strength testing.
ASSESSMENT: **Left ankle** sprain/strain, ankle arthrosis.
PLAN: Surgery is not recommended. Recommend left ankle injection as he is noted to have some ankle arthrosis.
WORK STATUS: Per primary treating physician.

07/25/2023 - Orthopedic Foot and Ankle Consultation, Franz Kopp. M.D., San Diego Orthopedic Associates, Page 236-239/241.

DATE OF INJURY: 07/21/2022
HISTORY OF INJURY: Patient presents for evaluation of his **left ankle.** He was injured while working in July 2022. While cleaning a ceiling lamp on a ladder, the ladder slipped out from beneath him on a wet floor causing him to fall. He noted acute onset of left ankle pain followed by swelling and bruising. He also sustained numerous other injuries including an injury to the **right shoulder, left knee, neck and back.** He continues to experience pain. He experiences pain involving the **left ankle and hindfoot.** Pain involves the entire ankle and hindfoot. Although pain is exacerbated by weight bearing activity, he also experiences pain even at rest and while sleeping.
PHYSICAL EXAM: **Left foot/ankle:** Ambulates with a slight limp favoring the left lower extremity. Mild swelling of ankle. Generalized tenderness about the entire ankle, hindfoot and lesser degree to the midfoot. Maximum tenderness over anterior medial aspect of ankle. Range of motion showed ADF to 10 degrees, APF to 40 degrees with pain. Anterior drawer test is positive. Breakaway type weakness associated with pain with strength testing.
LEFT ANKLE RADIOGRAPHS: There are no acute osseous abnormalities. There is some narrowing of the medial ankle joint space on the mortise view.
LEFT FOOT RADIOGRAPHS: There is no acute osseous abnormalities.
ASSESSMENT: **Left ankle** sprain/strain.
PLAN: Ordered follow up MRI of the **left ankle.**
WORK STATUS: Per primary treating physician.

05/31/2023 - Primary Treating Physician's Progress Report, Kent Karras, D.C., Kent Karras Chiropractic, Page 44-45.

SUBJECTIVE COMPLAINTS: Patient complained of 7-8/10 **lumbar spine** pain, 6-7/10 **left knee** weakness, 7/10 **left ankle** pain, 6-7/10 **right shoulder** pain. He has headaches and cannot sleep.
PHYSICAL EXAM: **Lumbar:** Positive Kemp's. Reduced range of motion. Positive straight leg raise on the right. **Left knee:** Positive Varus, Valgus, bounce home crepitus. **Right shoulder:** Positive Speed's, Yergason's. Memory loss. Blurry vision.
ASSESSMENT: 1) Concussion. 2) **Cervical spine** sprain/strain. 3) Rule out **cervical spine** HNP. 4) **Thoracic spine** sprain/strain. 5) **Lumbar spine** sprain/strain. 6) Rule out **lumbar spine** HNP. 7) **Right shoulder** pain. 8) **Left shoulder** pain. 9) **Right knee** pain. 10) **Left knee** pain. 11) Stomach pain.
PLAN: Transfer of care to ortho. 24 visits of chiropractic completed.

WORK STATUS: Return to modified duty with seated work only, no pulling racks or reaching.

04/04/2023 - Initial Neurological Consultation Report Requesting Authorization, Thomas Schweller, M.D., Page 232-235.

DATE OF INJURY: 07/21/2022

HISTORY OF INJURY: Patient had been employed at cleaning services from 2019 until he went on light duty. He would do cleaning of kitchens and ovens and now is doing some goodwill services where he will go from lifting 50 pounds now to lifting 10 to 20 pounds. On 07/21/2022, he was on a ladder and fell approximately 11 feet, landed on his stomach and briefly lost consciousness. He injured his **left ankle, left knee, and right shoulder.** He went to Concentra.

CURRENT COMPLAINTS: He has pain all the time in the top of his head with a buzzing sensation of his head with decreased sleep. He has not had an MRI of the head. He has some nausea and vomiting occasionally in the morning. He has **right shoulder** pain and he has **left ankle** pain. He has **left knee** pain. He has **low back** pain to the **right leg.**

PHYSICAL EXAM: **Neck:** Tenderness over cervical paraspinal muscles. **Lumbar spine:** Tenderness over lumbar paraspinal muscle. **Left knee** and **left ankle** tenderness. **Right shoulder:** Tenderness over anterior shoulder with abduction to 90 degrees, flexion to 90 degrees, internal rotation to 80 degrees, external rotation to 50 degrees.

IMPRESSION: 1) Closed head injury with concussion. 2) Bilateral temporomandibular joint syndrome secondary to jaw lash. 3) **Cervical** strain. 4) **Right shoulder** pain. 5) **Left ankle** pain. 6) **Left knee** pain. 7) **Lumbar** pain.

DISCUSSION: Recommend dental evaluation for assessment of temporomandibular joint syndrome as a result of jaw lash at the time of the trauma.

03/29/2023 - Primary Treating Physician's Progress Report, Kent Karras, D.C., Kent Karras Chiropractic, Page 40-41.

SUBJECTIVE COMPLAINTS: Patient complained of 6/10 **lumbar spine** pain, 6/10 **left knee** pain, 6/10 **right ankle** pain, 6/10 **right shoulder** pain.

PHYSICAL EXAM: **Lumbar:** Positive Kemp's. Reduced range of motion. Positive straight leg raise on the right. **Left knee:** Positive Varus, Valgus, bounce home crepitus. **Right ankle:** Positive Varus, Valgus, drawer test, swelling. **Right shoulder:** Positive Speed's, Yergason's. Memory loss. Blurry vision.

ASSESSMENT: 1) Concussion. 2) **Cervical spine** sprain/strain. 3) Rule out **cervical spine** HNP. 4) **Thoracic spine** sprain/strain. 5) **Lumbar spine** sprain/strain. 6) Rule out **lumbar spine** HNP. 7) **Right shoulder** pain. 8) **Left shoulder** pain. 9) **Right knee** pain. 10) **Left knee** pain. 11) Stomach pain.

PLAN: Request physical therapy x8.

WORK STATUS: Return to modified duty with seated work only, no lifting over 10 pounds.

03/22/2023 - Treating Physician's Progress Report, Jerome Hall, M.D., Page 182-183.

SUBJECTIVE COMPLAINTS: Patient was seen for follow up.

PHYSICAL EXAM: **Lumbar spine** exam reveals tenderness guarding and painful loss of range of motion in all planes of lower extremity. X-rays taken in the office is grossly within normal limits to some mild desiccation and loss of disc height at L5-S1 otherwise extracted MRI scan lumbar spine previously performed show some disc desiccation with a small disc protrusion at L5-S1 without significant spinal stenosis or neurologic impingement.
ASSESSMENT: [Not indicated]
PLAN: There is no indication for any invasive treatments of this patient's **lumbar spine.** Dispense anti-inflammatory medication. He appears to have been reaching MMI of his **lumbar** condition as he is 6 months after his industrial injury. Continue seeing primary treating physician Dr. Kent Karas, D.C.
WORK STATUS: Per primary treating physician.

03/02/2023 to 11/22/2023 - Physical Therapy Reports, Eugielyn Montero, P.T., Therapy Resources, Page 185-231.

Attended 18 sessions of physical therapy.
03/02/2023: Patient reports he was at work on the 11th steps of the stairs while cleaning a lamp. The ladder was moving and he felt. [as stated in the report] He reports landing on his front. His **left foot** was stuck on the ladder and **ankle** was swollen and bruised. He is presently back to work and is on modified work duties. He is involved with hanging clothes working with the steamer **(neck** pain was aggravated) presently just hanging clothes. He also has referral for Neuro consult for his head concussion, pain management for cervical spine. He complains of **right shoulder** with inability to move without hurting and **low back** pain.
11/22/2022: Patient complains of sharp **neck and low back** pain radiating to **right lower extremity** when moving and resting.
DIAGNOSIS: 1) **Cervical** disc disorder with radiculopathy, unspecified cervical region. 2) Intervertebral disc disorders with radiculopathy, **lumbar** region.
TREATMENT: Therapeutic exercise, neuromuscular reeducation.

03/01/2023 - Primary Treating Physician's Progress Report, Kent Karras, D.C., Kent Karras Chiropractic, Page 36-37.

SUBJECTIVE COMPLAINTS: Patient complained of 9/10 **lumbar spine** pain, 7/10 **left knee** pain, 8/10 **right shoulder** pain. He complains of headache and cannot sleep.
PHYSICAL EXAM: **Lumbar:** Positive Kemp's. Reduced range of motion. Positive straight leg raise on the right. **Left knee:** Positive Varus, Valgus, bounce home crepitus. **Right shoulder:** Positive Speed's, Yergason's. Memory loss. Blurry vision.
ASSESSMENT: 1) Concussion. 2) **Cervical spine** sprain/strain. 3) Rule out **cervical spine** HNP. 4) **Thoracic spine** sprain/strain. 5) **Lumbar spine** sprain/strain. 6) Rule out **lumbar spine** HNP. 7) **Right shoulder** pain. 8) **Left shoulder** pain. 9) **Right knee** pain. 10) **Left knee** pain. 11) Stomach pain.
PLAN: Referred for pain management and chiro care x8. Request neuro consult for concussion.
WORK STATUS: Return to modified duty with seated work only, no pulling racks or reaching.

02/15/2023 - Primary Treating Physician's Progress Report, Kent Karras, D.C., Kent Karras Chiropractic, Page 32-33.

SUBJECTIVE COMPLAINTS: Patient complained of 9/10 **lumbar spine** pain, 7/10 **left knee** pain, 7-8/10 **right ankle** pain, 8/10 **right shoulder** pain. He complains of headache and cannot sleep.
PHYSICAL EXAM: **Lumbar:** Positive Kemp's. Reduced range of motion. Positive straight leg raise on the right. **Left knee:** Positive Varus, Valgus, bounce home crepitus. **Right ankle:** Positive Varus, Valgus, drawer test, swelling. **Right shoulder:** Positive Speed's, Yergason's. Memory loss. Blurry vision.
ASSESSMENT: 1) Concussion. 2) **Cervical spine** sprain/strain. 3) Rule out **cervical spine** HNP. 4) **Thoracic spine** sprain/strain. 5) **Lumbar spine** sprain/strain. 6) Rule out **lumbar spine** HNP. 7) **Right shoulder** pain. 8) **Left shoulder** pain. 9) **Right knee** pain. 10) **Left knee** pain. 11) Stomach pain.
PLAN: Referred for pain management and physical therapy x8. Request neuro consult for concussion.
WORK STATUS: Return to modified duty with seated work only, no pulling racks or reaching.

01/30/2023 - Treating Physician's Progress Report, Jerome Hall, M.D., Page 179-180.

SUBJECTIVE COMPLAINTS: Patient was up on a ladder about 8 or 9 feet high when the ladder slipped out from underneath him. He reports landing on his **low back.** He was taken to Paradise Valley Hospital emergency room and x-rays were done which apparently negative. He was discharged. He started being seen at Concentra. He has undergone physical therapy and acupuncture treatment for complaints of **low back** pain. He is currently seeing Dr. Kent Karas and is receiving chiropractic treatments with Dr. Karris.
PHYSICAL EXAM: **Lumbar spine** exam reveals tenderness guarding and painful loss of range of motion in all planes of lower extremity. X-rays taken in the office is grossly within normal limits to some mild desiccation and loss of disc height at L5-S1 otherwise extracted MRI scan lumbar spine previously performed show some disc desiccation with a small disc protrusion at L5-S1 without significant spinal stenosis or neurologic impingement.
ASSESSMENT: [Not indicated]
PLAN: There is no indication for any invasive treatments of this patient's **lumbar spine.** Dispense anti-inflammatory medication. He appears to have been reaching MMI of his **lumbar** condition as he is 6 months after his industrial injury. Continue seeing primary treating physician Dr. Kent Karas, D.C.
WORK STATUS: Per primary treating physician.

01/11/2023 - Primary Treating Physician's Progress Report, Kent Karras, D.C., Kent Karras Chiropractic, Page 30-31.

SUBJECTIVE COMPLAINTS: Patient complained of 6/10 **lumbar spine** pain, 6/10 **left knee** pain, 6/10 **right ankle** pain, 6/10 **right shoulder** pain.

PHYSICAL EXAM: **Lumbar:** Positive Kemp's. Reduced range of motion. Positive straight leg raise on the right. **Left knee:** Positive Varus, Valgus, bounce home crepitus. **Right ankle:** Positive Varus, Valgus, drawer test, swelling. **Right shoulder:** Positive Speed's, Yergason's.
ASSESSMENT: 1) Concussion. 2) **Cervical spine** sprain/strain. 3) Rule out **cervical spine** HNP. 4) **Thoracic spine** sprain/strain. 5) **Lumbar spine** sprain/strain. 6) Rule out **lumbar spine** HNP. 7) **Right shoulder** pain. 8) **Left shoulder** pain. 9) **Right knee** pain. 10) **Left knee** pain. 11) Stomach pain.
PLAN: Referred for chiropractic care x8.
WORK STATUS: Return to modified duty with seated work only, no lifting over 10 pounds.

12/21/2022 - Primary Treating Physician's Progress Report, Kent Karras, D.C., Kent Karras Chiropractic, Page 27-28.

SUBJECTIVE COMPLAINTS: Patient complained of 8/10 **lumbar spine** pain, 7/10 **left knee** pain, 8/10 **right ankle** pain, 7/10 **right shoulder** pain.
PHYSICAL EXAM: **Lumbar:** Positive Kemp's. Reduced range of motion. Positive straight leg raise on the right. **Left knee:** Positive Varus, Valgus, bounce home crepitus. **Right ankle:** Positive Varus, Valgus, drawer test, swelling. **Right shoulder:** Positive Speed's, Yergason's.
ASSESSMENT: 1) Concussion. 2) **Cervical spine** sprain/strain. 3) Rule out **cervical spine** HNP. 4) **Thoracic spine** sprain/strain. 5) **Lumbar spine** sprain/strain. 6) Rule out **lumbar spine** HNP. 7) **Right shoulder** pain. 8) **Left shoulder** pain. 9) **Right knee** pain. 10) **Left knee** pain. 11) Stomach pain.
PLAN: Referred for ortho consult.
WORK STATUS: Return to modified duty with seated work only, no lifting over 10 pounds.

11/07/2022 - SOAP Notes, Kent Karras, D.C., Kent Karras Chiropractic, Page 26/29/34-35/38-39/42/43/46.

Attended 34 chiropractic sessions.
11/07/2022: Patient complained of pain in **both shoulders,** headaches, **bilateral knees,** and stomach pain. He also has low back pain, and thoracic spine pain.
05/03/2023: Patient was unimproved.
DIAGNOSIS: [Not indicated]
TREATMENT: CMT, myofascial release, traction, electric muscle stimulation.

10/21/2022 - Initial Orthopedic Surgeon Evaluation, David Smith, M.D., Concentra, Page 158-172.

DATE OF INJURY: 07/21/2022
HISTORY OF INJURY: The patient is employed by Cleaning Services as a kitchen specialist. His usual and customary duties involve cleaning kitchens. On 07/21/2022, while on work duty, he was up a ladder and fell off a ladder. He sustained injuries to his **left ankle, lower back and right shoulder.** He was subsequently evaluated at Concentra Medical Clinic. X-rays were obtained of the **right shoulder, left ankle and lumbar spine** and were felt to be within normal limits. He was given anti-inflammatory and analgesic medications and physical therapy was prescribed. He

underwent MRI of the **lumbar spine** which revealed some mild degenerative changes and mild disc bulging.
SUBJECTIVE COMPLAINTS: He is complaining of **left ankle** pain and **right shoulder** pain. He has mild **lower back** pain.
PHYSICAL EXAM: **Bilateral shoulders:** There is very painful range of motion of the right shoulder. Crepitus with range of motion. Positive impingement in right shoulder. **Ankles:** Considerable tenderness to palpation diffusely over left ankle. Pain with inversion and eversion stress test to left ankle.
ASSESSMENT: 1) Moderately severe **left ankle** strain/sprain secondary to fall from ladder while on work duty, 07/21/2022. 2) **Right shoulder** strain/sprain and **lumbosacral** strain/sprain secondary to fall from ladder while on work duty 07/21/2022.
CAUSATION: It appears the patient did sustain an injury to the **right shoulder, left ankle and lumbar spine** arising out of and caused by the industrial exposure of 07/21/2022.
PLAN: MRI of the **right shoulder** is pending. Referred to Dr. Averna for his **left ankle** symptoms.
WORK STATUS: Return to modified duty with no climbing/squatting, limited standing/walking to 2 hours (cumulatively) per 8 hour shift, limited pushing/pulling up to 10 pounds, 5 minute stretch breaks every hour from prolonged weight bearing, sit down job if patient cannot tolerate weight bearing.

10/14/2022 - Primary Treating Physician's Progress Report, Hai Lam, N.P./Stephen Leibham, M.D., Concentra, Page 150-157.
SUBJECTIVE COMPLAINTS: Patient was seen for follow up. He complained of pain in the **left ankle and low back.** He has an appointment with Dr. Smith on 10/21/2022. He wants more medications for the pain. Pain is 8/10, unable to identify factors causing his increased pain. He reports being off work due to no modified duty available, unable to progress work restrictions further this week given subjective complaints of persistent pain with repetitive use. He states he is not currently open to the idea of progressing his work restrictions this week.
PHYSICAL EXAM: **Shoulders:** Range of motion is normal with pain on external rotation and abduction. Tenderness to palpation along rotator cuff and trapezius. **Left knee:** Slight antalgic gait. Positive McMurray's. **Left ankle:** Edema along lateral ankle. Gait is antalgic. Normal range of motion with pain on inversion. Tenderness to palpation along lateral ankle, sinus tarsi region. Inversion stress test is positive.
ASSESSMENT: 1) Other **low back** pain. 2) Fall from ladder. 3) Shoulder strain, left. 4) Sprain of **left ankle.** 5) Strain of **cervical** portion of both trapezius muscles.
PLAN: He reports no improvement despite being off work. He is sedentary and poorly motivated to move of exercise. MRI of lumbar spine received. MRI of shoulder scheduled for 10/27/2022. MRI showed only findings consistent with age related degenerative changes and hepatomegaly. He was given his MRI report and advised to follow up with primary care physician. He will see Dr. Smith for further evaluation and possibly P&S if MMI. No further care on primary side Occupational Medicine.
WORK STATUS: Return to modified duty with no climbing/squatting, limited standing/walking to 2 hours (cumulatively) per 8-hour shift, limited pushing/pulling up to 10 pounds, 5-minute stretch

breaks every hour from prolonged weight bearing, sit down job if patient cannot tolerate weight bearing.

10/03/2022 - Primary Treating Physician's Progress Report, Hai Lam, N.P./Stephen Leibham, M.D., Concentra, Page 139-145.

SUBJECTIVE COMPLAINTS: Patient was seen for follow up. He complained of pain in the **left ankle and knee, back and bilateral shoulder** rated 8/10 with flare ups. MRI scheduled for 10/09/2022 and 10/12/2022 at Imaging Healthcare Specialist. He reports marginal improvement, worse pain along ankle from weight bearing. He is starting his second course of physical therapy.
PHYSICAL EXAM: **Shoulders:** Range of motion is normal with pain on external rotation and abduction. Tenderness to palpation along rotator cuff and trapezius. **Left knee:** Slight antalgic gait. Positive McMurray's. **Left ankle:** Edema along lateral ankle. Gait is antalgic. Normal range of motion with pain on inversion. Tenderness to palpation along lateral ankle, sinus tarsi region. Inversion stress test is positive.
ASSESSMENT: 1) **Knee** strain, left. 2) Fall from ladder. 3) Shoulder strain, left. 4) **Shoulder** strain, right. 5) Sprain of **left ankle.** 6) Strain of **cervical** portion of both trapezius muscles. 7) **Neck** pain. 8) Other **low back** pain. 9) Acute **left ankle** pain.
PLAN: Prescribed ibuprofen 800 mg. He has no interest in returning to work in any capacity. He also has a disabled mindset. Has risk for delayed recovery. He will need orthopedist evaluation for work clearance.
WORK STATUS: Return to modified duty with no climbing/squatting, limited standing/walking to 2 hours (cumulatively) per 8 hour shift, limited pushing/pulling up to 10 pounds, 5 minute stretch breaks every hour from prolonged weight bearing, sit down job if patient cannot tolerate weight bearing.

09/23/2022 - Primary Treating Physician's Progress Report, Hai Lam, N.P./Stephen Leibham, M.D., Concentra, Page 128-134.

SUBJECTIVE COMPLAINTS: Patient was seen for follow up. He has same pain in the lower back. He states neck/shoulder/knee/ankle pain has improved. He has some "weakness" in the knee. In general, pain has improved. MRI and ortho referral pending approval. He is not working. He reports experiencing flare ups but baseline pain is described as sharp, localized, on and off, more pain with activity, less pain with cold compresses and stretches.
PHYSICAL EXAM: **Shoulders:** Range of motion is normal with pain on external rotation and abduction. Tenderness to palpation along rotator cuff and trapezius. **Left knee:** Slight antalgic gait. Positive McMurray's. **Left ankle:** Edema along lateral ankle. Gait is antalgic. Normal range of motion with pain on inversion. Tenderness to palpation along lateral ankle, sinus tarsi region. Inversion stress test is positive.
ASSESSMENT: 1) Acute **left ankle** pain. 2) **Knee** strain, left. 3) **Shoulder** strain, right. 4) Sprain of **left ankle.** 5) Strain of **cervical** portion of both trapezius muscles. 6) Other **low back** pain.
PLAN: Awaiting orthopedic evaluation. He still needs MRIs as he still complains of lingering pain that are nonspecific along the **lower back, knee and ankle.** Some improvement reported but very little/mostly the same despite being off work, undergoing acupuncture.

WORK STATUS: Return to modified duty with no climbing/squatting, limited standing/walking to 2 hours (cumulatively) per 8-hour shift, limited pushing/pulling up to 10 pounds, 5-minute stretch breaks every hour from prolonged weight bearing, sit down job if patient cannot tolerate weight bearing.

09/16/2022 - Primary Treating Physician's Progress Report, Hai Lam, N.P./Stephen Leibham, M.D., Concentra, Page 117-123.

SUBJECTIVE COMPLAINTS: Patient was seen for follow up. Pain is 9/10 in the **shoulder,** 8/10 in the **ankle,** 7/10 in the **knee.** He reports no improvement with physical therapy, now undergoing acupuncture. Awaiting MRIs and orthopedic referral.

PHYSICAL EXAM: **Shoulders:** Range of motion is normal with pain on external rotation and abduction. Tenderness to palpation along rotator cuff and trapezius. **Left knee:** Slight antalgic gait. Positive McMurray's. **Left ankle:** Edema along lateral ankle. Gait is antalgic. Normal range of motion with pain on inversion. Tenderness to palpation along lateral ankle, sinus tarsi region. Inversion stress test is positive.

ASSESSMENT: 1) Fall from ladder. 2) **Knee** strain, left. 3) **Shoulder** strain, right. 4) Sprain of **left ankle.** 5) Sprain of **left ankle.** 6) Other **low back** pain.

PLAN: Awaiting orthopedic evaluation and clearance. He reports no improvement. He will be starting acupuncture.

WORK STATUS: Return to modified duty with occasional walking, sit down job primarily.

09/14/2022 to 10/04/2022 - Acupuncture Reports, Teresa Brannigan, L.Ac./Maria Lopez, L.Ac., Concentra, Page 113-116/124-127/135-138/146-149.

Attended 6 sessions of acupuncture.

09/14/2022: Patient fell from a ladder at work from 12 feet high. He landed prone on the ground and injured **both shoulders and left ankle.** He complains of pain in both shoulders and left ankle.

10/04/2022: Patient's pain did not decrease. Doctor is sending him for a full body MRI.

DIAGNOSIS: 1) Acute **left ankle** pain. 2) **Shoulder** strain, left. 3) **Shoulder** strain, right. 4) Acute pain of **both shoulders.**

TREATMENT: Acupuncture.

09/09/2022 - Primary Treating Physician's Progress Report, Hai Lam, N.P./Stephen Leibham, M.D., Concentra, Page 91-102.

SUBJECTIVE COMPLAINTS: Reviewing injury mechanism, patient works as a janitor on 07/21/2022 at 2-3 pm his hotel manager handed him a ladder that is roughly 12 rungs and told him to climb up the ladder. This was at an indoor pool area. The reason for him to climb up the ladder was to obtain a "photo" for documentation to send to "owner," states this photo was needed to prove to the owner that someone is actually cleaning the lamp. He states he was up about 12 to 15 feet high. There was no issue at this moment. Due to wet floor, the ladder slipped off from beneath him and he fell straight down with his **left ankle** between the rung and his chest impacted the floor. He states that the **right shoulder** impacted the ground. His **left ankle** swelled and still hurts. He states that he requested an ambulance, the hotel manager did not call an ambulance. He struggles

to recall the events that occurred after this. He got up with help from the manager (after laying on the ground for 20-30 minutes). He was then moved by the manager who grabbed him by the **right upper extremity** so that he can get to his feet and limped to a couch 10 ft away. He stayed there for 10 minutes. His supervisor ("Christine") arrived on scene and helped him to the car and transported him to Paradise Valley Hospital. There he received CT scan and was eventually cleared for any fractures/major injuries. He went home for 1 month, he eventually went back to Paradise Valley ER as his employer did not give him further instructions on when/where to seek care, at which point he retained an attorney who helped coordinate further care, eventually seeking care at this facility through instruction of the carrier. He still has lingering **right shoulder** pain and **left ankle** pain and **lower back** pain. He has completed 6 physical therapy sessions. Therapist suggests he has full function with suggestion of possible malingering.
PHYSICAL EXAM: **Shoulders:** Range of motion is normal with pain on external rotation and abduction. Tenderness to palpation along rotator cuff and trapezius. **Left knee:** Slight antalgic gait. Positive McMurray's. **Left ankle:** Edema along lateral ankle. Gait is antalgic. Normal range of motion with pain on inversion. Tenderness to palpation along lateral ankle, sinus tarsi region. Inversion stress test is positive.
ASSESSMENT: 1) Fall from ladder. 2) **Knee** strain, left. 3) **Shoulder** strain, right. 4) Sprain of **left ankle.**
PLAN: Ordered **right shoulder, left ankle, and lumbar spine** MRI. Referred to ortho specialist and acupuncture. Ordered **right shoulder** x-rays.
WORK STATUS: Return to modified duty with occasional walking, sit down job primarily.

09/02/2022 - Primary Treating Physician's Progress Report, Hai Lam, N.P./Stephen Leibham, M.D., Concentra, Page 78-84.
SUBJECTIVE COMPLAINTS: Patient was seen for follow up. He is now 40 days from injury and states **right shoulder, left ankle, and lower back** are unchanged. He still has severe pain in the areas.
PHYSICAL EXAM: Normal exam.
ASSESSMENT: 1) Acute pain of both **shoulders.** 2) Acute **left ankle** pain. 3) Fell from ladder. 4) **Knee** strain, left. 5) **Shoulder** strain, left. 6) **Shoulder** strain, right. 7) **Neck** pain. 8) Other **low back** pain. 9) Pain of **knee** after injury. 10) Sprain of **left ankle.**
PLAN: Prescribed ibuprofen 800 mg. Continue therapy.
WORK STATUS: Return to modified duty with sedentary job.

08/26/2022 - Primary Treating Physician's Progress Report, Hai Lam, N.P./Stephen Leibham, M.D., Concentra, Page 64-71.
SUBJECTIVE COMPLAINTS: Patient was seen for follow up. He reports left ankle pain hurts the most, some pain along lower legs/shin and left ankle. He also complained of shoulder/arm pain/tightness. He is experiencing flare ups, but baseline pain is described as sharp, localized, rated 3-4/10, on and off. He has more pain with activity, less pain with cold compresses and stretches. Off work since the fall on 07/21/2022.

PHYSICAL EXAM: **Shoulders:** Range of motion is normal with pain on external rotation and abduction. Tenderness to palpation along rotator cuff and trapezius. **Left knee:** Antalgic gait. Positive McMurray's. **Left ankle:** Edema along lateral ankle. Gait is antalgic. Normal range of motion with pain on inversion. Tenderness to palpation along lateral ankle, sinus tarsi region. Inversion stress test is positive.
ASSESSMENT: 1) Acute pain of both **shoulders.** 2) Acute **left ankle** pain. 3) Closed head injury. 4) Fell from ladder. 5) **Knee** strain, left. 6) Sprain of **left ankle. 7) Shoulder** strain, left. 8) **Shoulder** strain, right. 9) Strain of **cervical** portion of both trapezius muscles.
PLAN: Ordered **left knee** x-rays. Continue physical therapy.
WORK STATUS: Return to modified duty with occasional walking, sit down job primarily.

08/24/2022 to 09/09/2022 - Physical Therapy Reports, Alexander Lytle, D.P.T., Concentra, Page 59-63/73-77/85-90/109-112.

Attended 6 sessions of physical therapy.
08/24/2022: Patient fell from 12 feet at work. Pain is 9/10.
09/09/2022: Patient reports feeling better overall but still has severe pain throughout his body. Pain is 8/10.
DIAGNOSIS: 1) Acute pain of **both shoulders. 2) Neck** pain. 3) Other **low back** pain. 4) Acute **left ankle** pain. 5) **Knee** strain, left. 6) **Shoulder** strain, left. 7) **Shoulder** strain right. 8) Strain of **cervical** portion of both trapezius muscles.
TREATMENT: Therapeutic activities, neuromuscular reeducation, self-care/home management training.

08/24/2022 - Doctor's First Report of Occupational Injury or Illness, Cynthia Purviance, M.D., Concentra, Page 47-57.

DATE OF INJURY: 07/21/2022
HISTORY OF INJURY: Patient states he usually works in the kitchen but was ordered to go up a straight ladder to clean a chandelier for a photo. The ladder was unstable and he fell down approximately 12 feet landing prone. He states no one assisted him or called for medical attention. He noted pain to entire body including head. Eventually, he took himself to Paradise Valley ED where he had numerous x-rays of head, **neck, shoulders, knees, back, left foot/ankle.** All negative per patient. He has been taking his sister's ibuprofen 600 mg but none x3 days - some relief. Still has pain to entire body and **left foot** with ambulation. He tried to contact his supervisor but no response. He has not worked since the date of injury.
SUBJECTIVE COMPLAINTS: He complained of **neck** pain located in the entire neck described as constant, dull, moderate with neck stiffness and shoulder pain. He complained of pain in anterior **shoulders** bilaterally and lateral shoulders described as constant, dull, moderate with decreased range of motion and neck pain. He complained of **mid and lower back** pain described as constant, dull, moderate with back stiffness and associated with insomnia. He complained of left knee pain described as constant, moderate with tenderness. He has **left ankle** pain described as constant, dull, moderate radiating to the **right foot** with foot pain, stiffness and tenderness.

PHYSICAL EXAM: **Right shoulder:** Tenderness in lateral shoulder. Diffuse pain to lateral shoulder. Full range of motion with pain. **Left knee:** Tenderness diffusely over anterolateral aspect. **Left ankle:** Tenderness in anterior lateral gutter. **Cervical spine:** Tenderness in entire cervical spine. **Thoracic spine:** Tenderness in level 9-12, subjective pain. **Lumbar spine:** Tenderness in level 1-5, subjective pain.
ASSESSMENT: 1) Fell from ladder. 2) **Neck** pain. 3) Other **low back** pain. 4) Acute pain of both **shoulders.** 5) Pain of **knee** after injury. 6) Acute **left ankle** pain. 7) Closed head injury.
PLAN: Prescribed acetaminophen ES 500 mg, naproxen 500 mg. Administered ketorolac 30 mg/ml injection. Referred for physical therapy 3x2 weeks. Ordered x-rays of the **left ankle.** Dispensed moist electric heat pad, Perform Pain Relieving Roll On, hot/cold pack.
WORK STATUS: Return to modified duty with occasional walking, sit down job primarily.

08/07/2022 - Doctor's First Report of Occupational Injury or Illness, Kent Karras, D.C., Kent Karras Chiropractic, Page 25.
DATE OF INJURY: 07/21/2022
HISTORY OF INJURY: Patient fell from a 12-foot ladder face first. He suffered from concussion.
SUBJECTIVE COMPLAINTS: He complains of 8/10 cervical spine pain, 8/10 right shoulder pain, 7/10 left shoulder pain, headaches, 8/10 thoracic spine pain, 8/10 lumbar spine pain, 7/10 bilateral knee pain.
PHYSICAL EXAM: Positive Soto Hall, Kemp's, straight leg raise bilaterally. Positive Valgus, varus right knee. Positive Yergason's, Speed's bilateral shoulders.
ASSESSMENT: [Not indicated]
PLAN: Requested 8 sessions of chiropractic therapy.
WORK STATUS: Return to modified duty with no lifting over 10 pounds, seated work only, 10 minute stretch every hour.

07/21/2022 - Emergency Room Visit, Richard Obler, M.D., Paradise Valley Hospital, Page 1-§.
SUBJECTIVE COMPLAINTS: Patient was washing windows at 3 in the morning. He works at a local hotel. He fell off a ladder. He complains of moderate throbbing pain along the **left foot** with swelling, also pain in the **left shoulder.** He hit his head and was briefly unconscious. He has pain in the **left lower leg** and **low back** has mild throbbing pain worse with movement.
PHYSICAL EXAM: He had a hard cervical collar which was removed. Mild diffuse **back** muscular tenderness. Moderate swelling and tenderness along **left ankle.** Mild tenderness along **left leg.** Mild tenderness along **left upper arm.**
ASSESSMENT: 1) **Left ankle** sprain. 2) Contusion of **left upper extremity.** 3) Contusion of **left leg. 4) Back** strain. 5) Contusion of occipital region of scalp. 6) Concussion.
PLAN: Patient was ambulatory up and down the hallway with crutches. He was prescribed baclofen 10 mg, Norco with ibuprofen for pain. Discharged home.

Additional Medical Records

03/11/2024 - Preop History and Physical. Andrew Saleh, M.D., Shelter Island Medical Group. Page 311-312.

SUBJECTIVE COMPLAINTS: Patient presents for preop clearance for right shoulder arthroscopy to be done by Dr. Christopher Behr.
SURGICAL HISTORY: Left knee arthroscopy. Nasal surgery.
PHYSICAL EXAM: Normal exam.
ASSESSMENT: Preop clearance.
PLAN: Physical exam is normal. EKG and chest x-rays are within normal limits. A1c is mildly elevated at prediabetic level. He was notified and advised to follow up with his primary care physician. Recommend routine intraoperative blood pressure monitoring. He is medically cleared for this elective surgery.

03/11/2024 - Laboratory Report. Facility not Indicated. Page 313-314.

RESULT: CMP showed high glucose at 158 mg/dL (70-99), high BUN/creatinine ratio at 28 (9-20).

07/21/2022 - Laboratory Report, Paradise Valley Hospital, Page 18-22.

RESULT: Chemistry showed high glucose at 112 mg/dL (70-110), low calcium at 8.7 mg/dL (8.8-10.5). CBC showed high neutrophils at 71.1% (40-70), low eosinophils at 0.4% (1-6).

Cover Letters

04/19/2024 - Cover Letter. Nancy Enriquez. Adjuster. CopperPoint Insurance Companies.

Thank you for scheduling the above injured employee for a QME examination on 07/24/2024 at 4:30PM. 52-year-old Janitor, hired 01/05/2022. On 07/21/22 Mr. Thompson fell from a 12' ladder while cleaning a chandelier. This was a witnessed injury where the supervisor took the injured worker (IW) for emergency treatment. Most recently IW underwent a right shoulder arthroscopic rotator cuff repair, arthroscopic extensive debridement of partial biceps tear, and arthroscopic subacromial decompression completed by Dr. Christopher T. Behr on 03/27/2024.

We request that you perform a thorough, thoughtful, and unbiased assessment, and address the specific questions asked in this referral. Please perform the evaluation in full accordance with the standards defined by the Division of Workers' Compensation (DWC) of the State of California and the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. Please complete the attached Preliminary Status, and provide it to both parties within 48 hours of this examination. The evaluation should reflect a quality independent assessment. Therefore, the history should be complete, including a report of the injury, prior status, clinical chronology, current status, and past medical history. Please compare the history provided by the examinee with the history

documented in the medical records. The physical examination should document all pertinent positive, negative, and non-physiological findings. For extremity injuries, please document measurements bilaterally. Please assess whether your physical examination findings are consistent with those of other examiners. Your conclusions must be supportable. As part of the evaluation, it is critically important that you assess the patient's percentage value of Whole Person Impairment based upon a strict application of the AMA Guides, 5th Edition. That is, you are to assess impairment using the chapter, table, examples and/or methods that most closely correspond to the diagnosis that you have established for this patient. If the Guides do not provide any such tables or methods you are to use those tables and methods that are provided that, in your opinion, can be most closely associated with the unlisted diagnosis. This process is known as "rating by analogy" and it requires you to fully set forth your reasoning as to the propriety of the association between the unlisted diagnosis and the listed conditions analogized to for rating purposes. If you find that based upon your clinical training, experience and judgment an impairment rating produced by a strict application of the AMA Guides, 5th fails to "accurately" describe the patient's level of impairment, you may be able to state another, more "accurate" level of impairment by using other chapters, tables or methods contained in the AMA Guides, 5th Edition. While this process is similar to "rating by analogy," it does not necessarily involve an unlisted condition or strict adherence to proper rating protocol, but it does require you to fully set forth your reasoning as to the propriety of the association between the diagnosis and the resulting impairment, documenting the chapters, tables and methods used to achieve such alternative impairment rating. As part of our focus on quality assurance, we routinely have ratings reviewed by other experts to assure appropriate application of the Guides and accuracy of ratings.

The following specific questions should be considered.
1) What are the current diagnoses, and which of these are associated with the referenced injury? Please discuss fully these diagnoses and their significance.
2) Are the subjective complaints supported by objective findings? Please explain the rationale for your conclusions.
3) Are there any non-physiological findings present on examination? Please explain the rationale for your conclusions.
4) Is there evidence of dysfunctional illness behavior? Please explain the rationale for your conclusions.
5) Was the injury a new problem, an aggravation or contribution to a preexisting problem, or does this reflect a temporary exacerbation? Please present your medical conclusions, to a reasonable degree of medical certainty concerning the cause, the effect, and the relationship between the cause and effect. Please explain the rationale for your conclusions.
6) What is the overall percentage of permanent disability caused by the industrial injury, and what is the percentage of permanent disability due to all other factors, including pathology and/or prior injuries?
7) What is the prognosis? What is your basis for this prognosis?
8) What is the patient's current work capacity and what is the patient's projected work capacity within the next three months? What objective findings serve as the basis for any restrictions?

9) Is the current treatment covered by the Medical Treatment Utilization Schedule (MTUS)? If necessary to relieve or cure from the effects of the injury? Please explain the rationale for your conclusions.
10) Is any of the treatment inappropriate or likely to reinforce dysfunctional illness behavior? Please explain the rationale for your conclusions.
11) Would discontinuation of any of the care currently being rendered result in a deterioration of his function? Please explain the rationale for your conclusions.
12) What further diagnostic evaluation and/or treatment are required at this time? Please explain the rationale for your conclusions.
13) Please provide any other information that you feel would be useful in understanding this case.

Diagnoses

- Cervical Spine Myofascial injury - Symptoms significantly improved
- Lumbar Spine Myofascial injury
- Right Shoulder Massive Supraspinatus/infraspinatus Rotator Cuff tears status post Right Shoulder Arthroscopy with Partial Rotator Cuff Repair, Chrisopher Behr, M.D., 03/27/2024 with advanced supraspinatus and infraspinatus rotator cuff muscle belly fatty atrophy and recurrent rotator cuff tear on postoperative shoulder MRI (Obtained at IHS on 06/12/2024)
- Left Knee Medial Joint Line pain - Possible Meniscus tear
- Left Ankle Anterior Talofibular Ligament/Deltoid Ligament Partial Thickness tears

Discussion

Mr. Thompson is a 54-year-old right-handed male janitor who stated that he was employed with Cleaning Services Inc since approximately 2018 or 2019.

He reported that on 07/21/2022, he was cleaning a light fixture while standing on 6-8-foot ladder that was leaning against the wall. He was standing on the last step on the top when the ladder started to slide down. He lost his balance and fell forwards into the ladder as it slid down the wall. His left ankle/foot was caught in between the steps, and he subsequently hit his spine against the floor. The incident was witnessed by his manager, name unrecalled, who was also recording him cleaning the light fixture. He noted immediate pain all over his body and asked the manager to help him by calling the paramedics. The manager did not know what to do and called a second manager. He was assisted to stand and was taken to a bunk in the hallway and waited for the second manager to arrive. Once the second manager arrived, he was told to get up and continue working. He reported his symptoms and asked them to call the paramedics, but they refused. Christian, another manager was called and when he arrived, he drove Mr. Thompson to the emergency room.

On that same day, Mr. Thompson sought medical care in the emergency room at Paradise Valley Hospital. He complained of pain all over his body, more localized in his cervical spine, lumbar spine, left shoulder, left knee and left ankle. He completed radiographs of his left humerus, thoracic spine, lumbar spine, left foot, right ankle, left ankle, left leg, chest, and pelvis, as well as Cervical Spine and Head/Brain CT scans. He was prescribed pain-relieving medications and provided with a pair of crutches. He was placed off work for approximately 1 or 2 weeks.

Mr. Thompson opted to retain the services of an attorney, and he was then referred for medical care at Concentra. He was initially evaluated at Concentra in the middle or end of August 2022. He complained of cervical spine, lumbar spine, bilateral shoulder, bilateral knee and left ankle/foot pain. He was recommended to have left ankle radiographs, and he was referred for physical

therapy, as well as prescribed pain-relieving and anti-inflammatory medications. He was released to return to Modified Duty, precluding him from standing, walking, lifting and carrying.

His employer was unable to accommodate his restrictions and placed him off work. He continued to be evaluated at Concentra once every 2-3 weeks and started to receive physical therapy for his cervical spine, lumbar spine, shoulders, left knee and left ankle. He completed 6-8 sessions of treatment with minimal improvement. In approximately September 2022, acupuncture was incorporated into his treatment plan. He completed 6-8 sessions of treatment, but his symptoms remained unchanged. On 10/21/2022, at the referral of his primary care physician, Mr. Thompson was evaluated by orthopaedic surgeon Dr. David Smith, MD at Concentra. Dr. Smith requested authorization to refer him for a Right Shoulder MRI and requested authorization to refer him to an ankle surgeon. he continued to be off work.

On 08/07/2022, at the referral of his attorney, Mr. Thompson care was transferred to chiropractor Dr. Kent Karras, DC. At the referral of Dr. Karras, he started to receive chiropractic treatment to his cervical spine, lumbar spine, shoulders and knees. Physical therapy, acupuncture, and chiropractic treatment provided some relief of his symptoms.

In March 2023, he was evaluated by orthopaedic surgeon Dr. Jerome Hall. Dr. Hall evaluated his cervical spine and lumbar spine. However, no treatment was recommended other than for him to continue with physical therapy and medication.

On 04/04/2023, he was initially evaluated by neurologist Dr. Thomas Schweller, MD for his headaches and TMJ issues. Dr. Schweller recommended a dental evaluation to address his mandibular pain. However, this was not authorized.

On 07/25/2023, Mr. Thompson was evaluated by foot and ankle orthopaedic surgeon Dr. Franz Kopp, MD in San Diego. Dr. Kopp requested authorization to treat his left ankle and ordered a Left Ankle MRI, which Mr. Thompson completed on 08/23/2023 and revealed abnormal results. Dr. Kopp also administered a cortisone injection to his left ankle and foot on 09/14/2023, which provided significant but temporary relief of his symptoms.

On 10/24/2023, Mr. Thompson was initially evaluated by orthopaedic spine surgeon Dr. Maneesh Bawa, MD in San Diego. Dr. Bawa considered that he was not a candidate for cervical spine or lumbar spine surgery. He recommended treatment in the form of physical therapy and medication, as well as evaluation with a shoulder orthopaedic surgeon for his right shoulder. He received chiropractic and physical therapy to his cervical spine and lumbar spine at the referral of Dr. Bawa.

On 12/15/2023, Mr. Thompson was evaluated by orthopaedic shoulder surgeon Dr. Christopher Behr, MD in San Diego. Dr. Behr recommended Bilateral Shoulder MRIs. He stated that these studies took a long time to be approved. In the meantime, he continued to receive chiropractic and physical therapy for his cervical spine and lumbar spine at the direction of Dr. Bawa.

On 02/08/2024, Mr. Thompson completed a Right Upper Extremity MRI, which revealed supraspinatus and infraspinatus tears. These studies were reviewed by Dr. Behr, who recommended right shoulder arthroscopic surgery. Mr. Thompson agreed to proceed with surgery.

On 03/27/2024, Dr. Behr performed right shoulder arthroscopy with rotator cuff repair at Mission Valley Heights Surgery Center. Mr. Thompson received postoperative physical therapy in approximately the end of April or beginning of May 2024. He received approximately 10-12 sessions of physical therapy, which improved his symptoms. However, he continues to have discomfort and restricted range of motion in his right shoulder.

Mr. Thompson is currently waiting for approval for additional acupuncture as requested by Dr. Bawa or Dr. Karras. He completed a Left Knee MRI on 07/13/2024 at the request of Dr. Kopp or Dr. Behr.

Mr. Thompson is currently not under medical treatment.

Mr. Thompson is now considered to have reached permanent and stationary status or maximum medical improvement regarding his Cervical Spine, Lumbar Spine, and Left Ankle as of the date of this Repeat Orthopaedic Surgery Qualified Medical Examination (07/24/2024).

Mr. Thompson has not yet reached permanent and stationary status or maximum medical improvement regarding his Right Shoulder and Left Knee. He requires additional medical treatment at this time.

Objective Factors of Disability

- Operative Reports of 03/27/2024 and 09/14/2023, and Head/Brain CT, Cervical Spine CT, Thoracic Spine radiographs, Lumbar Spine MRI, Lumbar Spine radiographs, Chest radiographs, Right Shoulder MRI, Right Upper Extremity MRI, Left Humerus radiographs, Pelvis radiographs, Left Leg radiographs, Left Knee radiographs, Right Ankle radiographs, Left Ankle MRI, Left Ankle radiographs, and Left Foot radiographs report findings as referenced above in the medical records section of this report
- Mild to moderate central third and right cervical paraspinal tenderness
- Decreased cervical spine range of motion in left rotation and right rotation
- Mild lower quartile central and right lumbar paraspinal tenderness with mild to moderate associated muscle spasms and guarding
- Decreased lumbar spine range of motion in left lateral bend and right lateral bend
- Lumbar spine flexion and extension reproduced low back pain.
- Trace biceps, and no triceps and brachioradialis reflexes bilaterally.
- Girth measurements (cm): Arm 30.6 right and 31.1 left. Forearm 25.9 right and 25.6 left
- Well-healed arthroscopic portals right shoulder

- Mild biceps and AC joint tenderness right shoulder
- Moderate subacromial crepitus and pain with circumduction right shoulder
- Weakness at 4+/5 in external rotation, 5-/5 in supraspinatus
- Mildly positive ABER right shoulder
- Decreased shoulder range of motion in Flexion, Abduction, and Internal Rotation right shoulder
- Girth measurements (cm): Thigh 46.3 right and 46.2 left
- No patellar and 1+ Achilles and symmetric reflexes bilaterally
- Decreased hip range of motion in internal rotation bilaterally
- Mild to moderate medial Joint Line tenderness left knee
- Decreased knee range of motion in flexion bilaterally
- Mild anterior talofibular ligament and deltoid ligament tenderness left ankle/foot

Causation

Based on the history, review of medical records, clinical examination, and current reviewed medical literature, the above-noted injuries have significant industrial components regarding causation.

Apportionment

Relevant California labor code was taken into account including sections 4663 and 4664. Pursuant to California labor code Section 4663, apportionment of permanent disability shall be based on causation. Pursuant to California labor code Section 4664, the employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment. On contemplation of apportionment, a review of Mr. Thompson's past employment and prior injuries was taken into consideration along with a review of the history, medical records, and clinical examination.

The pertinent findings with regards to the Escobedo and Benson cases were also carefully considered with regards to the apportionment of permanent disability. Care was taken to provide "substantial medical evidence" in formulating the conclusions outlined in this QME report. Decisions were made based on pertinent facts and objective data, they were not speculative, and the reasoning behind the conclusions set forth throughout this report have been appropriately explained and documented. It should also be clearly stated that all the relevant factors were taken into account during decision-making, including the above-noted history and physical examination which I performed, review of the above noted medical records, and review of relevant medical knowledge/literature/research where appropriate.

As noted elsewhere in this report, all decisions and reasoning set forth in this report were made within a reasonable degree of medical certainty. All of the relevant factors were carefully considered based upon the above noted objective data in combination with sound medical reasoning and evaluation.

Upon contemplation of apportionment of the Cervical Spine, Lumbar Spine, Right Shoulder, Left Knee, and Left Ankle, the following factors were at play:

- History of acute injury
- Mechanism of injury that is consistent with the above-noted orthopaedic diagnoses and physical examination findings referenced above
- History correlates reasonably well with the medical records reviewed above
- Timely reporting of the injury
- No prior nonindustrial injury
- History of Prior Industrial Injury:
  - Left Knee, 30 years ago, White House Moody's
    Mr. Thompson filed a workers' compensation claim for a Left Knee injury while employed by White House Moody's as a maintenance worker/janitor. He was cleaning while standing on a slippery slope when he slipped on oil and twisted his left knee. He received treatment in the form of physical therapy and medication. He ultimately underwent left knee arthroscopy, and he received a course of post-operative physical therapy. He reported that the treatment and surgery were beneficial, and he was ultimately able to return to work. He hired an attorney and received a settlement. He reported a full recovery. He stated that he was essentially asymptomatic with minimal left knee pain at the time of the above-noted injury sustained on 07/21/2022 while working for Cleaning Services, Inc.
- Prior Orthopaedic surgery:
  - Left knee arthroscopy, 30 years ago
  - Right shoulder arthroscopy with rotator cuff repair, 03/27/2024
- 5+ decades of routine wear and tear on a nonindustrial basis over the course of time/Natural progression of pre-existing degenerative process/disease at play on a nonindustrial basis
- BMI is 27.5

- **Cervical Spine: 75% Current Industrial Claim (DOI 07/21/2022), 25% Nonindustrial Etiology**
- **Lumbar Spine: 75% Current Industrial Claim (DOI 07/21/2022), 25% Nonindustrial Etiology**
- **Right Shoulder: 70% Current Industrial Claim (DOI 07/21/2022), 30% Nonindustrial Etiology**
- **Left Knee: 40% Current Industrial Claim (DOI 07/21/2022), 40% Prior Industrial Claim (DOI approximately 30 years ago per the applicant), 20% Nonindustrial Etiology**
- **Left Ankle: 100% Current Industrial Claim (DOI 07/21/2022)**
  Upon contemplation of apportionment of Mr. Thompson's Cervical Spine and Lumbar Spine, he sustained an injury while working on 07/21/2022 in which he lost his balance on a 6-8 foot ladder and fell forwards as the latter slid down the wall. His left lower extremity was caught in between the steps of the latter, and he ultimately hit his cervical and lumbar spine

on the floor during the landing. This is a mechanism of injury that is compatible with the above-noted subjective complaints, objective findings, and orthopaedic diagnoses regarding his cervical spine and lumbar spine referenced above. On the other hand, there is also nonindustrial etiology play with regards to his cervical spine and lumbar spine, including 5+ decades of degenerative changes/routine wear and tear to consider on a nonindustrial basis. After carefully weighing all of the relevant factors, apportionment to the cervical spine and lumbar spine are both 75% to the current industrial claim, and 25% to nonindustrial etiology to within a reasonable degree of medical certainty for the reasons referenced above.

Regarding his Right Shoulder, he sustained an injury on 07/21/2022 in which he fell onto his right shoulder while falling onto the ground from a ladder. He could not recall the precise mechanism of injury as the event happened rapidly, although he could not lift his shoulder overhead and he had severe shoulder pain following the 07/21/2022 fall. He reported no significant shoulder pain or limited range of motion prior to the above-noted wall. This is a mechanism of injury that is compatible with the above-noted subjective complaints, objective findings, and right shoulder orthopaedic diagnoses. There are also nonindustrial factors at play with regards to the right shoulder, including 5+ decades of degenerative change/routine wear and tear to consider on a nonindustrial basis. After carefully weighing all of the relevant factors, apportionment to the right shoulder is 70% to the current industrial claim dated 07/21/2022 and 30% to nonindustrial etiology to within a reasonable degree of medical certainty for the reasons cited above.

Regarding his Left Knee, he reported prior industrial claim involving his left knee 30 years ago, which ultimately required left knee arthroscopy. The above-noted mechanism of injury is well described in which is left lower extremity was caught between the steps of the latter during the fall sustained on 07/21/2022. There is evidence of industrial injury to the left knee secondary to the 07/21/2022 injury as well as the prior industrial injury sustained 30 years ago. There is also evidence of nonindustrial etiology play including 5+ decades of degenerative changes/routine wear and tear to consider on a nonindustrial basis. After carefully weighing all of the relevant factors, apportionment to the left knee is 40% to the current industrial claim dated 07/21/2022, 40% of the prior industrial claim of approximately 30 years ago, and 20% to nonindustrial etiology to within a reasonable degree of medical certainty for the reasons cited above.

Regarding his Left Ankle, he had no prior pain or difficulties before the above-noted industrial accident sustained on 07/21/2022. The mechanism of injury is well described above. He reported no left ankle pain or prior industrial injuries to the left ankle before the above-noted industrial injury sustained on 07/21/2022. After carefully weighing all of the relevant factors, apportionment to left ankle is 100% to the current industrial claim dated 07/21/2022 to within a reasonable degree of medical certainty for the reasons referenced above.

Impairment per AMA Guides 5th Edition

Mr. Thompson is not considered to have reached maximum medical improvement and is not deemed to be medically permanent and stationary for rating purposes regarding his Right Shoulder and Left Knee. However, as a courtesy to the parties, whole person impairment will be rated at this time.

Mr. Thompson is now considered to have reached maximum medical improvement and is now deemed to be medically permanent and stationary for rating purposes regarding his Cervical Spine, Lumbar Spine, and Left Ankle.

Almaraz/Guzman analysis was performed, and the most relevant sections of the AMA guides 5th edition were appropriately chosen to address whole person impairment. Care was taken to thoughtfully and thoroughly review the AMA guides prior to selection of the appropriate portions of the guides that most accurately addressed the pathology present in this particular case.

Upon review of chapter 18 as well as the details of this case, "pain add-on" was not necessary or appropriate in this instance. Within a reasonable degree of medical certainty, the impairment as rated below by the AMA guides 5th edition adequately and appropriately addressed permanent impairment in this particular case.

- **Cervical Spine: No Whole Person Impairment**
  There is no whole person impairment regarding the cervical spine according to the AMA guides 5th edition.

- **Lumbar Spine: 5% Whole Person Impairment**
  Permanent impairment with regards to the lumbar spine is most accurately rated using the DRE method in this case. There is a history of muscle spasm/guarding, loss of range of motion and non-verifiable radicular complaints with presumed evidence of posterior disc herniation with foraminal stenosis places him firmly in the lowest end of lumbar spine DRE category II. Based upon the above noted symptoms and activity limitations including ADLs, the applicant is most accurately rated at 5% whole person impairment (Table 15-3, page 384) after carefully weighing all of the relevant factors.

- **Right Shoulder: 8% Whole Person Impairment**
  After carefully weighing all the relevant factors in this case, permanent impairment is most accurately rated in accordance with the AMA guides 5th edition via both the Range of Motion method and Postsurgical Status. Via the Range of Motion method, his impairment is as follows:
  - Loss of forward flexion: 1% upper extremity impairment (Figure 16-40, page 476)

- Loss of abduction: 1% upper extremity impairment (Figure 16-43, page 477)
- Loss of internal rotation: 2% upper extremity impairment (Figure 16-46, page 479)
- Total upper extremity impairment due to loss of range of motion: 4% upper extremity impairment

The applicant is status post shoulder surgery per above. Permanent impairment given the above noted pathology and postsurgical status is most accurately rated in the guides as 10% upper extremity impairment (Table 16-27, page 506).

Using the combined values chart (Page 604), 4% upper extremity impairment (UEI) combines with 10% UEI for a total of 14% UEI. 14% upper extremity impairment converts to 8% whole person impairment (Table 16-3, page 439).

- **Left Knee: No Whole Person Impairment**
  There is no whole person impairment regarding the left knee according to the AMA guides 5th edition.

- **Left Ankle: No Whole Person Impairment**
  There is no whole person impairment regarding the left ankle according to the AMA guides 5th edition.

Periods of Disability

All periods of disability were appropriate to date.

I also find all periods of total temporary disability were appropriate.

Treatment/Recommendations

Past medical treatment was reasonable and appropriate.

My opinion may change based on receipt of additional medical records (Left Knee MRI completed in Chula Vista at Imaging Healthcare Specialists) that the applicant advised of during the evaluation but were not included in advance with records received. An Orthopaedic Surgery QME Supplemental Report will be issued upon formal receipt and requested review of the above referenced medical records.

Work Restrictions/Vocational Rehabilitation

Mr. Thompson is currently not working. He is Off Work/Temporary Total Disability at this time per his primary treating physician, orthopaedic surgeon Dr. Christopher Behr. Work status can be advanced as per Dr. Behr's recommendations as he continues to recover status post right shoulder arthroscopy.

He has the same employer.

He is not able to engage in his previous occupation.

He is a Supplemental Job Displacement Voucher candidate if his employer cannot accommodate the above-noted work restrictions.

Future Medical Treatment

Future medical treatment that is indicated at this time:

- Continue Follow-Up Visits with Dr. Behr (primary treating physician orthopaedic surgeon)

Future medical treatment that may be required in the future for flareups/aggravation of the above noted diagnoses/conditions:

- Future Orthopaedic Surgery/Occupational Medicine Follow-Up Visits as needed
- Physical Therapy (up to 2X/week x 6 weeks) with a supervised home exercise program
- Right Shoulder Reverse Total Shoulder Arthroplasty (as a last resort moving forward with no conservative treatment measures have been exhausted. This surgery carries with it significant limitations. As such, it would be ideal to delay reverse total shoulder arthroplasty surgery until he is closer to age 70).

Summary

- **Mr. Thompson has not yet reached permanent and stationary status** or maximum medical improvement **regarding his Right Shoulder and Left Knee. He requires additional medical treatment at this time.**

- **Orthopaedic Surgery QME Supplemental Report** will be required after review of the **Left Knee MRI** in order to verify important decision-making that has been preliminarily outlined in this report.

- **Repeat Orthopaedic Surgery Qualified Medical Evaluation** will be required after **continued Follow-Up Visits with Dr. Behr** have been completed in order to declare him to be medically permanent and stationary (Estimated time to complete the required additional medical treatment prior to achieving medically permanent and stationary status with regards to the above-noted body parts will be in approximately 4-6 months, or once he is 8+ months status post right shoulder arthroscopy).

Disclosure Statement

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 record, 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 record which was initially outlined/excerpted by Stella Corpuz, all additional inquiries and examinations were necessary and appropriate to identify and determine the relevant medical issues were conducted. The history was obtained by historian, Karla Velazquez, from the Applicant, which I reviewed with him during the examination. A medical assistant, Ben Charles, was present during the exam. The report was transcribed by Haicy Ong.

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.

This report and my opinions are based on reasonable medical probability, from the perspective of available documentation and information submitted to this evaluator.

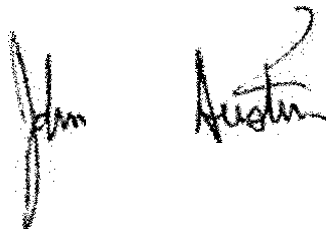
I declare under penalty of perjury that I did not discriminate in any way against the parties to the action or the injured worker in the evaluation process or in the content of the report.

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 07/30/2024, regarding this Orthopaedic Surgery Qualified Medical Examination performed in National City, California, County of San Diego.

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.

Sincerely,



John C. Austin, M.D.
Diplomate, American Board of Orthopaedic Surgeons
American Academy of Orthopaedic Surgeons, Member
Arthroscopy Association of North America, Member
State of California Qualified Medical Evaluator

cc:

- Attorney for Defense
  Pacific Comp Lit
  PO Box 5044
  Thousand Oaks, CA 91359

- Attorney for Applicant
  Rios Law Firm
  Manuel Rios, Esq.
  81894 Avenida Alcalde
  Indio, CA 92203

- Pacific Compensation Insurance Company
  Nancy Enriquez
  PO Box 36070
  Phoenix, AZ 85067

Physician's Retum••to•Work & Voucher Report

FOR INJURIES OCCURRING ON OR AFTER 1/1/13

☐ The Employee Is P&S from all conditions and ttie ir1iury has ca1.11ed **pe,manent** par1ial disability

E1nployee tast **Name**: **Thompson**

Employee First N•me: Mark

Ml

Date of 1n,ury: 07/24/2024

Claim Administrator: PACU:IC COMPhNSArlON INSlIRAN('F COMP,.\NY

Claims Rep(esentative: NAN.CY :NRIQtJEZ

Employer Name: CLEANING SERVICES INC

Employer Street Addre!&: 9609 *N* 22ND AVE

Employer City: PHOENIX

State: AZ

ZlpCOCle: 85021

Claim No: 1000053431

C The Employee can return to regular **worlt**

C The Employee can work with the following restnd1ons

	hOIKS' 1"2	2•<4	•·6	6-8	Non
$1a1Jdlng	0	C	0	0	0
W.lcing	0	0	C	0	a
Sitttng	0	C	C	C	c
Cl#'nbin	C	0	0	0	
Forward BencMg	0	0	0	0	
KnHlit)fl	C	C	0	Cl	0
Crawfing	0	0	C	0	0
TIIMIJ/'Jg	0	C	0	0	o;
Keyboert:trfg	0	0	0	0	0
RILJ811at Haod(SJ (arde) *Graspmg*	C	0	0	C	Ci
R/lJ8llat H8fld(s) (Ofdef *Pu$11/ftgl* ***Pulling***	C	0	0	C	C
Otr,e,: _____ (See belowt	C	C	C	O	0

Lift/Carry Restrictions May not lift/carry at a height of more than lbi. for morl! than _____ hours J)t'r day..

Describe in what ways the Imp.aired **activities are** limited:

O•k- to uJ *rir* YT f D- &Jv··

If a Job O.scnpt,on 1W been proVKJed, pltlsH comp¥ttt· OReQular D *Modified* ☐ *Alternative Work*

Job Title *Worl< LoeabOn.*

Are *the* MN1(***capacititls and ectMty restrictions*** compatible with the ***physical*** *requirements* set forth in the provided 100 de.scrtptJon? 0 Yes O*No, **expt.1n** beA:>w*

Phy&ici1n'1 Name: JOHN C AUSTIN, M D

RoJ& of Doctor (PTP, OME, AME) *g* -·

Physician's Signature: John C Austin

Date: 07/24/2024

OW:; AO Fom, 1013.3.36 {SJDB) Elf 111114

Form **W-9**
[Rev. March 2024]
Department of the Treasury
Internal Revenue

Request for Taxpayer Identification Number and Certification

Goto 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.

1 Name of **entity/individual, An entry** is **required. (For a sole proprietor** or **disregarded entity, enter** the **owner's name** on ltne **1,** and **enter the business/disregarded** entity's **name on line 2.)**

United Medical Evaluators LLC

2 Business name/disregarded **entity** name, **if different from above.**

3a Check the appropriate box **for federal** tax **classification of** the **entity/lnctiv1dual whose** name 1s **entered** on **line 1.** Check **only one** of **the** following seven boxes.

D Individual/safe **proprietor** D **C corpora11on** D S corporation D **Partnership** D **TrusVestate**

0 LLC. Enter the **tax** classification **(C** = **C corporation,** S = S **corporation,** P = Partnership) **S**

Note: Check **the "LLC"** box **above and, in the entry space, enter the** appropriate code **(C, S, or Pi for the tax** classification of **the LLC,** unless **it** 1 a **disregarded entity. A disregarded entity should instead check the** appropriate box **for** the tax classification of **its owner.**

☐ Other (see **instructions)**

4 Exemptions (codes **apply only** to **certain entities,** not **individuals;** see **instructions on** page 3):

Exempt payee **code** (if **any)**

Exemption from Foreign Account Tax **Compliance** Act **(FATCA)** reporting **code (if any)**

3b ff on **lrne** 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 ha>Je an ownership interes1.** check this box **if you** have **any foreign partners, owners, or beneficiaries. See instructions** ☐

***(Applies to** accounts maintained **outside** the United States.)*

5 Address (number. street, and apt or suite no.). **See** instructions.
910 PLEASANT GROVE BLVD SUITE 120-232

Reques1er's name and address (optional)

6 City, state, and ZIP code
ROSEVILLE, CA 95678

7 List account number(s) here (optional)

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 entitles, 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 instructions for 1 See also *What Name* and *Number To* Give *the Requester* for guidelines on whose number to enter.

Social security number
DJJ-[D-1 | | | |

or

Employer identification number
8 6 – 2 2 9 5 3 6 6

Part II Certification

Under penalties of perjury, I certify that:

1. 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
2. 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 1 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
3. I am a U.S. citizen or other U.S. person {defined below); and
4. 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

Date 1/9/2024

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 !low-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 *1t* has an **ownership** interest This change **Is** intended lo **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 informallcm return **with** the IRS 1s **giving** you this form **because they**

RECEIVED
By Laura at 2:29 pm, Jun 17, 2024

CopperPoint@
Insurance Companies

Pacific Compensation Insurance Company

04/19/2024

Dr. John Austin
3142 East Plaza Dr., Unit T
National City, CA 91950

EMPLOYEE: **Mark Thompson.**
POLICYHOLDER: **Cleaning Services Inc** **etal**
CLAIM NUMBER: **1000053431**
DATE OF INJURY: **07/21/2022**

Dear Dr. Dr. John Austin:

Thank you for scheduling the above injured employee for a QME examination on **07/24/2024 at 4:30PM.**

52-year-old Janitor, hired 01/05/22. On 07/21/22 Mr. Thompson fell from a 12[1] ladder while cleaning a chandelier. This was a witnessed injury where the supervisor took the injured worker (IW) for emergency treatment.

Most recently IW underwent a right shoulder arthroscopic rotator cuff repair, arthroscopic extensive debridement of partial biceps tear, and arthroscopic subacromial decompression completed by Dr. Christopher T. Behr on 03/27/24.

We request that you perform a thorough, thoughtful, and unbiased assessment, and address the specific questions asked in this referral. Please perform the evaluation in full accordance with the standards defined by the Division of Workers' Compensation (DWC) of the State of California and the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition.

Please complete the attached Preliminary Status, and provide it to both parties within 48 hours of this examination.

The evaluation should reflect a quality independent assessment. Therefore, the history should be complete, including a report of the injury, prior status, clinical chronology, current status, and past medical history.

Please compare the history provided by the examinee with the history documented in the medical records. The physical examination should document all pertinent positive, negative, and non-physiological findings.

For extremity injuries, please document measurements bilaterally. Please assess whether your

physical examination findings are consistent with those of other examiners. Your conclusions must be supportable.

As part of the evaluation, it is critically important that you assess the patient's percentage value of Whole Person Impairment based upon a strict application of the AMA Guides, 5th Edition. That is, you are to assess impairment using the chapter, table, examples and/or methods that most closely correspond to the diagnosis that you have established for this patient. If the Guides do not provide any such tables or methods you are to use those tables and methods that are provided that, in your opinion, can be most closely associated with the unlisted diagnosis. This process is knows as "rating by analogy" and it requires you to fully set forth your reasoning as to the propriety of the association between the unlisted diagnosis and the listed conditions analogized to for rating purposes.

If you find that based upon your clinical training, experience and judgment an impairment rating produced by a strict application of the AMA Guides, 5th fails to "accurately" describe the patient's level of impairment, you may be able to state another, more "accurate[1] level of impairment by using other chapters, tables or methods contained in the AMA Guides, 5th Edition. While this process is similar to "rating by analogy," it does not necessarily involve an unlisted condition or strict adherence to proper rating protocol, but it does require you to fully set forth your reasoning as to the propriety of the association between the diagnosis and the resulting impairment, documenting the chapters, tables and methods used to achieve such alternative impairment rating.

As part of our focus on quality assurance, we routinely have ratings reviewed by other experts to assure appropriate application of the Guides and accuracy of ratings.

The following specific questions should be considered. [PLACE NUMBERS HERE]

1) What are the current diagnoses, and which of these are associated with the referenced injury? Please discuss fully these diagnoses and their significance.

2) Are the subjective complaints supported by objective findings? Please explain the rationale for your conclusions.

3) Are there any non-physiological findings present on examination? Please explain the rationale for your conclusions.

4) Is there evidence of dysfunctional illness behavior? Please explain the rationale for your conclusions.

5) Was the injury a new problem, an aggravation or contribution to a preexisting problem, or does this reflect a temporary exacerbation? Please present your medical conclusions, to a reasonable degree of medical certainty concerning the cause, the effect, and the relationship between the cause and effect. Please explain the rationale for your conclusions.

6) What is the overall percentage of permanent disability caused by the industrial injury, and what is the percentage of permanent disability due to all other factors, including pathology and/ or prior injuries?

7) What is the prognosis? What is your basis for this prognosis?

8) What is the patient[1]s current work capacity and what is the patient's projected work capacity within the next three months? What objective findings serve as the basis for any restrictions?

9) Is the current treatment covered by the Medical Treatment Utilization Schedule (MTUS)? If

so, is it consistent with the MTUS? If not covered by the MTUS, is the treatment reasonable or necessary to relieve or cure from the effects of the injury? Please explain the rationale for your conclusions.

Regulations for the Medical Treatment Utitization Schedule can be found at: **http://www.dir.ca.gov/DWC/DWCPropRegs/MedicalTreatmentUtilizationSchedule/MTUS_regulations.htm**

10) Is any of the treatment inappropriate or likely to reinforce dysfunctional illness behavior? Please explain the rationale for your conclusions.

11) Would discontinuation of any of the care currently being rendered result in a deterioration of his function? Please explain the rationale for your conclusions.

12) What further diagnostic evaluation and/or treatment are required at this time? Please explain the rationale for your conclusions.

13) Ple se provide any other information that you feel would be useful in understanding this case.

Thank you.

Sincerely,

Nancy Enriquez
Adjuster II
(818) 575-2757

Rios Law Firm
81894 Avenida Alcalde
Indio CA 92203

Declaration Pursuant to Title 8, California Code of Regulations § 9793(n)

I, the undersigned, declare under penalty of perjury that I have complied with the provisions of Labor Code section 4062.3 before providing the documents enclosed to the physician. Furthermore, I attest the total page count of the documents provided is 339

Injured Worker Mark Thompson

Claim 1000053431

Date of Injury **7/21/22**

Cathy Brewer

Insured: Cleaning Services

Signed: ____ Cathy Brewer____ _

County: _____Los Angeles__ _

Dated: 6/13/24